Investigation into the circumstances surrounding the death of a man at HMP Whitemoor in January 2008

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

This is a report of an investigation into the circumstances of the sudden death of a prisoner at HMP Whitemoor, on 13 January 2008. The man was found collapsed in his cell at 8.24am. Tragically, efforts to resuscitate the man by prison staff and paramedics failed and he was pronounced dead shortly afterwards. I would like to offer my sincere condolences to all those who knew the man and were affected by his death.

My colleague conducted the investigation on my behalf. Although my office usually makes every effort to include families in our investigations, this was not possible because the man had no next of kin who wished to be involved.

An independent review of the man's medical care was undertaken by the Chair of the Clinical Care Review panel for Cambridgeshire Primary Care Trust (PCT). The Professional Performance Manager at Cambridgeshire Primary Care Trust, conducted staff interviews at Whitemoor on behalf of the Clinical Care Review panel. I am very grateful to the panel for their valuable contribution.

I would also like to thank the Governor of Whitemoor and his staff for their cooperation with the investigation. I am particularly grateful to the Senior Officer who provided a very high standard of prison liaison. A member of the Independent Monitoring Board, also made a valuable contribution to my investigation.

I conclude that the man's care at Whitemoor and the response to his collapse was generally satisfactory, but I make two recommendations in my report. The first relates to a review of the policy and distribution of radios. My recommendation is that all staff working on the prison wings should carry radios to ensure immediate response to medical emergencies. The other recommendation asks that all staff are issued with pocket masks to aid mouth to mouth resuscitation in emergencies. In this case the standard of record keeping in the Inmate Medical Records was poor. I make no recommendation because the Head of Healthcare informed my investigator that a new computerised patient record system was due to be implemented.

The issue I raised within my report regarding the responsibility for disposal of the remains of a prisoner without next of kin is currently being researched by the Prison Service. They have told my office that they are happy for the final draft of this report to be issued and I am grateful to them.

Jane Webb
Deputy Prisons and Probation Ombudsman **January 2009**

CONTENTS

Annexes

SUMMARY

The man was convicted of serious offences for which he received a life sentence. He was familiar with prison life as he had served a previous sentence for similar convictions. He was a category 'A' prisoner and served most of his sentence at Whitemoor. Due to the nature of his offences, the man was located on the vulnerable prisoner wing where he worked as a cleaner until he died.
Following a minor heart attack in 1993, the man had been diagnosed with coronary heart disease in November 1994. In 2006, he felt chest pain following exercise for which he was sent to hospital and released the same day. The man's medical record showed that he attended healthcare for a variety of ailments, not necessarily for heart problems. With regard to his heart condition, it is difficult to tell whether the man was regularly monitored as the clinical review panel found that healthcare record keeping fell below the standard expected.

On the morning of 13 January, the man's cell was unlocked at around 8.12am. The officer who unlocked him did not recall seeing anything wrong, neither did he recall getting a response from the man at that time. At around 8.24am a prisoner and friend of the man, shouted that he could not wake him up. Staff attempted cardio pulmonary resuscitation (CPR) and called an ambulance. Sadly, despite every effort, the man was pronounced dead by the ambulance paramedics a short time later.

The clinical reviewer noted that there had been a delay communicating with nursing staff as they did not carry radios. My investigation found that the only member of healthcare staff who carried a radio was Hotel 1, who was the person expected to respond to medical emergencies sent over the radio net. The lack of radios for other healthcare staff meant a delay in treating the man as the nurse had to be collected from the treatment room on the first floor.

The prison made lengthy enquiries regarding next of kin but no family who wished to be involved were found. My investigator found that the prison does not have a clear policy regarding what is to be done with the property and remains of a prisoner in these circumstances. She spoke with both the governing Governor and the chaplaincy in order to both highlight and resolve the issue between them.

The investigation also concluded that all staff, including healthcare staff should be provided with pocket masks and training in their use. In this case, the outcome would not have been different if mouth to mouth resuscitation had been used at first, but it could well have a bearing on the outcome of emergency situations in the future. My recommendations aside, I judge that the care the man received before his collapse and subsequently was appropriate.

