

**Investigation into the death of a man
whilst in the custody of HMP Lowdham Grange in
January 2006**

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

August 2006

This is the report of an investigation into the circumstances of the death of a man who died from apparently natural causes in Nottingham City Hospital in January 2006. The man was in the custody of HMP Lowdham Grange at the time. He was 42 years of age.

I would like to extend my personal condolences to his family and to all those touched by the man's death.

My investigator and I would like to thank the Director of Lowdham Grange and his staff for their cooperation during this investigation. A clinical review of the care the man received whilst in custody was undertaken by Newark and Sherwood Primary Care Trust (PCT). I am also very grateful to the PCT for their assistance.

I conclude that the clinical care the man received once he had been diagnosed with a heart condition was appropriate. The clinical review does indicate one instance of sub-optimal care pertaining to the man's reception into Lowdham Grange. There is also reference to the fact that he may have been displaying symptoms of heart disease as early as October 2003 when at HMP Parkhurst. Nonetheless, even diagnosis and treatment at that earlier stage might not have resulted in a better outcome

My investigation also highlights a number of areas for improvement with regard to Lowdham Grange's procedures. This report makes seven recommendations and three further recommendations relating to 'first response' are in the clinical review.

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The man who died was sentenced to eight years imprisonment for burglary and arson in May 2003. After sentencing, he was sent to HMP Parkhurst. He moved to HMP Lowdham Grange in December 2004 where he was placed on F Wing.

On 14 September 2005, he suffered a mild heart attack. The man was taken to Nottingham City Hospital and admitted to a short stay ward for observation and tests. The results confirmed that he had a significant narrowing of the artery and required surgery. On 20 September, he underwent an operation to insert a drug-eluting stent. The man was discharged the following day having been prescribed continuous medication, which included glyceryl trinitrate (GTN), to manage and control angina. He was allowed to return to work in the industries workshop, but was instructed to rest in his cell if he felt ill.

Over the next few months, the man continued to suffer with occasional chest pains. During this period he was monitored by both prison healthcare and his consultant cardiologist at Nottingham City Hospital. The cardiologist informed both the man and Lowdham Grange that he was at risk of suffering another heart attack. It was recommended that, should he experience recurring symptoms consistent with angina, he should be referred again to the cardiology department.

On 7 December 2005, his chest pains worsened. An ECG was taken by prison healthcare staff and faxed to his cardiologist for examination. Although the assessment was that the man was not acutely unwell, the cardiologist decided that he would schedule an appointment for 17 January to review him in person before considering a further procedure.

The man became increasingly anxious about his health during late December. Healthcare staff offered him support and reassurance that his hospital appointment was imminent.

During early January, the man continued to suffer with chest pains. However, it was assessed that the changes in his health were not significant enough for early action and he could wait for his appointment on 17 January. He continued to manage his condition using the prescribed medication, but became over-reliant on his GTN spray. Healthcare staff discussed this with him on a number of occasions and warned him of the adverse effects this could have on his health. He was warned that if he continued to overuse the spray he would be prescribed with patches. This caused him some concern, but he eventually agreed to comply.

At 6:25pm on a day in January, the man collapsed on F Wing having suffered a heart attack. Two prisoners and prison staff, including healthcare, quickly attended to the man and succeeded in resuscitating him before the ambulance arrived. He was stabilised and then taken to Nottingham City Hospital. Sadly, he

suffered a further heart attack at 10:39pm. He was pronounced dead at 11:02pm.

Investigation Process

The investigation was opened at HMP Lowdham Grange four days after the man had died. The Director made the man's prison and medical records available for examination. Notices were distributed around the prison informing staff and prisoners of the investigation.

A number of staff members, both prison and healthcare, were formally interviewed along with two prisoners who performed Cardio Pulmonary Resuscitation when the man collapsed on the wing.

My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of this investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist with his enquiries into the cause of death.

Newark and Sherwood Care Trust conducted a clinical review of the medical care and treatment that the man received during his time in custody.

One of my Family Liaison Officers (FLO) spoke with the man's mother and offered to meet with her. She did not wish to meet with my FLO but was grateful for contact being made. She raised no issues surrounding her son's medical care whilst he was at Lowdham Grange. The family were aware that he suffered from a heart condition.

HMP Lowdham Grange

The modern HMP Lowdham Grange opened in February 1998. It is a privately managed prison operated by Premier Custodial Group Ltd., part of Serco plc. It is located on the site of a former borstal which was demolished to accommodate the new prison.

Lowdham Grange is a Category B training prison for long-term prisoners. It has a largely industrial-based regime with an expanding education programme. There is a variety of vocational training, domestic and kitchen work, gymnasium, gardening and offending behaviour programmes.

