Investigation into the circumstances surrounding the death of a man at HMP Wolds in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report into the death of a man at HMP Wolds in March 2011. He died of natural causes and was 57 years old. A post mortem showed that he died from acute myocardial insufficiency (heart failure) and coronary artery atheroma (fatty lumps that restrict and reduce the blood flow through the artery to the heart, or hardening of the arteries).

I offer my condolences to the man's family and friends for their loss. One of my family liaison officers contacted the man's sister on 11 April 2011, to inform her about the investigation and to provide the family with an opportunity to raise any issues about the care he received in custody.

The investigation was carried out by my colleague. I would like to thank the Director and her staff for their co-operation, in particular the liaison officer for his liaison during the course of our enquiries.

I am also grateful to the local Primary Care Trust (PCT) for appointing a clinical reviewer to review the man's clinical care. As he died from natural causes, the findings in the clinical review were essential to my own conclusions. The review concludes that overall the standard of care he received was equitable to that which he could have expected in the community. However, I am concerned at the response to his chest pain on 6 March, and conclude that the PCT will want to consider the events of 6 March further.

Whilst I agree that the man's care was equitable to that expected in the community, there are areas for improvement. I make seven recommendations concerning healthcare assessment and care planning, requesting an emergency ambulance, response at unlock, family liaison officer training, and record keeping.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2012**

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SUMMARY

1. The man was sentenced to five years imprisonment at Crown Court, on 13 October 2008, and arrived at HMP Wolds on 28 October. His medical history included asthma, and he disclosed a family history of heart disease.

2. Having experienced discomfort on 6 November 2009, the man was admitted to hospital. He was subsequently diagnosed with a right hemispheric ischaemic cerebrovascular accident (CVA also known as a stroke) and asthma. He was discharged back to Wolds on 13 November, advised of healthy diet options and prescribed medication to reduce his cholesterol level.

3. Over the following year, the man's cholesterol reduced and he experienced no further symptoms. On 6 March 2011, he alerted staff that he was feeling unwell with pains in his chest. He was assessed by nursing staff and, following telephone advice from the on-call prison doctor, treated for indigestion. I am concerned regarding this and make a recommendation. The following day his symptoms continued, and he was admitted to outside hospital. It was discovered that he had suffered a heart attack and he underwent an operation to have a 'stent' fitted (an artificial tube inserted to increase blood flow in the heart). He was discharged back to Wolds on 12 March.

4. Several days later when staff unlocked the cells, the man was discovered in bed. Healthcare staff attended, but it was clear to them that he had died some hours earlier, and there was no attempt to revive him. Paramedics attended at 9.39am and formally pronounced that he had died.

5. The man had identified his next of kin as his sister. The Director of Wolds and a member of the chaplaincy team visited her at home later that morning to tell her of her brother's death. She was not at home but a conversation was had with her husband, who later informed her of the news. The prison offered financial support towards the funeral costs.

6. I am satisfied that the care the man received at Wolds was comparable to that which would be expected in the community. I make seven recommendations concerning healthcare assessment and care planning, requesting an emergency ambulance, response at unlock, family liaison officer training, and record keeping.

THE INVESTIGATION PROCESS

7. The investigation was opened on 24 March 2011, when the investigator issued notices announcing the investigation to staff and prisoners. She met the Director of Wolds and the liaison officer for my investigation. She also met with a member of the Independent Monitoring Board (IMB), who provided a short report, the prison family liaison officer and she visited B unit where the man died. During this visit she met with several members of staff and a group of prisoners, two of who she invited to be formally interviewed. My investigator was provided with all documentation relating to him. One further prisoner came forward in response to the notice of my investigation.

8. The investigator visited HMP Wolds again on 19 and 20 April. During these visits she interviewed seven members of staff and three prisoners. Following the completion of the interviews, the investigator met with the Director to give verbal feedback on the investigation at this stage. A further telephone interview was also completed with a member of staff on 5 May.

9. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care on their behalf and he was provided with all relevant documentation to assist this review. I thank him for undertaking this review and for his report.