The standard of medical record keeping in this case was poor. The Head of Healthcare told my investigator that a new system of patient record keeping was due to be implemented (SYSTEM 1) and this would reduce this problem.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 14 January 2008. Terms of Reference and Notices were issued to staff and prisoners at Whitemoor telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of the man's core record, medical record, and other records relevant to his time in custody and to his death. She also received a note of the events following the man's death from a member of the Independent Monitoring Board (IMB).

2. My investigator also contacted the Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post Mortem Report. The report concludes that the man died of:

    1a. Myocardial infarction
    1b. Hypertensive ischaemic heart disease
    1c Atherosclerosis.

    The Coroner has requested a copy of my report upon completion and I am happy to comply.

3. My investigator visited Whitemoor on 28 and 29 May 2008. She met the Governor, Head of Healthcare, a member of the IMB and the chaplain. My investigator visited the healthcare department and met the staff. She also met informally with staff and prisoners on the wing where the man was located and subsequently died. When my investigator visited, the vulnerable prisoner unit was closing and only a small number of prisoners remained.

4. The clinical review of the man's medical care at Whitemoor was commissioned from Cambridgeshire Primary Care Trust (PCT). The clinical review is an annex to this report.

5. My investigator has consulted investigation reports relating to the deaths of prisoners at Whitemoor since 2004, but there were no similarities in the circumstances of this case. My investigator has also read the report of an announced inspection of Whitemoor in 2006 by Ms Anne Owers, HM Chief Inspector of Prisons. In her report, Ms Owers highlighted the impact of chronic staff shortages in healthcare on prisoners. Ms Owers concluded that it meant that prisoners such as the man who suffered from a chronic disease had "only a basic level of care, with very little chronic disease management." A report prepared by the Independent Monitoring Board (IMB) in 2006 – 2007 has found that the prison is functioning reasonably well in most areas.

HMP WHITEMOOR

11. HMP Whitemoor is part of the Prison Service High Security Estate. It accepts Category A and B prisoners and those serving a sentence of over four years. The maximum prison capacity is 458 men.

12. Healthcare provision is the responsibility of Cambridgeshire Primary Care Trust. The healthcare centre is located on two floors. The lower floor provides a treatment room and nine in-patient beds. The upper level contains offices and further treatment rooms for clinics such as dentistry, opticians, and diabetic, podiatry and x-ray facilities. Nurse-led clinics include diabetic and well-man. A cardiac clinic is a recent addition. The healthcare centre employs one full time doctor and provides 24 hour nursing care. An out of hours service is provided to the prison by Suffolk doctors on call (SUFDOC).

13. The man was located on 'C' wing which was designated for vulnerable prisoners. When my investigator visited the prison, only a very few prisoners remained on the wing. This was because it was being re-roled to a main wing for prisoners on normal location and would no longer cater for vulnerable prisoners.

14. My investigator was informed that the healthcare department is currently transferring to a new system for holding patient records and updating information. This is called System 1 and means that in the future, patient notes will be computerised. My investigator noted that when it is implemented, it will meet a recommendation by HM Chief Inspector of Prisons, Ms Anne Owers, that "an electronic patient record system should be installed".

15. My office had received a complaint regarding the impact on prisoners of the wind turbine at Whitemoor. The complaint raised concerns regarding the negative effects of the noise of the turbine which research had linked with depression. My investigator spoke with the Governor, his staff and prisoners about the turbine. My investigator was told that the local newspaper had voiced concerns initially over the noise of the turbine and the impact upon the landscape when it was installed. To date, staff and prisoners were not aware of any complaints of any nature from staff or prisoners regarding either noise or the turbine. Neither had any effects been linked to health matters in the prison.

KEY FINDINGS

20. The man was remanded into custody and located in the segregation unit at HMP Gloucester on 17 December 1993. He had been convicted of serious offences following a trial at a Crown Court. On 25 February 1994, a life sentence with a tariff of ten years was imposed.

21. The man transferred to HMP Wakefield on 7 March 1994. He was unsuccessful in his appeal against his life sentence in February 1995. After a period in HMP Full Sutton, he transferred to Whitemoor on 1 December 1999, where he remained until his death on 13 January 2008.