The prison has an operational capacity of 524 prisoners, providing single cell accommodation in two identical houseblocks. Each houseblock has four wings which are divided into two landings. The wings are arranged in a cruciform shape around a central control room.

The healthcare unit does not have an in-patient facility. Nursing staff are directly employed by the prison and work a 12 hour shift. Out of hours cover is provided by a nurse based in the healthcare unit overnight. Patients who require specialist healthcare are identified and referred to an outside hospital. A doctor attends the healthcare unit for 15 hours per week and provides out of hours advice.

All discipline staff have current first aid training. The healthcare manager is in the process of buying three new defibrillators which will be located on the wings. It is envisaged that all discipline staff will be trained to use them. I very much welcome this initiative.

Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an unannounced inspection of Lowdham Grange in March 2004. The inspection report described Lowdham Grange as providing "a secure but respectful environment for prisoners and staff" and said that healthcare was delivered "in a respectful and professional way".

There have been three deaths at Lowdham Grange over the last 12 months, including this man's. One of these was apparently self-inflicted.

Events leading up to the death of the man

The man was charged for burglary and arson on 27 January 2003 and was held on remand at HMP Chelmsford. This was not his first time in custody, having previously been at HMP Wandsworth.

During his medical assessment on reception at Chelmsford, the man said his family had a history of diabetes. He had no other health concerns.

The man remained at Chelmsford until he was sentenced to eight years imprisonment in May 2003. He was then transferred to HMP Parkhurst to begin serving his sentence.

Initial health screen checks at Parkhurst record that the man was well. It was noted that he was heavy smoker and unfit, but no other medical problems were identified. However, on 22 and 23 October 2003, he was seen by healthcare after suffering chest pains. These pains were diagnosed as “non-cardiac” related.

On 12 January 2004, the man took an overdose of ibuprofen which had been prescribed to manage a severe toothache. (He had been given the tablets to keep in his possession.) He was found at 2:30am lying on his cell floor with tablets scattered around him. He was immediately taken to St Mary’s Hospital, Newport, Isle of Wight, by ambulance. The man was discharged from hospital at 11:00am the same day.

Although it was concluded that the man’s overdose was accidental, the incident was treated as a possible attempt at self harm as he told staff he felt depressed. A form F2052SH was opened on 12 January. (An F2052SH is a standard form used by prison staff to assess, monitor and review a prisoner believed to be at risk of suicide or self harm. Any concerns that arise from the initial assessment are recorded and the prisoner is monitored by staff until it is decided they are no longer at risk.) In this case, the F2052SH was closed four days later on 16 January once he had finished his course of antibiotics. During this period, he was not permitted to hold any medication in his possession.

There were no other significant entries in the man’s medical record for the duration of 2004.

On 7 December 2004, he was transferred to HMP Lowdham Grange. The first health screen on reception at Lowdham Grange notes that the man’s father had suffered from increased cholesterol and died from heart disease. It also notes that he was a heavy smoker. Although these two entries were made on the health screen, the man did not have his cholesterol levels checked at this stage.

The man was located in a single cell on F wing. He quickly settled at Lowdham Grange and applied for employment as well as a number of training courses. He was given a position in the industries workshop and was put on a waiting list for various training courses.

On 14 September 2005, the man complained of chest pains which radiated down his left arm. He was taken to the healthcare unit where an electrocardiogram (ECG) was performed. The ECG results were faxed to the prison's doctor. The man was given aspirin and two sprays of glyceryl trinitrate (GTN). He was told to contact healthcare immediately if he suffered from further pains or shortness of breath. Later that day, he was again seen by doctor who made a provisional diagnosis of acute coronary syndrome. The man was taken by ambulance and prison escort to Queens Medical Centre in Nottingham and admitted to a short stay ward. It was confirmed that he had suffered a mild heart attack and the man remained in hospital for further observation and tests.

On 20 September, test results confirmed that the man had a significant narrowing of a coronary artery. He underwent a successful operation to insert a drug-eluting stent. The consultant cardiologist prescribed continuous medication of aspirin, simvastatin, clopidogrel, bisoprolol and ramipril along with a long acting GTN spray. The man was discharged from hospital on 21 September and returned to Lowdham Grange.

The healthcare unit continued to monitor the man over the next couple of days. Although he was prescribed his medication in possession he chose to have it dispensed at set times by healthcare staff, apart from the GTN spray which he would have with him at all times. He sought advice to stop smoking and requested nicotine patches which were given to him on 23 September. Although the man had good intentions to stop smoking, he never managed to give up.

On 24 September, the man attended the healthcare unit and was seen by a nurse. An entry in his continuous medical record refers to the man describing himself as "fed up" and being eager to return to work. There is also reference to his concern over his condition and the prognosis. The nurse reassured him that he had recovered well from his operation and that leading a healthier lifestyle would help. She encouraged him to continue with the plan to stop smoking and offered him continued support and observation until he settled back into his normal routine. The man commenced a smoking cessation course on 26 September.

