

**Investigation into the circumstances surrounding the
death of a man in February 2010 in hospital, while in the
custody of HMP Lindholme**

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

May 2011

This is the report of an investigation into the death of a man February 2010 at a hospital. He complained of chest pain on that evening and a nurse was called to see him. He was breathless and the nurse asked for an emergency ambulance. He was taken to hospital where, despite efforts by medical staff, he died at 9.44pm. He had a history of heart disease and was 34 years old.

Her Majesty's Coroner for South Yorkshire East District held a post mortem into the man's death. It was recorded that he had died of aortic stenosis (a narrowing of the aortic valve in the heart). I extend my sincere condolences to his partner, family and friends at the tragic loss of a young man. I must apologise for the delay in issuing this report and any additional distress that this caused.

The investigation was undertaken by one of my colleagues. A review of the man's healthcare was commissioned with Doncaster Primary Care Trust (PCT) which is annexed to the report. I am grateful for that clinical review. I would also like to thank the Governor and his staff for their help and assistance with this investigation. I am especially grateful to investigation liaison officer.

The investigation was suspended from 1 March to 6 May, at the request of South Yorkshire Constabulary, whilst they made enquiries into the man's death. I would like to thank a Detective Constable and an Acting Detective Sergeant for their assistance.

One of my family liaison officers contacted the man's family to inform them of our investigation and any issues they would like to be considered. In June, one of my Family Liaison Officers and my investigator met the man's family and their solicitor to discuss the points they wished my investigator to consider.

I make three recommendations: the first is for the Head of Healthcare at Doncaster and relates to urgent secondary care appointments. The second recommendation for Doncaster and the Head of Healthcare at Lindholme, concerns hospital appointments for transferred prisoners. My third recommendation to the Governor of Lindholme, concerns informing families of a prisoner's death. I note a recommendation from the clinical review for the consideration of the Head of Healthcare at Lindholme regarding information systems on prisoner's specific health conditions.

In this final report, the responses to the draft report are noted in the investigation process section, paragraph 16.

Jane Webb
Acting Prisons and Probation Ombudsman

May 2011

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SUMMARY

1. The man arrived at Doncaster on 20 April 2009, following an appearance at Crown Court. He was sentenced to 21 months imprisonment, plus a further three months for failing to appear in court in 2006.
2. A first reception health screen document was completed and it was noted that the man had heart problems. (This document records the prisoner's current and past medical history, their medication and mental health.) A nurse took the man's blood pressure and pulse rate. Two days later, he was assessed by a doctor who noted that the man had low blood pressure and endocarditis (an inflammation of the inner tissue of the heart). The doctor referred him to a cardiologist at a hospital.
3. The man was transferred to Lindholme on 15 May and on his arrival the doctor noted that the man was feeling well and waiting for a cardiology appointment at a hospital. Healthcare staff contacted the hospital to tell them that the man was now at Lindholme. Nevertheless, the hospital sent the notification of his cardiology appointment to Doncaster. Neither Lindholme staff nor the man received this notification, and consequently he missed his cardiology appointment.
4. In August, the man complained to the healthcare unit that he not been to see the cardiologist. While his complaint was being considered, the man saw the doctor on 8 September, who made an urgent referral to hospital. Subsequently, the man was seen at the hospital and arrangements were made for him to be fitted with a 24 hour electrocardiograph (ECG) monitor, to check his heart rate, on 8 December.
5. Three weeks later, on 30 December, the man was told the results of a 24 hour of his ECG which indicated a severe aortic regurgitation. (Aortic regurgitation is when blood leaks back through the aortic valve as the valve does not close properly.) He was told that he would be seen again in cardiology out patients in six months time. The man was also prescribed a nasal spray and paracetamol for cold like symptoms.
6. A nurse was on duty at 7.20pm on 2 February 2010, when she responded to an emergency call on K wing. The man was having chest pain and the nurse took his blood pressure and pulse rate before asking for an ambulance to be called. The man became breathless, hot and unable to tolerate an oxygen mask. The nurse then asked that the ambulance request was upgraded to an emergency. The man told the nurse that he had taken Clonazepam which was not his. (Clonazepam is an anti-anxiety medication.)
7. The man was transferred to hospital at 8.30pm and arrived in the accident and emergency department at 8.40pm. Whilst hospital staff examined the man he became unconscious and, despite attempts to revive him, his death was confirmed at 9.44pm.