22. There is a documented medical history of the man's period in custody and this has been examined more fully in the clinical review. The man had a mild heart attack on 14 March 1993 while at Gloucester prison. An entry in the man's personal records on that day says he was admitted to Gloucester Royal Infirmary**.** He was discharged from hospital on 18 March 1993.

23. Following a referral by the prison, the man was seen at Pinderfields General Hospital, Wakefield on 28 November 1994 by a Senior Lecturer in Cardiology. The doctor wrote to the Medical Officer at Wakefield, on 28 November 1994 to say that "The diagnosis of coronary disease is not in doubt and I think the indication for further investigation would be progressive shortness of breath or more significant pain on exertion". The doctor suggested that the man's condition should be managed by medication and a reduction in his prescription of atenolol could be considered. (Atenolol is a drug to help lower blood pressure.)

24. Between the end of 1994 and September 1996, the man attended healthcare for medical ailments other than for his heart condition but his health appeared stable. An entry in his medical record dated 3 September 2006 says healthcare staff had been asked to see the man as he had complained of chest pain while exercising the day before. The following day, his condition had not improved and he was sent to Pinderfields General Hospital for investigation. The man returned to the prison the same day. My investigator noted that, although the record gave detailed reasons for the man going to hospital, the outcome had not been recorded. It is also a concern that the next entry is dated 18 January 2007. If the IMR is an accurate record of patient contact, it would indicate that the man had not been seen by healthcare between his discharge from hospital to his appointment with the prison doctor, on 18 January some four months later.

25. The clinical reviewer and my investigator found the standard of record keeping was poor. The Inmate Medical Record (IMR) was difficult to follow at times as entries were not always made in chronological order and some staff handwriting was difficult to read. The Head of Healthcare acknowledged that this was a problem. She informed my investigator that a new computerised patient record system called SYSTEM 1 was due to be implemented. It would require medical staff to record appointments and medical treatments onto a

Events of 13 January 2008

26. An officer on C wing said that he unlocked the cells on 'C' wing at around 8.15am and did so in accordance with the policies and procedures he learnt in training. He said that he looked through the flap in the cell door. (This was to ensure that the door was not blocked and that there was nothing of concern with the prisoner in the cell.) Then he unlocked the man's cell. He could not recall whether or not he received a response from the man, but he did not recall anything wrong at the time. He said that it was a Sunday morning and prisoners sometimes sleep late on a Sunday.

27. My investigator obtained and read prison service basic training protocols regarding cell unlock procedures. The protocol is very clear that a response should be received from the prisoner. The hot debrief notes stated that responses were obtained from prisoners on the day that the man died. The implication is that this would have included a response from the man, suggesting he was alive when the cell was unlocked. However, as the officer cannot recall if he received a response or not, it is difficult to be clear as to whether the man was alive when the cell was unlocked or if it was assumed he was sleeping.

28. At around 8.24am, a second officer said he heard a prisoner, and friend of the man, calling to him from behind the locked gate to 'C' wing where the man was located. The officer said that the other prisoner was 'in a distraught state' saying that he could not rouse the man. The officer immediately went to the centre wing office to ask for assistance from a third officer. Both the third officer and the other prisoner went to cell B3-26 where they found the man collapsed. They described finding the man as being half on and half off the bed. His head and upper body was positioned between the bed and a chair next to his bed. His lower body was fully on his bed.

29. On checking the man for signs of life, neither the officer nor the other prisoner could find a pulse. They said that they commenced cardio pulmonary resuscitation (CPR) at that point.

30. Around the time the man was discovered, a senior officer was overseeing the movement of prisoners from 'C' wing down to the servery to collect their breakfast. A nurse was in the treatment room on her own dispensing medicines to prisoners. The senior officer said he overheard the third officer, who was outside the man's cell, asking for assistance from staff. The senior officer said he went to the man's cell but two officers together with the nurse were already there. He said there appeared little he could do to assist within the cell. However, he instructed wing staff who were not involved in the incident to secure all prisoners in their cells and to carry out a roll check. He instructed the wing collator, (a wing collator is responsible for the administrative tasks on the wing) to tell healthcare, the control room and Oscar 1. (Oscar 1 is the person who is in charge of the operational running of

31. The wing collator said she carried out the senior officer's instructions. She telephoned healthcare, informed them of the emergency, and asked them to bring a defibrillator.