On 4 October, the man's consultant cardiologist wrote to one of the prison doctors, to confirm what treatment the man had received whilst at Nottingham City Hospital. He said that the man had "an excellent angiographic result", however the location of the inserted stent was "an area associated with an increased risk of restenosis and restenosis at this point could potentially lead to significant myocardial ischaemia." This meant that the man was at risk of

suffering another heart attack. The consultant cardiologist recommended that, should the man experience any recurrence of symptoms consistent with angina, he should be re-referred to the cardiology department.

The man continued to have recurring mild chest pain throughout October which was managed by the healthcare unit. He returned to work in the industries workshop, but was given leave to rest in his cell when he was in ill health. Fellow prisoners on the wing would support the man by taking him his meals if he was not fit enough to collect them himself.

On 3 December at 9:50am, the man was seen by healthcare staff on the wing after experiencing chest pain and feeling weak. The pain was not continuing, however he was advised to rest in his cell. The man returned to healthcare at 5:50pm on 5 December with persistent central chest pain. Again, he was advised to rest in his cell. At 6:15pm, the man was brought back to healthcare and an ECG was performed by a nurse. The pain subsided after he received two doses of his GTN spray. The man returned to the wing and discipline staff were told him observe him overnight. A copy of the ECG was sent to the consultant cardiologist at Nottingham City Hospital.

The man went to work on 7 December. However, a phone call was made to the healthcare unit from the industries workshop at 11am to say that he was experiencing a “crushing” pain in his chest with some facial pins and needles. He was taken straight to healthcare where another ECG was performed. This time the GTN spray was only effective for short periods of time. An appointment was made for him to see the medical officer that afternoon. In the meantime, he was advised to rest in his cell. On seeing the medical officer, a copy of that day’s ECG was faxed to the cardiologist at Nottingham City Hospital.

Due to his persistent ill health, the man began to worry about his position in the industries workshop. He was worried that he would start to receive a reduced sick pay allowance rather than his normal wage. The man was reassured by healthcare on 9 December that this would not be the case and he would be classified as a Labour Grade 3 for 1 month. (This means that a prisoner is declared as “unfit for work at present time” and should receive the same wage.)

The consultant cardiologist wrote to the prison doctor on 17 December to confirm receipt of the ECG faxed on 7 December. The cardiologist had spoken with healthcare staff at Lowdham Grange earlier that day. They had informed him that the man had suffered a number of episodes of short-lived chest pain but no other associated significant symptoms. The cardiologist’s assessment was that the man was not acutely unwell, but that he would like to schedule an appointment to review him in person before considering any further procedures. An appointment was made for 17 January, but the cardiologist advised that if in the meantime the man’s chest pains became increasingly unstable then he

should be taken to the hospital. Although an appointment had been secured, the man was not given the date. This is consistent with the prison's security policy.

Over the Christmas period, the man felt particularly upset about his ill health and was anxious to receive his hospital appointment. On 25 December, he was placed on a level 3 risk assessment (F2052SH) due to his low mood, although he had no thoughts of self harm. Level 3 means that the man was subject to 30 minute checks for the duration of the day. He was reassessed on 27 December, when it was decided that he was feeling more positive and the F2052SH could be closed.

Early in January, the man complained of severe chest pain during the night. An ECG was performed and was reviewed by the prison doctor. Again, there were no significant changes compared with previous ECGs. It was decided that the man should wait for his cardiac appointment on 17 January.

The next day, the man was seen during the afternoon by a nurse at healthcare after experiencing chest pain which radiated down his right arm. The pain eased on using his GTN spray.

A few days later, the man was seen by healthcare staff to discuss his use of the GTN spray. It had been reported to staff that the man was using his spray more than the prescribed amount. Overuse of the spray can result in chest pains and dizziness. Healthcare staff advised him of the dangers and explained to him that if he continued to overuse the spray he would be given GTN in the form of patches to be applied to the skin. He was reassured that his outside appointment was imminent and that the cardiologist might be able to offer alternative treatments.

The man seemed content with the explanation, but returned to healthcare after a few days to request a new spray. Again, he was informed of the dangers of overuse but this time he became angry and frustrated. The man felt the spray was the only way to alleviate the pain he was experiencing.

Two nurses visited the man in his cell later that day to discuss his medication. The man said that he no longer wanted help from healthcare. He asked the nurses to leave and requested an officer to lock his cell door. One of the nurses returned at the end of her shift to speak with the man again about his medication and their concerns for his health. He was apologetic about his earlier behaviour and agreed to listen to their advice regarding the GTN spray. The nurse said that healthcare would continue to monitor his use of the spray and provide support whilst he was waiting for the cardiac appointment.