8. I make three recommendations about hospital appointments, referrals for secondary healthcare and informing families of a death of a prisoner. I note one recommendation made by the clinical reviewer.

THE INVESTIGATION PROCESS

9. The investigation into the man's death was opened on 9 February 2010, when my investigator visited Lindholme. She was met by the liaison officer and reviewed the man's prison and medical files. Selected copies from those documents were forwarded to her. Later, my investigator met the Governor, the Deputy Governor and Head of Residence. Due to a recent death of a member of the prison staff, my investigator did not visit any areas of the prison.
10. Notices of the Ombudsman's investigation and notices to staff and prisoners were sent to the prison in advance of my investigator's visit. No members of staff or prisoners have responded to those notices. The Independent Monitoring Board (IMB) did not ask to see my colleague and her details were made available to them. (The IMB are a group of community based volunteers who monitor the day to day life of the prison, its staff and prisoners.) She met a Senior Officer from the Prison Officer's Association.
11. A review of the man's healthcare was commissioned by Doncaster PCT. There was an initial delay in the PCT appointing a clinical reviewer. Eventually, a reviewer was appointed to carry out the review on behalf of the PCT. The clinical reviewer's review was further delayed by waiting for a response from the cardiologist at the hospital. The clinical review was not received by the investigator until 28 January 2011 which delayed my own report.
12. On 1 March, the investigation into the man's death was suspended whilst South Yorkshire Constabulary carried out enquiries into his death. The investigation resumed on 6 May.
13. One of the Ombudsman's Family Liaison Officers contacted with the man's father to see if he wanted any issues to be considered as part of the investigation. On 26 March, my investigator wrote to the family solicitor to disclose documents relating to the investigation.
14. My investigator visited Lindholme on 19 May to interview three officers. On 29 June, she and another of my family liaison officers met the man's family at their solicitor's office. Following a discussion with the family the main points they wished to be to be considered as part of the investigation are:
 - Whether the man's history of heart disease was managed appropriately including knowledge of previous treatments and medication?
 - The cancelled outpatient appointment.
 - Being told inappropriately about the man's death.
 - How the man had managed to take unprescribed medication?
15. On 23 August, my investigator and the clinical reviewer jointly interviewed three members of the healthcare staff.

16. In this final report the man's family raised one point. They asked for copies of the hospital notes as referred to in the clinical review. I do not have those notes and therefore unable to disclose them to his family. If they wish to pursue this course of action then an application should be made to the hospital via the Patient Advice and Liaison Service. The prison service has accepted the three recommendations. There were three factual inaccuracies, two minor ones and an amended paragraph 17.

HMP LINDHOLME

17. HMP Lindholme is a purpose built prison on the site of a former Royal Air Force Airfield. It opened as a prison in November 1985. The accommodation has been converted from dormitory conditions into single occupancy rooms on lockable spurs. Within the last 9 years purpose built cellular accommodation has been erected'. It has an operational capacity of 1010.
18. Serco, an independent medical service, has provided healthcare services in Lindholme since June 2008. There are no inpatient beds and medical services are provided by a visiting doctor, who visits daily and sees prisoners who have applied for an appointment. The clinical staff provide a day time service, and are all appropriately qualified. Sickness and treatments are managed by nursing staff. Out of hours medical emergencies are provided by an on call doctor's service
19. The last inspection of Lindholme by the former Her Majesty's Inspector for Prison's which noted 17 recommendations in areas of healthcare services. (This was prior to the change in healthcare service provision and at the time healthcare was provided by Doncaster PCT.) She said:

"Prisoners considered the overall quality of health services to be poor. Tenders had recently been issued for the operation of primary care services."
20. I understand that an inspection of Lindholme has taken place recently but the report is not yet available.
21. The Independent Monitoring Board said in their annual report for 2009-2010:

"The Doncaster Primary Health Care Trust has the responsibility for the provision of Healthcare delivered under contract by Serco. This has been problematic to say the least. Despite this staff have responded in a professional and dedicated manner to the demands placed upon them."
22. There have been four previous deaths at Lindholme due to natural causes since 2004, when my office took responsibility for investigating deaths in custody. Two of those deaths were from heart disease. In both cases it was noted that healthcare staff acted appropriately and no recommendations were made in relation to emergency responses.