32. At the time the man was found, prisoners were unlocked and waiting at the servery on the ground floor to collect their breakfast. The servery is located near to the treatment room on the first floor.

33. In her statement, the nurse said that an officer came to the treatment room and asked her to see the man as he was 'suffering from chest pain'. To my investigator, this has suggested that the man had been able to speak to staff. However, in interview, the nurse made it clear that she thought the officer said this because she did not want to alarm prisoners who would have overheard her.

34. The two officers did not call for healthcare assistance over the radio net because neither officer was carrying a radio. A fourth officer did not have a radio either and so she ran from the central office to the ground floor and then to the treatment room. She wanted assistance from the nurse, who also had no radio and had been called verbally by the fourth officer who ran to alert her.

35. At interview with my investigator, the nurse said that when she arrived at the man's cell at 8.28am, she was disappointed to find that the officers had not started CPR. The man was face down on the bed "with his head hanging down between the bed and the chair". The nurse said that she rolled the man on to his front and checked for a pulse for around ten seconds. She told my investigator that pocket masks for giving mouth to mouth resuscitation were not carried by all staff. There was one available on the wing and healthcare staff had been issued with them but the nurse did not have one. Therefore she started CPR with chest compressions only, assisted by two officers, until a mask was provided. The second officer began the task of logging the incident with action taken and movements by various members of staff entering and leaving the cell.

36. The nurse said that she asked for healthcare staff to be contacted immediately and to bring emergency equipment. The third officer called to the wing collator who was in the central office to ask for assistance. The wing collator said that she contacted healthcare and stated that there was an emergency and asked staff to bring the defibrillator.

37. A few minutes later, a second nurse arrived with the defibrillator. When attached to the man, the defibrillator showed that he had a non-shockable

38. At approximately 8.35am, the wing collator telephoned the control room and asked Oscar 1 to call for an ambulance to attend the wing. The control room log sheet shows that an ambulance was called and arrived at the gate at 8.39am. The first paramedic crew had difficulty in inserting a canula (a tube which puts essential liquid medication directly into a vein) into the man. The nurse said she continued CPR until the second paramedic crew arrived at 8.50am. The two nurses and the forth officer left the cell in order to allow the paramedics space to care for the man.

39. In the East of England Ambulance Service report, it is recorded that paramedics took over administering CPR at 8.50am. They conducted an electrocardiogram (ECG) test to measure the electrical activity of the man's heart and administered adrenaline through an intravenous line. Unfortunately, all attempts at resuscitation by both staff and paramedics were unsuccessful and the man was pronounced dead at 9.15am by the paramedic crew.

40. The other prisoner was taken to healthcare by staff to be cared for and monitored while he adjusted to the loss of his great friend. The prisoner informed the Reverend that "staff have been brilliant". The Reverend informed my investigator that, on the same day, he went to each cell on 'C' wing to inform every man personally of the man's death.

41. At 10.15am, the IMB member said that she arrived on 'C' wing with Oscar 1. She saw the right hand side of the landing was screened off and also noted that the staff involved were calm.

42. The Deputy Governor, arrived to chair a hot debrief at 10.26am. The IMB member's report states that "the hot debrief was calm and well balanced with both the deputy governor and Oscar 1 ensuring staff welfare was known to be of equal importance as ensuring the regime continued as smoothly as possible". The Staff Support & Care Team member reiterated his and the team's availability at any time.

43. The duty doctor from the SUFDOC out of hours service, attended the cell, accompanied by Oscar 1 to examine the man. He confirmed death at 11.00am. Other members of staff, including the Governing Governor attended the cell and spoke to the other prisoner later that morning. The man was removed from his cell by the undertaker at 11.52am and the cell sealed.