At around 5:30pm on the day the man died, a fellow prisoner (Prisoner A) who worked on the servery, noticed that the man had not come to collect his dinner. The prisoner left his workstation to go to the man's cell to check that he was

alright. Before reaching the cell, he noticed him in the shower area and returned to the servery and carried on with his shift. During an interview with the prisoner, he stated that he would normally check on any person who had not come to collect his meal.

At the end of mealtime, around 6.25pm, the prisoner was clearing up the servery when he heard someone shouting his name. He left the servery and looked down the landing, around 30 to 40 feet away, to see another prisoner (Prisoner B), shouting and beckoning him to come over. He noticed that the man was slumped across one of the tables in the communal dining area.

Prisoner B shouted to another prisoner (Prisoner C), to alert staff. This prisoner ran up the central staircase to the office on the upper landing. Prisoner A lifted the man's head to find it covered in perspiration, particularly across his top lip. He noticed that the man's lips had turned blue. Prisoner A had received first aid training, including cardio pulmonary resuscitation (CPR), during his time in custody at HMP Frankland. He knew how to move the man into the recovery position and check for a pulse and signs of breathing. Prisoner A was unable to find a pulse and the man's chest was not moving. With Prisoner B's help, they turned the man on to his back. They found the man's GTN spray in his pocket and Prisoner A opened the man's mouth, pulled down his tongue and sprayed three times. Prisoner A also suffers from angina and so was aware of how and when the spray should be used. He then proceeded to administer CPR.

During this time, Prisoner C was informing two Prison Custody Officers (PCOs), who were in the office on the upper landing, that a man had collapsed and required urgent assistance. Without hesitation, one of the PCOs left the office whilst the other one followed and locked the door. The first PCO saw the man on the floor. Prisoners A and B were moving him into the recovery position. The first PCO pressed the personal alarm button on his radio which alerts the control room to put a call out over the radio for a 'first response'. This alerts staff that a situation has occurred which requires an immediate response. In the meantime, the second PCO had reopened the office and phoned healthcare to request that nurses immediately attend. It was a matter of seconds before both PCOs were on the lower level with the man who had collapsed.

The PCOs allowed Prisoner A to continue administering CPR. Like all discipline staff at Lowdham Grange, both PCOs are current first aid trained, however their assessment was that Prisoner A was performing CPR correctly and there was no need to take over at this stage.

At this time, a third PCO arrived on F wing. On finding the situation he pressed the alarm on his radio and raised a 'code blue' medical alert. ('Code blue' means that someone is having difficulty breathing and that an emergency medical response is required. The control room would in turn issue a code blue alert

which would indicate to all staff attending what level of response was required. This ensures that healthcare staff in particular are fully prepared.)

Healthcare staff arrived approximately a minute or two after they received the phone call from the second PCO requesting they attend F wing. Nurse asked which prisoner had collapsed, and on hearing who it was he knew that it would be a code blue emergency as he was aware of his heart condition. The nurse grabbed the blue emergency medical bag, which contains a defibrillator and oxygen. As he was leaving the healthcare unit, he heard the 'first response' call put out over the radio. Another nurse was also present in healthcare and said she would follow him across. As the healthcare unit is situated roughly 100 yards from F Wing, they were able to get to the man very quickly.

The nurse with the emergency bag arrived at F Wing, along with a student nurse was working at the healthcare unit that day. On arrival, he saw Prisoners A and B administering CPR, whilst other prisoners and staff stood aside. The nurse shouted to a nearby officer to call for an ambulance. The control room log shows that an ambulance was called for at 6:33pm.

Prisoner A briefed the nurse on what had happened and let him take over. At this point the man was convulsing and deeply cyanosed (a blue colour to the skin). The nurse administered a 'pre-cardial blow' to the man's chest which resulted in spontaneous respirations and a pulse. This action performed the same outcome as a shock delivered by a defibrillator. The nurse then set up the oxygen and put the mask on the man. At this stage the man had a feeble and erratic pulse, but his colour had begun to improve.

The second nurse arrived on the wing to assist. She set up the automatic defibrillator and connected it to the man in order monitor his heart rate in case he began to fibrillate again. It was difficult to hear the machine clearly as the wing had not been cleared and staff and prisoners were still around. The student nurse listened to the machine and relayed the read-out to the first nurse. The defibrillator indicated that no further shock was required and they should continue with CPR. The man had regained consciousness and began asking for his mother. The first nurse tried to comfort the man and explained that the ambulance was on its way. He then left the second nurse with the man whilst he went to locate Prisoner A to thank him for his actions and get more detail on what had happened.

It was at this stage that the Operational Manager came on to F Wing. He had heard the first response alert over the radio. (The Operational Manager is required to attend any response on the house block that they are assigned to.) The Operational Manager instructed the PCOs to clear and secure the area. Prisoners were returned to their cells.