KEY EVENTS

23. The man was born in September 1976. He had a partner in Ireland and family living in South Yorkshire. The man had previous convictions, however this was his first custodial sentence.
24. In December 2006, he was sentenced to 21 months' imprisonment by a Crown Court. He did not appear for the court proceedings and in his absence an arrest warrant was issued. The man was subsequently arrested in April 2009. Following a court appearance he was remanded to HMP Altcourse.
25. He appeared at a Crown Court in April where he received three months in custody, to be added to his original sentence of 21 months. The man was taken to HMP Doncaster. A first reception health screen document was completed and it was noted that the man had heart problems. He said that he had previously used illegal drugs, however he told healthcare staff that he had not taken any substances for over a month. The man's blood pressure was recorded as 138/32 (an average range for a blood pressure reading would be 130/80) and his pulse rate was 72 beats per minute or bpm (an average reading would be between 60-100 bpm). Despite these observations being in the normal range, he was referred to see a doctor, as he was a newly arrived prisoner.
26. The man did not go to healthcare the following day. On 22 April, he saw the doctor and it was noted that he had low blood pressure and endocarditis. His observations were recorded as blood pressure 140/40 and a pulse rate of 72 bpm. The doctor ordered blood tests to be taken and referred him to a cardiologist.
27. The following day, despite five attempts, a nurse was unable to obtain a blood sample from the man. It was written that the sample would be taken again at the earliest opportunity. A fax was sent to a hospital referring the man to the cardiology department.
28. On 24 April, the man had an electrocardiograph (ECG). A doctor reviewed the results of the ECG which confirmed his heart condition. The man told the doctor that he had previously been treated for endocarditis when he was in Ireland. Whilst at the healthcare unit for his ECG, the man complained of chest pain. He was booked to see the doctor the following day, but did not attend. No reason was recorded as to why the man failed to keep his appointment.
29. The healthcare administrator wrote to a hospital in Ireland, to ask for the man's medical records. A doctor examined the man on 29 April and noted that that he had intermittent chest pain, which he described as short lived but not sharp. The doctor recorded the man's previous medical history of heart disease and that he had misused intravenous drugs ten years earlier. A blood test was taken in the healthcare unit the following day. The man's medical notes were received and forwarded to the hospital by the healthcare unit on 7

May. They confirmed that the man had been treated for infective endocarditis in July 2008.

30. The man was transferred to Lindholme on 15 May where he saw a nurse who noted that he had heart disease. Later, he saw the doctor who wrote that the man was waiting for a cardiology appointment, but that he felt well. Contact was made with the medical records department at the hospital to inform them of the man's transfer to Lindholme so that all the future correspondence about his outpatient cardiology appointment would be sent to the right prison.
31. A month later, the man failed to attend a doctor's appointment on 16 June at 9.30am. At 10.25am, a wing officer telephoned the healthcare unit to say that the man had told her about his heart problems, he was breathless and felt unwell. The officer was advised to ensure that the man came to the healthcare unit to see the doctor. Later, he was examined by a doctor who prescribed paracetamol.
32. Coincidentally the man should have attended an outpatient appointment at the cardiology department at the hospital on the same day and this appointment was not kept either. Furthermore, nothing was recorded in his medical notes about why the man did not go to hospital. At interview, the former Healthcare Manager said that the appointment date had been sent to Doncaster, and staff at Lindholme were unaware of this.
33. The Head of Healthcare further explained that the man had made a formal complaint via his solicitors that he had not yet been seen by the cardiologist. The Head of Healthcare wrote to the man's solicitor in response suggesting that he should make a further appointment with the doctor to "resolve the issue". She said that another hospital appointment had not been made, and so the man would need to be referred by a doctor again.
34. The man saw a doctor on 8 September, who noted that he was unhappy that the prison had not taken him to the hospital for his appointment. The doctor examined him and noted that his blood pressure was 144/62 and his pulse rate was 110 bpm. The man told the doctor that he felt well and the doctor observed that he had a good skin colour. Following the examination, the doctor made another referral to hospital cardiology department. The doctor noted that the previous appointment in June had not been kept due to management problems and asked for an urgent referral.
35. An entry in the man's wing contact log noted that he was seen in the company of a prisoner who was believed to be involved in the illegal drug and mobile telephone culture on wing. Three weeks later, the contact log further recorded that the man was "flitting" around the wing and would "need watching".
36. On 8 December, the man went to the cardiology department and a 24 hour ECG monitor was attached to his chest to detect any irregular heart rhythms. A healthcare nurse contacted the wing office to explain that it would be taken

