

**Investigation into the circumstances surrounding the death of
a man at HMP Winchester on 27 October 2004**

Report by the Prisons and Probation Ombudsman for England and Wales

June 2005

This is the report of an investigation into the circumstances of the death of a man at HM Prison Winchester on 27 October 2004. He died from a heart attack almost certainly brought on from sudden exercise.

I extend my sincere condolences to the man's family and friends for their loss.

I would like to thank the Governor at Winchester Prison at the time of our investigation. I would also like to thank the members of her staff who assisted us, in particular the then head of healthcare.

This was the first time the man had been in prison; it was as a result of his first offence. He was a quiet man who did not like to make a fuss, and was looking forward to his release.

The man's heart attack could not have been predicted. However, the symptoms he presented were not correctly identified. Whilst it is impossible to know whether his death could have been prevented, I believe he should have been transferred to a hospital outside of prison. This would have given him the greatest chance of survival. I have taken advice from the clinical reviewer. Having done so, I have concluded that the Prison Service should consider whether the circumstances are such that disciplinary action be taken in respect of the action of two members of staff, or whether further training is required.

I have also criticised aspects of the prison's family liaison. The man's widow has not been treated respectfully.

I make 10 recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The man was sentenced to four months in prison on 8 October 2004. This was as a result of his first offence and was his first time in prison. He was a quiet man, who wanted his sentence to pass quickly. It was said he did not like to make a fuss.

The man shared a cell with his co-defendant. He worked in workshops and spent a lot of time in the Chapel.

On 27 October, the man visited the gym. He had not exercised properly for 15 years. After a while, the man started feeling unwell. He showered and returned to the wing. Here, he experienced chest pain, and tingling in his left hand. The man's cellmate and a wing officer were concerned and called healthcare; convinced he was having a heart attack. The Healthcare Officer (HCO) did not feel that the man had all the symptoms of a heart attack, and felt that the man might have strained a muscle.

A second HCO visited the man a short while later. His pulse and blood pressure had increased. The man was taken to the healthcare centre for observation at about 8.30pm. However, the man was not checked on until approximately 9.55pm, at which point he had lost consciousness. Despite resuscitation efforts, he was pronounced dead at 10.15pm.

I conclude that several errors of judgement were made by healthcare staff. The first HCO did not recognise that the man was suffering a heart attack. The second HCO did not consult a doctor or paramedic when it was found that the man's blood pressure and pulse had risen significantly in a short period of time. Two nurses did not carry out their own assessments of the man and accepted the HCO's diagnosis. Furthermore, the man was not transferred to outside hospital even though regular checks could not be made on his condition.

Aspects of family liaison by the prison have also caused me concern. The man's wife has never received a letter of condolence and, at the time of writing, has not received the man's possessions.

Investigation process

My investigator, Ms Thea Walton, visited Winchester accompanied by an Independent Clinical Reviewer employed by my office, Ms Tracey Campbell. They met with the then head of healthcare. They were able to visit the cell where the man had died and the wing where he had lived. They also visited the gym and spoke to gym staff.

Ms Walton and Ms Campbell issued notices to staff and prisoners informing them of the investigation and inviting comment.

Ms Walton offered to meet with representatives from the Independent Monitoring Board (IMB) and the Prison Officers' Association (POA).

Access to the man's prison records, including his medical records, were readily provided to the investigation. The Coroner also provided Ms Walton with the post mortem report and statements from the police.

Following the initial visit, Ms Campbell interviewed two nurses and two healthcare officers. She took notes of the interviews and sent them to the relevant staff to sign and return.

Ms Walton spoke with the man's cellmate at Winchester. Ms Walton also returned to Winchester with another investigator, Mr David Cameron, in order to speak further to staff and formally interview one of the officers.

One of my family liaison officers, Ms Lucy Phelan, contacted the man's wife. Ms Phelan and Ms Walton went to visit the man's wife to discuss the investigation. The man's wife was concerned about the level of healthcare her husband had received. Ms Phelan kept her updated on the investigation and report.