Whilst CPR was being performed, another PCO had been paged to inform him that he would be required as an escort officer to take the man to hospital. He was called to the security office to pick up the escort pack and relevant paperwork was prepared. The security policy for a category B prison is that prisoners are to be escorted from an establishment wearing both standard cuffs and a closeting chain. However, due to the man's condition, the PCO was instructed to only use the closeting chain until the man was deemed well enough to wear standard cuffs.

After speaking with Prisoner A, the nurse returned to the man. He found that the man's colour had further improved. The healthcare team continued to administer oxygen until the paramedics arrived at 6:47pm. At this time the man had stabilised and they were able to move him onto the ambulance. The nurse followed the paramedics to the ambulance with a view to accompanying the man to hospital. However, there was not enough room in the vehicle. Only the escort officers were allowed in the ambulance.

The ambulance remained in the prison grounds for approximately 30 minutes whilst the paramedics located a vein to administer drugs and took three to four cardiograms. They arrived at Nottingham City Hospital at approximately 7:45pm. The man was admitted to the coronary care unit having suffered an acute myocardial infarction (heart attack).

Escort staff opened the bedwatch log at 7:50pm. They sat with the man, wearing the closeting chain. At 8:14pm, one of the escort staff phoned the prison to notify them that the man would need to remain in hospital overnight. At this stage the man was alert and talking to the officers. At 8:30pm, he appeared to have improved to the extent that the officers sought confirmation to apply standard cuffs. At 10:15pm, a doctor came to see the man and asked that the cuffs be removed.

At 10:17pm, the escort staff changed shifts and two new staff took over the bedwatch. One PCO was cuffed to the man using only the closeting chain. The other contacted the prison to inform them that standard cuffs had been removed and only the closeting chain was being used due to the man's poor condition. By 10:35pm, the chain was also removed as the man began to deteriorate. At 10:39pm, the man suffered a further cardiac arrest. Despite the medical crash team's attempts to resuscitate him, he was pronounced dead at 11:02pm.

Events following the man's death

The escort staff informed the Duty Director at Lowdham Grange of the man's death. The death in custody contingency plan was put into action. This included informing the Director, Head of Healthcare, the coroner and the police. The police arranged for Braintree police in Essex to inform the man's mother. She was told the sad news of her son's death at 1:15am that night.

The following day, The Director telephoned the man's mother offering condolences for the family's loss. He let her know that the prison's family liaison officer (FLO) would be in touch. The FLO offered to meet with the family and answer any questions and discuss how the prison could help with the funeral arrangements. The family were also invited the family to visit the prison and to see the man's cell if they so wished.

The day after the man's death, the Chaplain, went to F Wing to talk to the prisoners and provide support to those affected by the man's death. The prison's psychology team also visited the wing and offered support to both staff and prisoners. Prisoner A was seen by the head counsellor at Lowdham Grange. He also received a letter of commendation and thanks from the Director. The Director offered Prisoner A a reward for his actions. Prisoner A chose to donate this to Nottingham City Hospital.

The Chaplain spoke to the man's mother. She wanted to thank everyone at the prison for their support but did not want to come to the prison. Both she and the rest of her family felt it would be too distressing at that stage. There have been subsequent conversations between the man's family and the prison about a possible visit, but thus far the family have decided against.

The Director issued notices to staff and prisoners as official notification of the man's passing. Prisoners and staff were invited to pass on their condolences or send cards and flowers to the man's family should they wish.

A 20 minute commemorative service was held in the prison chapel. This was an open service for all prisoners and staff.

Both the prison FLO and Director remained in contact with the man's mother to assist with the basic costs of the funeral and to arrange for the return of his property. After some negotiation, it was decided that the property would be posted to the man's mother rather than the family travel to the prison.

Findings and conclusions

Clinical Review

Newark and Sherwood PCT undertook a clinical review of the care that the man received whilst at Lowdham Grange.

List of relevant events

6 December 2004: The man was declared fit for transfer at Parkhurst Prison. Medical notes prior to that point indicate no significant physical or mental health problems although he had taken an accidental overdose of medication on 12 October 2004; the medication was of analgesics for severe toothache. A record entry on 22 October 2003 refers to “non-cardiac chest pain”.

7 December 2004: transferred to Lowdham Grange.

8 December 2004: at the medical reception it was noted that his father had increased cholesterol and died of heart disease aged over 65 and that the man smoked heavily (the recorded number of cigarettes ranged from 20-30 to 60 per day).

6 January 2005: ‘attended HCC for cholesterol check’ but there is no subsequent record of test result or further mention thereof.