off the following day. The tape would then be returned to the hospital for analysis.

37. Following a dental appointment on 11 December, the man needed further dental treatment. The dentist noted that he would speak to the doctor as the man might need antibiotic treatment before the treatment could be carried out. At the time, antibiotics were used to reduce the risk of infection when patients with certain heart related illnesses were undergoing dental treatment. A doctor at Doncaster had written in the man's medical record that he would need to take antibiotics if any dental treatment was needed.
38. A physician from the cardiology department wrote to the doctor at Lindholme on 21 December. The results of the man's 24 hour ECG monitor indicated that he had a severe aortic regurgitation. (Aortic regurgitation is when blood leaks back through the aortic valve as the valve does not close properly.) There was also evidence of other heart problems. The physician wrote that he would see the man at his clinic in six months time.
39. Nine days later, on 30 December, a doctor examined the man in the healthcare unit and told him the results of the ECG. The man was not receiving any treatment at that time but told the doctor that he was experiencing some night time palpitations which the doctor reassured him about. The doctor prescribed paracetamol and a nasal spray, though without noting the reason. At interview, the doctor told the investigation team that he recalled the man having a blocked nose and a cold which is why he prescribed the medication.
40. The man attended a dental appointment on 28 January 2010, with a different dentist than he had seen on his previous appointment. The dentist explained to him that the most recent guidelines from the National Institute for Clinical Excellence indicated that patients suffering infective endocarditis no longer needed antibiotic medication when they were receiving dental treatment. (NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.) The man was not prescribed an antibiotic before his treatment but was told to tell staff if he felt unwell, in pain or if he experienced any sweating and fever like symptoms.
41. An officer told my investigator that wing staff were aware that the man had heart problems and there was a notice in the wing office to advise staff to call for an emergency ambulance if he had any problems. The investigator could not establish who posted this notice.
42. Found in the man's prison file after his death and written in his hand, was an undated list of symptoms he was experiencing, including breathlessness. There is no date or reference to this list noted in his medical notes. Furthermore, the investigator was unable to clarify whether the list was intended to be read by healthcare staff as there was no indication who it was intended for.

2 February

43. A nurse was on evening duty on 2 February 2010. After completing her medication round and returning to the healthcare unit, she received a call on her radio at 7.20pm. She was told her that a prisoner on K wing had chest pain. She went to the healthcare unit and collected an emergency bag (which holds equipment to deal with breathing and cardiac problems) and made her way to K wing.
44. On arrival at K wing, she saw the man crouching on the floor close to the wing entrance. He was fully conscious and talking and he told the nurse that he was having chest pain. The nurse asked him about his general health and The man told her of his heart problems. The nurse helped him to a chair and told wing staff to call for an ambulance to take the man to hospital.
45. Following a further conversation and an assessment, the nurse told wing staff that a call should be made to the Ambulance Service to upgrade the first call to an emergency. Furthermore, the nurse asked for the man's medical notes to be brought to the wing from the healthcare unit. The nurse took his blood pressure which read 100/60 and his pulse was faint but regular.
46. The man was given a Glyceryl Trinitrate (GT) spray to help his breathing and pain, along with aspirin and oxygen. (A GT spray helps to improve and regulate the heart rate.) His skin was cold and clammy, he was agitated, restless and tried to remove the oxygen mask. The man told the nurse that he was "burning up" and insisted on taking off his top clothes and sitting near an open door. The nurse advised him to take oxygen but he could not tolerate the oxygen mask on his face.
47. The nurse asked the man if he had taken anything, meaning illicit drugs or alcohol, and he replied that he had some Clonazepam which was not his. (Clonazepam is an anti-anxiety medication.) The nurse checked the man to see whether he had an allergic reaction but there was none. She asked for an update on the arrival of the ambulance and was told that it would be another 14 minutes before it arrived. The nurse assessed the man's condition as stable, but nevertheless she said that she wanted the ambulance to arrive as soon as possible.
48. The man still insisted on sitting near to an open door. His hands had turned blue, and the nurse asked him if he felt cold but he repeated that he was "burning up". He still declined the oxygen and would not allow the nurse to put on the blood pressure monitor.
49. On the arrival of the ambulance, the man was taken to hospital escorted by two officers at 8.30pm. As the man was still conscious, the officers used an escort chain, which is a 1.8 metre length of chain with one cuff attached to the prisoner and the other to an officer, to prevent his escape. The nurse handed over the man's medical notes to the ambulance crew.