Background

The man was born on 1 September 1958 in Maltby, where he was raised by his parents with his sister and stepbrother. The man had two children, and had been married to his current wife for seven years.

The man had 28 years experience working with heavy goods vehicles. He worked hard and long hours. His pre sentence report refers to references from employers being exceptional, commenting on his loyalty and hard work. The man committed his first and only offence in 2002. He volunteered information to the police and was remorseful for his involvement in the crime. During the two years before the man was sentenced, he found it progressively stressful. He suffered anxiety attacks and was depressed. His doctor had prescribed antidepressants.

The pre sentence report that was prepared for him notes: *“(The man) seems genuinely fearful of a custodial sentence...I have grave concerns that he would not recover from such a sentence. His health has clearly declined since the offence and I doubt that mentally he could cope in a custodial setting”*. The report goes on to recommend a Community Punishment and Rehabilitation Order.

The man was sentenced to four months imprisonment and taken to Winchester prison on 8 October 2004.

The events leading up to the man's death

The man arrived at Winchester prison on 8 October. He underwent an initial healthcare reception screening conducted by a nurse where it was identified that he had suffered depression and was on antidepressants. The man did not disclose that he had recently suffered an anxiety attack for which he had had to attend hospital. The following day, the man saw the medical officer. It was noted that his general health was good, and he was described as stout and strong. The doctor prescribed the man his antidepressants, and some other medication for a continuing minor medical problem. The man later decided he wanted to try not taking the antidepressants, and the medical officer agreed.

Over the next two weeks, the man was described by staff as quiet. He spent a lot of time at the Chapel and was employed in a workshop with his cellmate, who was also his co defendant and whom he had known through work for a couple of years. Over this period of time, staff were working towards transferring the man to a prison closer to his home, and the possibility of his being released on a Home Detention Curfew.

On 27 October, the man had gone to work with his cellmate. That evening they went to the gym at about 6.15pm. The man had not been to the gym for about 15 years. The cellmate reported that the man had been working out for about 20 minutes when he started to feel unwell. The man stopped exercising and went to have a shower. After the class had finished they walked back to the wing together. The cellmate said that the man told him he was in pain and felt dizzy, and asked him to stay with him to *"keep an eye on him"* until they got back to the wing.

When they returned to their cell, the man was feeling cold so the cellmate put some blankets over him. The cellmate reported that the man was obviously in pain. He was groaning and bending over, and is reported to have said, *"I think I am having a heart attack or stroke or something"*, so the cellmate alerted an officer.

The officer who attended reported that she remembered the evening clearly. They had been short staffed on the wing and had borrowed an officer from another wing. It was approximately 6.45pm to 7pm when the prisoners who had been at gym came back and she noticed that the man looked unwell. Shortly after, the man's cellmate approached her and asked her to come and see the man. She went to his cell, where the man told her he had been to the gym and was feeling very cold and tired. The officer asked the cellmate to close the window and tried to make the man feel more comfortable. The man told her that he had pains in his chest, arm and hand. The officer reported that she was very concerned and thought the man was having a heart attack. She left the cell and spoke to the senior officer on the wing, who radioed healthcare for assistance, and she then returned to the man's cell. The cellmate fetched a drink of water, and they tried to keep him comfortable and calm. At this point, the officer noticed the man was having some involuntary

face movement. She was worried as to what this might be, and went out to the senior officer who reassured her that healthcare staff were on their way.

The first HCO arrived at the man's cell at about 7.15pm. The first HCO said that the man was complaining of chest pain and tingling in his left hand. He was not short of breath; he had good colour and complexion and was not cold or clammy. The first HCO took his blood pressure and pulse. The man's pulse was strong and regular at 66 beats per minute, and his blood pressure was 117/86, which is not worryingly high.