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

11. One of the family liaison officers wrote to the man's sister on 11 April 2011 to inform her about the investigation and to invite her to ask questions or raise concerns about the care of her brother. Another of his sisters responded to this letter on 20 April. The following questions were asked about the care their brother received:

    - Would earlier transfer to hospital on 6 March have changed the outcome?
    - What treatment did he receive whilst in hospital between 7 March and 12 March?
    - Why were the family not notified of his admittance to hospital on 7 March and that he had undergone an operation?
    - What time was he pronounced dead?
    - What was the date and time of the post mortem?
    - Why were the family not advised of their right to visit him prior to the post mortem being undertaken?
    - Why was a healthy diet not available to him?

    I hope this report provides answers to these questions and helps the man's family have greater insight into the events leading to his death.

12. Initial feedback from the investigation was provided, in writing, to the Director on 11 May. I received a letter from her dated 13 May, in response to the initial

feedback provided. It was pleasing to see that my concerns have already positively influenced decisions regarding training and the recommendations made at the end of this report give direction for continued progressive change.

HMP WOLDS

13. HMP Wolds opened in early 1992 as a remand prison, but in 1993 its function changed to a category B local prison. It has since been changed to be a category C training prison serving the needs of second stage life sentenced prisoners.

14. Wolds is operated by the private firm G4S and accommodates 395 adult male prisoners aged over 21 years who are serving medium to long-term sentences. The prison offers several courses designed to address offending behaviour and a variety of daytime and evening education classes, as well as more mainstream skills training in workshops.

15. Healthcare services are provided by Primecare under a contract with G4S. Primecare provide nursing cover throughout the core day, from 7.30am until 8.30pm, on Mondays to Thursdays. On Fridays, nursing staff are on duty from 7.30am until 6.00pm and at weekends from 8.30am until 4.30pm. There are no in-patient services at Wolds.

Her Majesty's Chief Inspector of Prisons

16. HM Chief Inspector of Prisons last conducted an announced inspection of the prison between 7 December to 11 December 2009. The then, Chief Inspector noted that:

> "On our last visit in 2007 we described it as an improving establishment but, on our return for this full announced inspection, we found that there had been deterioration in a number of areas."

17. In relation to healthcare facilities, the report said:

> "Despite a wide range of health services being in place, access to many clinics, and overall delivery and development of most health services, was severely restricted because of staff shortages. Chronic disease management was reasonably good but compromised by infrequent clinics and the lack of training for staff."

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB), whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

19. In their annual report for the period 1 June 2009 to 31 May 2010, the IMB made the following comments specifically about the healthcare provision:

> "There have been a couple of occasions when prisoners, who require more nursing/medical care than could be provided at HMP Wolds, were refused timely transfer to a prison with 24 hour Healthcare. Until the Clinical Transfer Policy, which is under development, has been agreed, this situation could re-occur. The Board has highlighted a gap in care provided to prisoners, who because of temporary incapacity, need help with their essential needs e.g. rehabilitation support following a stroke, personal hygiene following physical injuries, maintaining cleanliness and order in cell. Whilst recognising that this falls outside the roles of Healthcare staff and PCOs, other prisons do have carer roles undertaken by prisoners."

20. The total number of prisoner complaints dealt with by the IMB during this period totalled 61, 11 of these related specifically to healthcare provision. The man did not submit a complaint about any issue to the IMB.

Performance rating

21. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four; 4 = Exceptional performance, 3 = Good performance, 2 = Requiring development, 1 = Serious concerns. The last published performance report dated Quarter 4 2009/10, HMP Wolds was given a rating of 2, a drop in performance form the previous rating of 3.

Risk assessments

22. On each occasion a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or a two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

Categorisation

23. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. A category D prisoner is one who can be reasonably trusted in open conditions.

Incentives and Earned Privileges (IEP) Scheme

24. The Incentives and Earned Privileges, or IEP scheme was introduced in 1996 to encourage and reward good behaviour in prisons. Governors have responsibility to develop their own schemes although the scheme must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges and incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association.