50. Ten minutes later, the ambulance arrived at the hospital and the man was admitted to a resuscitation room. Hospital staff were in the processing of assessing the man's condition at 9.10pm, when he became unconscious. The officers removed the escort chain to allow hospital staff to start cardiac pulmonary resuscitation (CPR). At 9.44pm, the doctors pronounced that the man had died.
51. At midnight the man's father was visited by police officers and told of his son's death. (The man's father lives within a 30 minute drive of Lindholme prison.) After receiving the news, he telephoned his two daughters, who both lived nearby, and they made their way to the hospital.
52. At 2.15am, the man's sisters arrived at the hospital and were met by the prison's family liaison officers. The officers offered their condolences and made themselves available to support the man's family. Over the following days, the liaison officers maintained regular contact with the family.
53. Prisoners on K wing arranged a collection and sent a floral tribute to the funeral service, which was attended by the Head of Residence as a representative of the prison. The prison offered financial assistance towards the cost of the funeral.

ISSUES

Clinical Care

54. A review of the man's medical care was commissioned by Doncaster PCT. A healthcare professional carried out that review on behalf of the PCT. She reviewed the man's medical notes, interviewed healthcare staff with my investigator and made enquiries with a cardiologist at the hospital.

The man's endocarditis

55. On 24 April, a doctor at Doncaster reviewed the man's ECG reading indicating that he had a heart condition. The doctor wrote to the local cardiology appointment asking for the man to be reviewed urgently. It is the clinical reviewer's opinion that it would have been beneficial for the man to be seen by a cardiologist straight away, rather than simply making a referral. The clinical reviewer said.

"It is unknown if the intervention at this stage would have affected the outcome but it is possible that early treatment may have had a beneficial effect. Untreated Endocarditis is known to be potentially fatal in the long term."

56. I therefore endorse the following recommendation for the attention of the Head of Healthcare at Doncaster:

The Head of Healthcare at HM&YOI Doncaster must ensure that doctors are aware of the circumstances when prisoners need immediate attention from secondary care services following ECGs. A clinical audit should be conducted to ensure that appropriate clinical responses take place following ECGs.

Cardiology appointment

57. Despite Lindholme contacting the hospital to notify them of his transfer, the man's appointment to see a cardiologist on 16 June was sent to Doncaster instead of Lindholme. There was no evidence of communication between the prisons and the man did not attend this appointment. Furthermore, when he complained to Lindholme healthcare staff that he had not been seen by the cardiologist, he was told that it was his responsibility to see the prison doctor and ask for another appointment.

58. Like the clinical reviewer, I take the view that healthcare staff should have arranged another appointment for the man once it became apparent that he had missed it. I agree with the clinical reviewer that it was the man brought the missed appointment to the attention of staff and considering his history of heart disease, I think that staff should have ensured that the appointment was rearranged at the earliest opportunity. I therefore endorse the following recommendation for the attention of the Heads of Healthcare at Lindholme and Doncaster.