14 September 2005: The man complained of chest pains radiating down his left arm (characteristic of cardiac pain). An ECG was performed and faxed to the medical officer aspirin was given as well as glyceryl trinitrate. Not all ECG’s in the records are dated; there are none dated 14 September 2005 although there is one marked “first one”. The man was seen by the medical officer later on 14 September when a provisional diagnosis of acute coronary syndrome was made and he was admitted as a emergency to Queens Medical Centre, an ambulance having been called by ‘999’. The diagnosis was confirmed, the man having been transferred to Nottingham City Hospital.

All ECGs should be dated either manually or by ensuring that the date on the machine is correct.

20 September 2005: Investigations indicated a significant stenosis to the circumflex artery and a drug-eluting stent was placed in his coronary artery. The man was commenced on aspirin, simvastatin, clopidogrel, bisoprolol and ramipril along with a long acting glyceryl trinitrate by the consultant.

21 September 2005: The man was discharged back to Lowdham Grange.

23 September 2005: The man was seen with regard to cardiac rehabilitation including smoking cessation.

The man continued to have bouts of chest pain through October and in December an ECG was performed on 5 December and again on 7 December. The latter was sent to the Consultant Cardiologist by fax in accordance with the requirements of the Consultant Cardiologist in his letter of 4 October ("It is my suggestion therefore that he should be re-referred should he experience any re-occurrence of his symptoms which would be consistent with angina.")

23 December 2005: In his letter of 17 December 2005 the cardiologist states, "given that the man is not acutely unwell I would prefer to review him in clinic before considering a further procedure for him. He has a clinic appointment on 17 January 2006. Of course, should he suffer more significant unstable chest pain that gives you cause for concern then he should be admitted acutely to hospital."

The man continued to have severe chest pain through the beginning of January and was having difficulties using his glyceryl trinitrate appropriately though there is no report of persistent chest pain not responding to GTN.

Early January 2006: A further ECG was performed with the medical officer reporting no changes from previous ECG's.

January 2006: At approximately 18.25, the man collapsed and was found by the attending nurse to be convulsing and cyanosed. A blow administered to the chest wall resulted in spontaneous respirations and the presence of a carotid pulse (the use of an automatic defibrillator was thus not necessary, the blow achieving the same outcome): oxygen was administered. The ambulance arrived at approximately 18.55 and the man was transferred to Nottingham City Hospital where he arrived at around 19.45 and a diagnosis of myocardial infarction was made. He would thus have been treated with fibrinolytic drugs very soon after the onset of his heart attack, thus improving his chances of survival. Despite this, he subsequently suffered a cardiac arrest and was declared dead at 23.02.

Assessment of the quality of care

The man arrived at Lowdham Grange with no significant medical history. During his first reception medical assessment, it was identified that he had a family history of raised cholesterol and was a heavy smoker. This should have triggered a formal assessment of Coronary Heart Disease (CHD) risk and where appropriate the commencement of medication. However, no cholesterol levels were taken and whilst the medical records note that he "attended HCC for cholesterol check" there is no subsequent record of results from that test and there is no further mention. There was an intention to do this on 6 January 2005,

but it was not carried through. This represents sub-optimal care compared to the requirements of the National Service Framework (NSF) on CHD.

The identification, assessment and, where appropriate, treatment of patients at risk of CHD should be in accordance with the National Service Framework (NSF) for CHD and recent National Institute for Health and Clinical Excellence (NICE) Guidance on the use of statins.

On 14 September, the man developed clear symptoms of coronary heart disease and was managed appropriately with an emergency 'blue light' admission to hospital where coronary artery stenosis was diagnosed and treated with an angioplasty.

The man continued to be troubled with angina in subsequent months, but this responded to glyceryl trinitrate (GTN). In early January 2006, the consultant cardiologist was asked to report on an ECG taken in compliance with his recommendations in his discharge letter of 4 October. The consultant cardiologist recommended that the man did not require further intervention at that time and should attend his next clinic appointment on 17 January. Medical care was thus appropriate in accordance with advice given.

The man collapsed on his wing in January. He was successfully resuscitated and then transferred to hospital. With qualified nurses on site, he had access to a level of healthcare that would not be available to members of the public at liberty. Actions taken at Lowdham Grange were appropriate and rapid.

Unfortunately, he suffered another heart attack at Nottingham City Hospital and staff there were unable to resuscitate him.

Discussion and Conclusions

CHD is unpredictable. The man had been given appropriate treatment with angioplasty in September and started on anti-coagulation treatment, including clopidogrel. The consultant cardiologist noted that the particular site of his stenosis (narrowing artery) was problematic and prone to restenosis (re-narrowing of the artery). Whilst stenting is known to reduce the symptoms of coronary heart disease it does not have a very significant impact on the risk of death.

The man's death was an unfortunate consequence of his underlying disease, not of a failure of medical care. The delay in the investigation of his CHD risk status would not have materially contributed to his eventual death, although it is indicative of sub-optimal medical care in comparison with national standards.