The man told the first HCO that he had been performing bench presses in the gym, and had not previously exercised in about 15 years. He had also been feeling anxious about waiting for a transfer and it was his wife's birthday. He reported that he had not been sleeping well. The man stood up, and walked around the cell. When he did this, the pain worsened, so the first HCO asked the man to stay resting. The first HCO decided that the pain was most likely to be muscular or nerve related.

The man had requested pain relief so the first HCO went to the treatment room to collect some Ibuprofen. Whilst there, he telephoned the nurse based on reception to check his decision. She agreed that the first HCO had made the correct decision.

In interview, the nurse based on reception said she had received the call from the first HCO at a time when she was very busy. She recalled the first HCO saying that the man was suffering from muscular pain having overdone it at the gym, and had a bit of chest pain. She agreed she would review the man later before the shift was over.

The prison officer was very concerned about the man and told the investigation that she specifically asked the first HCO if he was sure that it was not a heart attack. She said that the man was quite calm, but obviously in a great deal of pain.

The man wanted to phone his wife, as it was her birthday. The officer said he could use the office phone. This meant he could sit down. Whilst there, a second HCO came to the wing to check how the man was feeling. It was about 8.10pm when he arrived at the wing. The second HCO noted that the man was not breathless, but he was still complaining of pain in his left arm. The second HCO retook his observations. The man's pulse had risen to 100 beats per minute and his blood pressure had reached 150/100. The second HCO decided that, due to this change in his observations, the man should be admitted to the healthcare centre. The man was reluctant to go, but collected some things from his cell and walked to healthcare unaided.

At about 8.30pm, the man and the second HCO arrived at the healthcare centre. The second HCO said that he verbally handed over to the nurse based in healthcare, and suggested hourly observations. The nurse based on reception was also present and agreed on this course of action. However,

she commented in her interview that it is difficult to conduct observations at night because they do not hold keys, so it is up to the discretion of the nurses.

The nurse based in the healthcare centre said she received a verbal handover before the other staff went off duty. Although she could not remember exactly what was said, she recalled that the man's main problem was thought to be anxiety and he had been brought over to the healthcare centre as a precaution. The nurse based in the healthcare centre then wrote the care plans for patients in healthcare. She had identified the problem as being chest pain associated with raised blood pressure following a gym session. The short-term goal was to exclude a cardiac cause, although it is not documented how this would be achieved, and to eliminate chest pain. Interventions were documented as giving medication as prescribed, give analgesia, monitor vital signs as required, and refer to hospital as necessary.

The man was sharing a cell in the healthcare centre. In his police statement, the man's healthcare cellmate reports that the man came into his cell around 9pm. The man told him he had pains in his arm and he thought he had overdone it in the gym. The man was unable to make his own bed so the healthcare cellmate helped him, and they spoke for a short while. The healthcare cellmate reported that after a while the man started to breathe heavily. Thinking that he was trying to sleep, he stopped talking and started reading his book.

The nurse based in the healthcare centre started her drug round between 9.30 and 9.45pm. She approached the cell the man was in at approximately 9.55pm to give the healthcare cellmate his medication. The nurse based in the healthcare centre saw that the man's hands looked waxy and was concerned. She asked the healthcare cellmate to shake the man's shoulders, and when he did the man was lifeless. The healthcare cellmate then checked for a pulse and could not feel one. The nurse based in the healthcare centre called for the Night Orderly Officer. Once he had arrived, they entered the cell.

The nurse based in the healthcare centre commenced CPR until the paramedics arrived but to no avail. The man was pronounced dead at 10.15pm.

All contingency plans were followed. Officers broke the news to the man's cellmate the following morning. They were supportive and compassionate, and the prison facilitated a move to a prison closer to his family.

Findings and Conclusions

The man visited the gym on 27 October. He had not visited a gymnasium for about 15 years. He was inducted into the gym and signed a compact, part of which stated that all injuries should be reported immediately to gym staff.

The man returned from the gym with chest pain following strenuous exercise, and reported he had not exercised in 15 years. The officer who attended to the man acted appropriately and compassionately when alerted to the man's ill health.