The Heads of Healthcare at HM&YOI Doncaster and HMP Lindholme should introduce a robust system to ensure good communication about prisoner's healthcare needs and any pending appointments when prisoners are transferred to another prison.

The man's history of infective endocarditis

59. The clinical reviewer noted in her review that patients who have previously suffered from infective endocarditis are at risk of contracting this condition again. The man was seen by the doctor on 30 December 2009, with cold symptoms and prescribed a nasal spray. However, in the clinical reviewer's opinion, those symptoms should have been further investigated and tests taken to rule out any return of infective endocarditis. Whilst the post mortem examination shows that the man died of aortic stenosis, I agree with the clinical reviewer that "it might have been beneficial" for The man to have been tested for infection on 30 December.

Dental treatment

60. The man received dental treatment on 28 January 2010. The doctor at Doncaster had noted in the man's medical record that he should be prescribed antibiotic medication prior to dental treatment, given his history of endocarditis. The guidance for prescribing antibiotics for dental treatment was changed in 2008, following advice from NICE. The dentist who carried out The man's treatment did not prescribe antibiotics which was in line with current NICE guidelines. The clinical reviewer said:

"It is unknown if the man was suffering from Infective Endocarditis prior to his death, or if the fact that The man had dental surgery is significant in this case but I am satisfied that the dentist involved followed the national guidelines available to him."

Response to The man's collapse

61. In the clinical reviewer's opinion, the nurse's response to the emergency call on 2 February was "swift and appropriate". The nurse accessed the man's medical record as she had not previously met him or had any knowledge of his pre-existing medical condition.

62. The clinical reviewer commends the nurse for her attempts to treat the man and make him comfortable. However, the clinical reviewer also comments that it might have been helpful if the nurse could have quickly identified his medical condition thereby enabling her to pass this information on to the Ambulance Service. The clinical reviewer noted, "... there was no way of knowing if this would have changed the outcome in anyway". She commends the nurse and asks the Governor to pass this to her.

63. Within the confines of medical information being held in confidence, I ask the Head of Healthcare at Lindholme to consider the recommendation made by the clinical reviewer, for information to be made available to wing staff or

visiting healthcare staff, about a prisoner's specific health conditions, the risks and possible treatment options. Additionally, advice could be given about useful and appropriate information which could be passed to the emergency services.

Illicit drug use

64. The toxicology report from the man's post mortem indicated there were traces of Clonazepam in his gastric juices, but not in his blood stream. This drug is used to treat convulsions, panic disorder and is also a muscle relaxant. The drug is used to treat epilepsy. At no time was the man prescribed Clonazepam.
65. At interview, the man's personal officer told my investigator that it was suspected that the man might have been involved in illicit drug use on K wing. Entries had been made by wing officers on the man's contact log to the effect that he should be observed as he was seen to be associating with prisoners who were similarly suspected to be involved in illicit drug use.
66. The officer told my investigator that the illicit drug use could either be drugs brought into the prison or by prisoners selling or giving their own prescribed medication to other prisoners. The South Yorkshire Police carried out their enquiries as to how the man had come to be in possession of Clonazepam. Following their investigation, I am advised that there no criminal charges will be brought.
67. The post mortem report notes that the man's cause of death was congenital heart disease bicuspid aortic valve stenosis (abnormal narrowing of the aortic valve opening). From the post mortem report the pathologist added that, "sudden cardiac death can occur at any time in such individuals".
68. The clinical reviewer noted in her review that the medication Clonazepam is prescribed for anxiety and as a muscle relaxant. She said,

"It does not have any side effects that would account for the symptoms that the man experienced on the day of his death. There is no reason to believe that if the man had taken this drug, that it would have contributed in any way to his death."
69. The use of illicit drugs is problematic across the prison estate. While resources and searches are used to address this problem, it continues to be a matter of serious concern. By his own admission, the man had taken an illicit drug and taking unprescribed medication can be dangerous to any individual's health.
70. In concluding her review of the man's clinical care, the clinical reviewer writes that he had suffered from a long-term heart problem. She recognises that he might have needed surgery had he lived. However, there were some inconsistencies in his care that should be used to learn lessons for the future care of prisoners.