Prison Service Orders

25. Prison Service Orders were long-term instructions intended to last for an indefinite period. They were introduced to replace Standing Orders, Advice to Governors and Instructions to Governors and were updated by the issue of Prison Service Instructions (PSIs). Guidelines written in italics within the PSO are mandatory instructions

Previous deaths in custody at Wolds

26. The man's was the only death to have occurred at Wolds in the past year. There have been two previous deaths since the Ombudsman was given responsibility for investigating deaths in custody in England and Wales in April 2004 one due to natural causes, the other was self-inflicted. There are no similarities in the findings of previous deaths and that of his.

KEY EVENTS

27. The man was born in Shipley, West Yorkshire. His family advised that he was born in September 1947, although the prison records state 1953 and, prior to his imprisonment, lived in the West Yorkshire area. He appeared at Crown Court on 13 October 2008, when he was sentenced to five years imprisonment. He was due for release on 14 April 2011. This was not his first experience of prison. He had a history of drug misuse and was a smoker.

28. Initially, the man went to HMP Leeds, where he underwent an initial health screening. I am told that this would have been undertaken by a nurse, although there is no name or signature on the form. He told staff that he had asthma but no other medical conditions, although there was a family history of heart disease.

29. The man was transferred to Wolds on 28 October. He had previously been in custody at Wolds during another sentence. It is unclear if he underwent a healthscreen as the only related entry is a hand written note which states "start of new sentence, no change in medical circumstances".

30. The next entry in the man's medical record is dated 15 April 2009. He fell halfway down the stairs on B unit whilst reading his diary. He sustained bruising and cuts to his knees, which were cleaned and dressed. There were no other injuries.

31. The transition from paper to electronic medical records appears to have been fully completed in May 2009. On 14 May, the man was examined by Prison Doctor A as he experienced pain in his left shoulder following weight training and badminton. He was given advice on care for his shoulder.

32. On 6 November 2009, prison staff contacted healthcare colleagues at 12.45pm and requested that the man be examined as he was unwell. He told staff that he was unable to bear weight on his left leg and was not able to fully co-ordinate. A nurse observed him to be pale in colour with an irregular pulse. He was taken to the prison healthcare centre for further assessment.

33. An electrocardiogram test (ECG this measures the electrical activity of the heart to help with diagnosis) was performed which highlighted irregular heart waves and an ectopic beat (a disturbance of the heart rhythm). The man's colour did not improve but his skin was not clammy. His blood pressure was recorded as 131/87. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) The nurse consulted the doctor, who advised that he should be taken to hospital by ambulance.

34. Following a risk assessment, the man was taken to hospital escorted by two prison officers and a single cuff restraint was used.

35. The following day the man had a computerised tomography (CT scan, which is a test that uses X-ray equipment and computer software to create a picture of the inside of the body). The scan of his head was assessed by a neurological consultant. On 9 November, healthcare staff were advised by the hospital that he was being treated for a transient ischaemic attack. (TIA, a set of symptoms that lasts a short time and occurs because of a temporary lack of blood to part of the brain. It is sometimes called a mini-stroke. However, unlike a stroke, the symptoms are short-lived and soon pass. This means that you can recover fully. The word ischaemic means a reduced supply of blood and oxygen to a part of the body.)

36. The man remained in hospital until 13 November, when he returned to Wolds. The discharge letter from the consultant neurologist noted that the diagnosis was a right hemispheric ischaemic CVA (cerebrovascular accident, also known as a stroke) and asthma. His cholesterol was recorded as 7.1. (Cholesterol is a fatty substance known as a lipid. It is mostly made by the liver from the fatty foods we eat and is vital for the normal functioning of the body. Having an excessively high level of lipids in the blood (hyperlipidemia) can have a serious effect on health as it increases the risk of having a heart attack or stroke. The government recommends that cholesterol levels should be less than five.) He was prescribed aspirin (to lower the risk of blood clots), dipyridamole (to prevent blood clots) and simvastatin (to lower cholesterol).

37. On 22 December, an ECG monitor used by the man over a 24 hour period to record and highlight any abnormalities, was returned to the hospital for assessment of the recording.

38. On 30 December, the man was escorted by two officers, with a single cuff restraint, to the vascular clinic at hospital for a scan of his arteries. There is no entry on his electronic medical record in relation to this visit, or the outcome of this examination. The information was obtained by the investigator from the Person Escort Record (PER) that went with him to hospital.