The first HCO, who visited the man on the wing, appears to have confused the signs and symptoms of a Myocardial Infarction (MI) with muscle strain and possible nerve involvement. Although the man's observations were recorded as being within normal limits, the other signs, such as the increased pain on exertion and decreased pain when resting, chest pain and tingling in left fingers, should have alerted the first HCO to the potential cardiac involvement. Ibuprofen was recorded in the IMR as administered; this was not documented in the prescription chart.

The first HCO contacted the nurse based in reception. Without having seen the man, she appeared to make the decision that he was not at risk.

The second HCO, who attended to the man did not seek assistance, despite his recent history of chest pain, the increase in his pulse rate and blood pressure, along with the ongoing complaints of pain in his left arm. Although he admitted the man to healthcare for overnight observation, he did not document how often the observations should be.

In medical emergencies, there is a term called the "golden hour". This refers to the 60 minutes following the trauma, or pain when it is crucial a victim receives medical treatment for any chance of survival. In a prison, the rules governing the golden hour are just the same as anywhere else. A medical team has 60 minutes to get a victim from incident site to the operating table. In this case, the emergency situation was not identified.

I must make a judgement as to how reasonable the HCOs' actions were. To this end, I must consider whether other HCOs would have acted the same way, and whether the man received the same level of healthcare as he would if he were not in prison. I am surprised that the advice of a doctor was not sought when the first HCO, attended to the man, especially when confronted by wing staff who were extremely concerned that the man was suffering from a heart attack. Furthermore, I am surprised that an ambulance was not called when the second HCO attended, and the man's blood pressure and pulse were substantially raised. The fact that neither HCO identified the potential that the man was having a heart attack informed the decision making by the nurses. Having taken advice from the independent clinical reviewer:

I recommend that the Prison Service consider whether the circumstances are such that disciplinary action be taken in respect of the actions of the two HCOs.

I recommend that the Governor of Winchester reminds healthcare staff that, when a pulse rate and blood pressure is significantly raised in a patient with a very recent history of chest and left arm pain, the emergency services should be called.

The second HCO stated that, on arriving in healthcare at 8.30pm with the man, he gave the nurse based on the healthcare centre a verbal handover and suggested hourly observations. The man does not appear as an entry in the 'Hand Over Observation' log.

The nurse based in the healthcare centre, having received a verbal handover regarding the man at approximately 8.30pm in which hourly observations were suggested, did not visit the cell until 9.55pm. She states that she went to the cell to issue night time medication (this is the routine on healthcare). Prior to starting the drug round, she completed a nursing care plan. The care plan does not include basic observations of pulse and blood pressure. She had identified the problem as being chest pain associated with raised blood pressure, following a gym session. The short-term goal was to exclude cardiac cause (it is not documented how she intended to do this), and eliminate chest pain. Interventions were documented as: 1. Give meds as prescribed (the only prescription on the man's drug chart was Amitriptyline); 2. Give analgesia PRN; 3. Monitor vital signs as required (no indication as to how often this was required); 4. Refer to hospital as necessary. It is of great concern that no observations were conducted in order to exclude a cardiac cause.

The nurse based in the healthcare centre stated that the making of observations is not practical at night as she is only on duty with an operational support grade (OSG). The then head of healthcare, stated that if observations were needed, an officer with keys would visit to facilitate this. The nurse based in the healthcare centre did not seem aware of this, and I question the practicality given staffing levels at night. The nurse based in the healthcare centre certainly appeared to view her evening round to be for issuing medication rather than performing observations. Given that proper observation could not or was not given to the man, it is difficult to understand why consideration was not given to the man being taken to a hospital outside the prison.

Nursing observations require the nurse to have physical contact with the patient, for example to measure the pulse. If these observations are needed, either staffing levels need to be provided to facilitate such measures, or the patient needs to be transferred to hospital. Where a clinical judgement is made that observations are necessary, these must be facilitated.