Notifying the family of the man's death

71. The man's father told my colleagues that he was told of his son's death when police visited him at his home shortly after midnight. He telephoned his daughters who then arranged to go to the hospital. On their arrival at the hospital, they were met by the prison's family liaison officers.

72. The family felt that they should have been told of the man's death by a representative from the prison who would have had more information about what had happened and been better able to tell them of what would follow. The Prison Service Order (PSO) 2710, family liaison guidance recommends:

"The family should be informed face to face as soon as possible after the death. Wherever possible, this should be done by a dedicated Family Liaison Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain."

73. Whilst acknowledging the lateness of the day, I agree that the prison should have liaised with the police and made arrangements for a joint visit if this was thought to be more appropriate.

The Governor should ensure that families are notified of a death in accordance with PSO 2710.

74. It should also be noted that the man's family felt well supported by the prison following his death and were appreciative of the assistance of their family liaison officers.

CONCLUSION

75. The man was already known to have a potential life threatening heart condition when he came into Doncaster prison. Following an ECG procedure, the doctor referred the man to a cardiologist at the hospital. In clinical reviewer's opinion the man's referral should have been dealt with as an emergency rather than as a referral. Furthermore, the first appointment was missed which might have been the result of communication problems between Doncaster and Lindholme's healthcare units. Lindholme's healthcare unit should have taken responsibility for re-arranging the appointment rather than asking the man to raise this with them himself.
76. The response to the man's collapse was timely and appropriate. Nevertheless, the clinical reviewer noted that healthcare information for prisoners with specific medical conditions should be readily accessible in the unforeseen event of a medical emergency. This information should be made available within the confines of medical in confidence.
77. The post mortem examination indicated that the man died from a narrowing of the aortic valve in the heart which was linked to his history of heart problems. The pathologist deemed that the man could have died at any time. Seemingly his dental treatment, cold symptoms and on his own admission, taking an illicit drug, were not linked to his death. The clinical reviewer observed that there were some inconsistencies in the man's healthcare and she makes three healthcare recommendations. I endorse two of those recommendations for the Heads of Healthcare at both Doncaster and Lindholme and note the third for the consideration of the Head of Healthcare at Lindholme
78. The man's family were understandably distressed about the way in which they were told of his death. I also consider this to have been insensitive and have made a recommendation that PSO 2710 should have been followed and prison staff should have told the family about the man's death.

RECOMMENDATIONS

The Head of Healthcare HMP &YOI Doncaster

1. The Head of Healthcare at HM&YOI Doncaster must ensure that doctors are aware of the circumstances when prisoners need immediate attention from secondary care services following ECGs. A clinical audit should be conducted to ensure that appropriate clinical responses take place following ECGs.

Accepted – “HMP & YOI Doncaster, clinical audits completed six monthly intervals, all secondary care services are followed by the doctor as a routine procedure.”

The Heads of Healthcare at HMP & YOI Doncaster and HMP Lindholme

2. The Heads of Healthcare at HM&YOI Doncaster and HMP Lindholme should introduce a robust system to ensure good communication about prisoner’s healthcare needs and any pending appointments when prisoners are transferred to another prison.

Accepted - HMP & YOI Doncaster

“HMP & YOI Doncaster has a tracking protocol for all hospital appointments in place, this enables us to follow patient’s journey through custody and ensures relevant documentation is transferred with the patients. Plans are afoot for System 1 also; this will reinforce the above process.”

Accepted - HMP Lindholme

“Any prisoner being transferred from one prison establishment to another should have a healthcare transfer including the IMR/SystemOne records being transferred at the time of transfer. When transferring a prisoner with an outstanding secondary care appointment, direct contact should be made with the receiving establishment to ensure follow up of this individual. If Lindholme are the receiving establishment, a named nurse should be nominated to follow up care. These recommendations will be developed into an operating procedure for the healthcare staff to follow.”

The Governor

3. The Governor should ensure that families are notified of a death in accordance with PSO 2710

Accepted – “Families will be notified of a death in accordance with PSO 2710. (Within this case the Police Family Liaison Officer notified the family and not the Prison Family Liaison Officer.)”