44. The following Thursday, a memorial service for the man was held at the prison. It was well attended by prisoners and staff and was conducted with the aim of possible closure regarding the man's death, which the Reverend considered important.

45. The IMB member told my investigator and the clinical reviewer that, in her view, the prison had learnt lessons from previous deaths. She said that the prison had a "real desire to deal with it [the man's death] professionally".

ISSUES

The clinical review

46. The clinical review was undertaken by the Chair of the Clinical Care Review Panel for Cambridgeshire Primary Care Trust (PCT) and the Professional Performance Manager at Cambridgeshire Primary Care Trust. Interviews with medical staff and officers at Whitemoor were conducted on behalf of the Clinical Care Review panel. Although the panel acknowledged that the clinical records were poor, they were able to conclude that the care the man received was reasonable and equitable with that he would have received outside prison.

47. In 1993 the man had been diagnosed with chronic heart disease. The panel found that, due to poor recording keeping, it was difficult to tell whether the man had attended the cardiac clinic or if he had been identified as a prisoner who would benefit from chronic disease management. It may have been the case that the man did not wish to avail himself of the cardiac clinic. However, there is no evidence in his medical records that the man was aware that the clinic was available to him. I have made no recommendations regarding recording keeping as improvements are in hand via the computerisation of medical records at Whitemoor.

The provision of equipment

48. The panel concluded that there had been a delay in communication on the day the man died. I agree that there are issues regarding communication which should be addressed. My investigator understood that healthcare staff generally had access to two radios. However, on the day the man died, healthcare staff only had access to one radio. This had been issued to the member of healthcare staff who was Hotel 1 and responsible for responding to emergencies. Neither the nurse nor the staff unlocking prisoners had radios. This meant that when the man was discovered, an officer had to run downstairs to fetch the nurse. The nurse lost time in attending as she had to secure the medicines and lock the treatment room. She would have been alerted to the emergency sooner via the radio net if she had carried a radio. In the man's case, healthcare staff not having a radio would not have altered the outcome, but it might be a crucial factor in another emergency in the future.

The Governor should review the policy for the distribution of radios to staff. He should ensure that sufficient healthcare staff and a greater number of wing staff carry radios to enable an immediate response to medical and other emergencies.

49. The nurse said that she had not been issued with a pocket mask since beginning her work at the prison. While acknowledging this did not delay matters, this should be rectified and all staff should be issued with pocket masks with appropriate training in their use.

The healthcare manager should ensure that all staff are issued with a pocket mask and are given appropriate training in its use.

The man's ashes

50. The prison does not have a clear policy regarding what is to be done with the property and remains of a prisoner without next of kin. To her great credit, the family liaison officer made every effort to find the man's next of kin, without success. The family liaison officer acted in the best interests of decency and with the greatest of respect for the man when she assumed responsibility for scattering his ashes without the benefit of such policy or guidance. However, the question of how the remains of a prisoner without family are disposed of remains the responsibility of the Governor. My investigator alerted both the Governor and the Reverend to the problem and they will develop a policy to deal with the issue.

Conclusion

51. The man was a well respected prisoner whose death was sudden and unexpected. When he was found collapsed in his cell, staff and ambulance paramedics made every effort to save his life, but were unsuccessful.

52. Although I have made recommendations relating to the issue of pocket masks and the distribution of radios, the investigation found that the quality of care that the man received was reasonable and equated to that which he would have received in the community.

RECOMMENDATIONS

1. **The Governor should review the policy for the distribution of radios to staff. He should ensure that all healthcare staff working on the prison wings should carry radios to enable immediate response to medical emergencies.**

   'Accepted. A review of the policy relating to the distribution of radios will be undertaken. In addition to this, HMP Whitemoor will also examine an alternative paging system (similar to hospitals) to be used by the Health Care Centre for their nurses on duty to complement existing systems of communication.' A target date has been set for [28] February 2009.

2. **The Governor should ensure that all staff are issued with a pocket mask and are given appropriate training in its use.**

   'Accepted. All staff with direct prisoner contact will be issued with a pocket mask. As part of the rolling training programme 2009/10 training will be delivered on the use of pocket masks.'