CHD sometimes presents very late, indeed frequently with sudden death. The man may have had symptoms of heart disease as early as October 2003 at

Parkhurst. The record of 'non-cardiac chest pain' may represent a misdiagnosis. Nonetheless, even diagnosis and treatment at that earlier stage may not have resulted in a better outcome.

General

Whilst record keeping at Lowdham Grange is largely comprehensive and up to date, it would have been useful to see recorded accounts by discipline staff of the man's collapse. There are entries made by healthcare staff in his medical record and the bedwatch logs provide insight into the last three hours of his life. However, wing staff were not required to make statements regarding their involvement in attending to the man once the 'first response' call had been made. My investigator spoke with the Director regarding this issue. It is not policy at Lowdham Grange for staff to provide a statement unless they were present when the prisoner died. This is why there are statements by the escort staff but none from the two officers who were first on the scene. My investigator suggested that for the future it would be useful to request that all staff involved provide a statement. This helps provide a clearer picture of events and enables staff have a better recollection of the incident if they are later interviewed as part of an investigation.

The Director should require discipline staff who are first on the scene to a medical emergency to provide a written account of their involvement. These statements would be in addition to any statements made by my bedwatch escorts.

Although all discipline staff at Lowdham Grange are current first aid trained, which includes CPR, the two officers who were first on the scene did not attend to the man. This was because Prisoner A, a prisoner on F Wing, was the first person with medical training to come to the man's aid. Prisoner A was fully first aid trained whilst serving a sentence at HMP Frankland. He also suffers from angina so was familiar with the symptoms and knew how to address the situation. The clinical review notes that the man was successfully resuscitated by Prisoner A and healthcare staff, and Prisoner A's actions merit the highest praise. However, it is necessary to consider whether the PCOs were correct not to intervene. Both officers stated during interview that, had they felt that Prisoner A was not performing CPR correctly, they would have been prepared to take over the situation. I do not criticise their actions but PCOs should recognise that they have a duty of care to prisoners and ultimately the responsibility for performing first aid in an emergency falls to them, and not fellow prisoners.

The Clinical Review contains three recommendations relating to first response. In addition, I recommend:

The Director should remind staff of their duty of care for prisoners in a life-threatening situation.

The Director should send a further letter to Prisoner A referring to my commendation for his actions.

Although 'first response' and 'code blue' calls were both quickly raised by officers, the request for an ambulance was not made until healthcare staff attended. On arriving at F Wing, the first nurse requested that the emergency services be called. The wait for healthcare to attend before the call was made meant a delay of eight minutes. A letter from the Director of Prison Health and Deputy Director General, Department of Health, to all Prison Service Governing Governors on 22 March 2004 clearly sets out that:

"It is the responsibility of the Governing Governor to ensure that a protocol exists at each prison to facilitate the immediate access to both the prison and the individual prisoner when emergency paramedic services are summoned. It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the Health Care Team to attend the scene before Emergency Services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Health Care Team arrive with the patient and deem that an emergency ambulance response is not required."

The Director should consider revising the prison's policy to make discipline staff equally responsible for calling emergency services. An ambulance can always be cancelled if on arrival the healthcare team decide it is no longer necessary.

Both discipline and healthcare staff had made efforts to reassure the man and provide support both during and after his operation in September 2005. The man did not always fully understand how to manage his heart condition and this often led to increased stress levels. During these times, the healthcare staff at Lowdham Grange took the time to explain what was happening to him and what the next steps would be. On the day that the man collapsed he received sensitive and compassionate treatment both at the prison and when he arrived at hospital.

Both staff and prisoners at Lowdham Grange were deeply saddened by the man's passing. The prison's psychology team and chaplaincy have provided appropriate care to those who were affected by his death. The care support team were swift to attend the wing and this support had been continuous where required.

One of the bedwatch escort staff was not directly informed of the man's death. He found out through an indirect conversation with the chaplain. It had been overlooked that both he and the other PCO were the original escorting officers and they had not been informed when they came back on duty the following day. Whilst the PCO has not raised this as an issue, the Director will wish to ensure that all staff involved in a serious incident are sensitively debriefed.

On implementing a death in custody contingency plan, the Duty Director should take note of all staff involved and ensure that they are properly debriefed. Staff who have been party to a bedwatch where the prisoner has subsequently died should be informed of the death directly, and not learn through second hand information.

With this one exception, I judge that the actions of Lowdham Grange following the man's death were both kind and professional. The Director will wish to share that judgement with all his staff.