39. The same day, the man complained to healthcare that he was not offered a choice of food, as he could not tolerate spicy foods and that he had gained weight. He was examined by a nurse and his weight was recorded as 94kg (ideal body weight for his height was 70.28kg) who agreed to contact the kitchen regarding his menu choices to promote a healthier diet.

40. A letter was received from the hospital on 12 January 2010, with the results of the 24 hour ECG completed in December. A cardiologist noted multiple ventricular rate topics with a short run of VT and supraventricular abnormalities (irregular heartbeat). He suggested that the man should be referred to a cardiology clinic, although there is no record that this was done.

41. Two days later, the man saw the prison doctor and again complained about spicy food. He was examined and his weight was constant and recorded as 93kg. He failed to attend for a follow up appointment scheduled for 27 January; there is no reason recorded for his non-attendance.

42. On 4 February, healthcare support worker (HCW) obtained copies of the man's menu choice form, following his complaints about the choice of food. She noted that his options were not healthy, that he chose puddings instead of fruit and often chips and battered fish instead of the healthier options that were available. She advised the prison doctor.

43. One week later, the man had a series of blood tests. His weight was recorded as 95kg and his cholesterol as 3.5. The results of these blood tests were normal, and he was told that no further action was necessary but that he should continue his simvastatin medication.

44. The man was due to attend hospital on 12 March for a carotid doppler (an ultrasound scan that looks at the blood flow through the blood vessels in the neck and used to assess the risk of stroke) but did not attend. A letter, received on 31 March, was sent to the prison by a consultant neurologist which requested a further referral if this test was still deemed necessary. There is no record in his medical notes that the prison were aware of this appointment or any explanation as to why he did not attend. I note from the significant event report completed internally following his death by Wolds that this was because 'Operational issues necessitated cancellation'. There is a record on 31 March which noted that he did not attend a hospital appointment (this probably relates to the missed appointment on 12 March) but there is no record of what this appointment was for, or the reason for non-attendance.

45. Prisoners' security categories are routinely reviewed. On 11 October, the man was written to advising that he was to remain a category C prisoner, due to information on his wing history sheet that he did not always comply with requirements. He successfully appealed this decision and attained his category D status on 2 November. Although in theory this would mean a transfer to open conditions, my investigator was advised that this was dependant on available spaces.

46. Over the next few months, the man had little contact with healthcare staff, but his cholesterol was monitored. On 6 December, his cholesterol level was recorded to have increased to 6.1. He disclosed that he had not taken his cholesterol medication and, following a glucose test, it was confirmed that he had raised blood sugar (a potential indicator for diabetes). He told the nurse that he was smoking 20 cigarettes a day. He was referred to the prison doctor. The doctor examined him on 10 December, and prescribed dipyridamole and simvastatin. He also requested further blood sugar tests and undertook an ECG which revealed nothing of concern.

47. The next time the man was seen by healthcare staff was on Sunday 6 March, when he complained of feeling unwell. At 3.22pm, there is a record that he reported to the healthcare centre and was assessed by a member of the healthcare staff. He said that he had chest pains, aching down both arms and felt faint. His temperature was recorded as 36 degrees centigrade (normal temperature is 37 degrees centigrade), his pulse was 92 beats per minute (bpm) (normal range is between 60 – 80 bpm and his blood pressure was

160/90. She contacted the doctor, who was not in the establishment but was the on-call doctor. The doctor advised her to give him Gaviscon (to treat indigestion) and to observe his condition. She was later called over to B unit at 5.08pm by prison officers who were concerned that he had continued to feel unwell. His observations (blood pressure, temperature and pulse) were within normal range and he was moving around comfortably, although he still complained of central chest pain and aching in his arms. He told her that he thought the Gaviscon had helped. She contacted the prison doctor with an update. He advised that the man should be given further Gaviscon tablets for continued relief of indigestion.