The nurse based in the healthcare centre did not enter the cell until the Night Orderly Officer arrived, despite having access to the emergency key pack. Instructions to nurses are given not to open the cell at night without the Night Orderly Officer present. She stated during the telephone interview that she

did not think it was worth risking entering the cell, as it was obvious that the man was not alive.

Both nurses involved appear to have taken the HCOs' word for what was wrong with the man, without investigating thoroughly themselves. It may be that there is a *de facto* reliance on healthcare officers to make clinical judgements. The independent clinical reviewer concluded that the actions and lack of action by the four members of staff involved in the care of the man during the episode of chest pain had a direct impact on his chances of survival. I therefore make the following recommendations, drawing from the independent clinical review.

I recommend that the healthcare manager, in conjunction with the local Primary Care Trust, should ensure that all members of healthcare staff are aware of their different roles and responsibilities to ensure accountability and high levels of care.

I recommend that nurses should be reminded to protect their professional registration and remember their responsibility for the duty of care of patients, by satisfying themselves that care recommended by HCOs is appropriate and any diagnosis accurate.

I recommend that HCOs and nurses should take into account all observations and information the patient is giving and err on the side of caution. A doctor should be called to attend patients complaining of chest pain, particularly when there is left arm pain as well, even in the absence of abnormal pulse and BP observations.

I recommend that the frequency of required observations should be clearly documented in the IMR and nursing care plan, to facilitate continuity of suitable care.

I recommend that handovers should then be documented in the IMR or nursing notes and in the Hand Over Observation log. The staff giving and receiving hand over should sign and print their names on the log.

I recommend that the nursing care plans should be completed accurately, carefully and thoroughly. Basic observations should be taken and documented on all patients admitted to healthcare.

The prison's contact with the man's wife

The man's wife was contacted by the police to inform her of her husband's death. They gave her a phone number to call for more information. The man's wife phoned the number at the prison. Nobody knew anything about the death. Finally she was told that he had died in the hospital and was given the number. When she phoned the hospital, the sister she spoke to said they knew nothing about her husband. The man's wife was finally told that he had died at the prison. The man's wife set off for Winchester not knowing what had happened.

Where the next of kin lives far from a particular prison, it is best practice if a Governor from a jail closer to the next of kin's home is approached and asked to break the news in person.

The man's cell was still sealed at the time of the man's wife's visit and she was told that staff would notify her when she would be able to visit. She has heard nothing further. The man's wife did not receive a letter of condolence from the Governor and, at the time of writing this report, she still had not received her husband's possessions. This is wholly unacceptable.

I recommend that the man's possessions are delivered to his wife as a matter of urgency.

I recommend that Winchester's contingency plans are amended such that the appointed prison family liaison officer ensures that a condolence letter is sent to the bereaved family from the Governor at the earliest opportunity, and possessions are gathered and returned to family members in a timely and sensitive manner.

List of Recommendations

I recommend that the Prison Service consider whether the circumstances are such that disciplinary action be taken in respect of the actions of the two HCOs.

The Prison Service considered this recommendation and felt this was a training issue for the nurses involved, with advice and guidance.

I recommend that the Governor of Winchester reminds healthcare staff that, when a pulse rate and blood pressure is significantly raised in a patient with a very recent history of chest and left arm pain, the emergency services should be called.

I recommend that the healthcare manager, in conjunction with the local Primary Care Trust, should ensure that all members of healthcare staff are aware of their different roles and responsibilities to ensure accountability and high levels of care.

I recommend that nurses should be reminded to protect their professional registration and remember their responsibility for the duty of care of patients, by satisfying themselves that care recommended by HCOs is appropriate and any diagnosis accurate.

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The Prison Service have returned the man's possessions to the man's wife

I recommend that Winchester's contingency plans are amended such that the appointed prison family liaison officer ensures that a condolence letter is sent to the bereaved family from the Governor at the earliest opportunity, and

possessions are gathered and returned to family members in a timely and sensitive manner.

The Prison Service has drawn up an action plan to address the issues highlighted in the report.