Recommendations

- The identification, assessment and, where appropriate, treatment of patients at risk of CHD should be in accordance with the National Service Framework (NSF) for CHD and recent National Institute for Health and Clinical Excellence (NICE) Guidance on the use of statins.
- The Director should remind staff of their duty of care for prisoners in a life-threatening situation.
- The Director should send a further letter to Prisoner A referring to my commendation for his actions.
- All ECGs should be dated either manually or by ensuring that the date on the machine is correct.
- The Director should require discipline staff who are first on the scene to a medical emergency which results in a prisoner dying in an outside hospital to provide a written account of their involvement. These statements would be in addition to any statements made by bedwatch escorts.
- The Director should consider revising the prison's policy to make discipline staff equally responsible for calling emergency services. An ambulance can always be cancelled if on arrival the healthcare team decide it is no longer necessary.
- On implementing a death in custody contingency plan the Duty Director should take note of all staff involved and ensure that they are properly debriefed. Staff who have been party to a bedwatch where the prisoner has subsequently died should be informed of the death directly, and not learn through second hand information.

Three other recommendations relating to first response may be found in the Clinical Review.

Response to the recommendations

Since seeing this report in draft form, the Safer Custody Group has responded to the recommendations.

In response to the clinical review and the first recommendation, it is stated that both the National Service Framework and National Institute for Health and Clinical Excellence guidelines are included in Lowdham Grange's healthcare policies. In addition, they are referred to in all cases of coronary heart disease. The healthcare centre does promote smoking cessation and has annual well-man clinical checks. The man was seen for a cholesterol check at a well-man clinic as follow up to information that was obtained regarding his father's condition and death as a result of a heart attack. The prison states that the clinical review failed to acknowledge these notes in the man's records.

I agree that there was no dereliction of care and the clinical review does not suggest that the man was neglected. The clinical reviewer's recommendation arose because the man received CPR from a fellow prisoner who was competent in resuscitative procedures rather than from trained prison staff.

The Area Manager accepts that the Director should remind staff of their duty of care for prisoners in life threatening situations. New CPR guidelines state that a person competent in CPR should deliver treatment and a notice has been issued to staff. However, in accepting the recommendation the prison states that there was no dereliction of care in this instance.

Whilst the man received CPR delivered by a person competent in resuscitative procedures, this was not delivered by trained prison staff. The man was attended to by Prisoner A before healthcare staff arrived. The clinical reviewer's recommendation refers to the need for staff to assume their duty of care in life threatening situations. It does not suggest that the man was neglected.

The Director sent a further letter to Prisoner A on 14 June 2006 conveying the Ombudsman's commendation of his actions.

The recommendation that all ECGs should be dated either manually or by ensuring that the date on the machine is correct has been accepted. A new ECG machine is now in place which records the date, time and results.

The recommendation that discipline staff who are first on the scene of a medical emergency which culminates in a prisoner dying in an outside hospital should provide a written statement of their involvement has been accepted. Whilst the prison states that this is not their normal practice, it is acknowledged that such

statements would assist in providing continuity of evidence for any investigation. All staff involved in any such event will be expected to submit an account.

The Safer Custody Group partially accepts the recommendation to consider revising the prison's policy to make discipline staff equally responsible for calling emergency services. The response argues that healthcare staff arrive within four minutes of a medical response code being raised, therefore discipline staff summoning the emergency services before their arrival could be unnecessary and result in urgent cases in the community being missed. The prison feels that an inappropriate call to emergency services which resulted in a death in the community would be indefensible and embarrassing. However, the prison accepts that if a member of discipline staff is competent to assess the need for an ambulance, this action would not be prevented. Lowdham Grange has amended its Director's Rules to reflect this.

The recommendation that a Duty Director ensure that all staff involved in a death in custody, including bedwatch staff, are informed firsthand is part accepted. In the case of the man, the two members of staff not informed had gone home after the event and not returned to the prison until the next morning. The prison felt that informing staff at home during the night would be bad practice. The Director accepts that, despite this, two members of staff were missed and Lowdham Grange's death in contingency plans will be amended to reflect this concern.

So far as the recommendations in the clinical review are concerned, the recommendation to consider training all or selected non-clinical staff as 'first responders' has been accepted. In addition to all staff receiving first aid training, all staff are also being trained to use defibrillators, which in essence provides them with 'first responder' skills. The prison feels this mitigates the need to draw up a roster as a trained person will always be present. Training is ongoing to all new staff with yearly refresher courses.

The recommendation to consider extending 'first responder' training to selected prisoners and placing prisoners at medical risk in cells with those trained was not accepted. In my draft report, I also included a recommendation relating to the training of prisoners in first aid techniques that was not accepted. I was informed that every member of discipline staff in Lowdham Grange will be first aid trained to meet the needs of prisoners. I have decided to remove my recommendation from this final version of my report, and to accept the Safer Custody Group's decision in respect of the clinical reviewer's recommendation. However, I will wish to consider these issues further on a future occasion.

The recommendation that a 'first responder' should assume care of a collapsed prisoner immediately on attendance was accepted. All staff with defibrillator training will assume the responsibilities of a 'first responder'.