48. The following morning, the man was examined by Prison Doctor B. He continued to experience chest pains and aching in his arms. His blood pressure was recorded as 130/80 and he had a regular pulse of 70 bpm. The doctor decided to send him to outside hospital at 5.30pm, as his symptoms had not subsided. Following a risk assessment and as a result of his re-categorisation to D, he was escorted by one officer, without restraints.

49. Upon arrival at hospital, the man was taken to the acute assessment ward. He underwent a number of tests and was examined by a doctor. Throughout the night he was regularly observed by hospital staff.

50. The following day, the man was advised by a consultant at the hospital that he had suffered a heart attack and would be referred to a cardiologist for appropriate treatment. Later that day, he was examined by a doctor, who told him that he would be moved to another hospital to have an angiogram (a procedure that involves injecting a special dye into the blood vessels which show any abnormalities inside the blood vessels). He accepted the news, was aware that he would remain in hospital and requested his own clothing and money. Later the same day, he received £4.50 in cash from the prison for telephone calls. His condition was not assessed as life threatening, and the prison did not have a duty to advise the next of kin of his admittance. He had funds and access to a telephone, and was able to contact his family had he chosen to.

51. The man moved to another hospital at 2.50pm on 9 March. At 5.10pm he was credited with a further £9.00 to pay for the television and telephone. The next morning he underwent a percutaneous coronary intervention (also known as an angioplasty) and a ‘stent’ was inserted into an artery on the right side of his heart (a ‘stent’ is an artificial tube inserted to increase blood flow). He was visited by a member of the Wolds IMB at 2.15pm.

52. Over the next few days the man remained in hospital. The doctor gave him advice on his heart condition and organised further tests for him. He remained stable and spent much of his time resting or watching the television. He was discharged back to Wolds at 4.15pm on 12 March, following a full assessment by a consultant. The discharge letter from a consultant cardiologist confirmed that he underwent an urgent percutaneous coronary (known as balloon angioplasty) intervention and was prescribed aspirin and clopidogrel (to reduce the risk of further stroke or heart attack), verapamil (to

treat high blood pressure), ramipril (to treat high blood pressure and prevent heart attack), beclomethasone (to treat asthma), GTN spray (glyceryl trinitrate to manage angina – muscle pain in the heart) salbutamol (to treat asthma) and atorvastatin (to lower cholesterol). He was diagnosed with moderate disease in the right coronary artery but the letter said that no follow up appointment was necessary.

53. The man returned to his single cell on B unit. There are no entries in his prison clinical record to indicate that he needed to have any special observations and no information about his medical condition was communicated to unit staff. There was no care plan following his discharge from hospital.

54. On 15 March, the man submitted a complaint form, detailing his annoyance that his family had not been told of his admittance to hospital. The same day, the operations manager responded, advising him that the prison only contacted next of kin if the condition is assessed as life threatening.

55. Prison Doctor A sent a letter to the catering manager on 16 March, to request that the man was given a low fat diet. During interview the doctor was unsure what prompted him to write this letter, but said “I think the idea of that was to maybe offer a little bit more variety for the man”.

Events of 17 March

56. Officer A was responsible for unlocking the prisoners on B unit. He started this process at 8.05am and, when he unlocked the man’s cell (B2-37), he thought he was asleep. He did not want to disturb him and continued to unlock the remaining cells. Prisoners are unlocked and have approximately 30 minutes to have a shower and/or have a hot drink before leaving the houseblock to attend work or education classes. The man had been given permission by his workshop instructor to attend work later in the day, to allow him more time to rest, following his recent operation. Given their understanding of the situation, neither the officer nor his colleague, Officer B, thought it unusual that he had not left his cell.

57. Officer B went to the upper landing to start his routine cell checks at 8.55am. During interview, the officer said that when he entered the man’s cell:

> “He [the man] was in bed on his right hand side. I called his name and I got no response. I shook him and then no response and then I called for my colleague Officer A… I’ve radioed for healthcare to come straightaway because I knew something wasn’t right, it just didn’t look right, and Oscar 1 [the person in charge of the operational management of the prison] had got to attend as well. I checked all his vital signs ABCs [airway, breathing, circulation] and I couldn’t get nothing”.

58. The officer used his radio to request emergency assistance from healthcare, and he was joined by Officer A. Healthcare staff immediately attended and

assessed the man. During interview the nurse said that he had been dead for some time and there was clear evidence of rigor mortis.

59. The duty governor and the prison doctor were contacted, and an ambulance was requested. Paramedics arrived at the cell at 9.25am when he was formally pronounced dead. The prisoners who had not yet left B unit to attend work were locked in their cells to maintain the man's decency while prison staff went and informed each of them of his death. Undertakers arrived at 11.59am and removed his body from Wolds.

60. The Director, with a chaplain, went to inform the man's family of his death. They visited his nominated next of kin, his sister. Contact was initially made with her husband at 12.45am, and he agreed to inform her of his death.

61. A hot debrief (a meeting immediately after an incident) was held with all the staff involved in the finding of the man, and support was made available for them. A notice to staff and prisoners was issued by the Director the same day announcing his death and reminding them of the available support, through the care team and Listeners/Samaritans respectively. During interview, all staff said they felt well supported.

62. A post mortem was undertaken, commencing at 3.04pm, on 17 March, which recorded the cause of death as acute myocardial insufficiency (heart failure) and coronary artery atheroma (fatty lumps that restrict and reduce the blood flow through the artery to the heart, or hardening of the arteries).

63. The following day a prison family liaison officer was appointed. She contacted the man's family and financial assistance was offered for the cost of the funeral. Arrangements were made for the family to visit the prison the same day. The family went to B unit, were able to spend some time in his cell and were given condolence cards from the man's friends, who they spent time talking to. They were given his possessions.

64. A memorial service was held at Wolds on 24 March, which was attended by the man's friends. His funeral was held on 31 March and was attended by prison staff, with the family's permission.

ISSUES

Clinical care

65. A clinical reviewer was commissioned by the local Primary Care Trust to review the medical care that the man received whilst in prison custody. His clinical review looks at the care and treatment he received at Wolds and measures whether it was appropriate and comparable to that which is available in the community.

66. The clinical reviewer makes three recommendations, which I endorse and have reflected in my own consideration of the issues. He concludes:

> "I do know that he [the man] was on preventative medication for cardiovascular disease and that it is likely that there was no preventing his sudden death. It is equally likely that his blood pressure had not changed significantly from his discharge from hospital or that he had ongoing symptoms that would have warned of an imminent death. Unfortunately sudden death does occur in patients with recent heart attacks and whilst we may attempt to alleviate as much risk as possible it can only be expected that it will occur at times."

67. The clinical reviewer and I are satisfied that, overall, the care the man received was appropriate. However, this is with the exception of certain specific areas.

Assessment of needs following hospital discharge

68. When the man was discharged from hospital and returned to Wolds in November 2009, following a stroke, there appears to have been no assessment of his needs. Further, following his return to Wolds from hospital on 12 March 2011, there was no recorded assessment of his needs or care plan implemented.

The Head of Healthcare should ensure that all prisoners returning from outside hospital have a full initial assessment of their needs, a plan on the co-ordination of further care is completed and ensuring as well as possible that compliance to the plan including medication is undertaken.

The man's chest pain on 6 March

69. The man complained of chest pains radiating down his arms on 6 March 2011. Advice was sought from the on-call prison doctor over the telephone and he was treated for indigestion. The clinical reviewer writes in the clinical review:

> " … it is difficult to know why he [Prison Doctor A] felt that indigestion was the most likely problem. … Currently anyone with a suspected acute coronary syndrome (ACS) is generally advised to attend hospital immediately either at their own summoning of a 999 ambulance or by medical team involvement. … It is easy to consider these things in retrospect but I do feel that a transfer to hospital on Sunday 6th March would have been the appropriate management of his chest pain."

He makes the following recommendation:

> "I would also recommend that significant event enquiry is undertaken around the presentation of chest pain within HMP Wolds in this case so that important lessons are identified and acted upon."

East Yorkshire Riding PCT may wish to consider a separate investigation into the decision not to request an ambulance.

70. The man told staff that he thought that this treatment had eased his symptoms. There was an ECG machine available for a trained member of staff to use, but this assessment was not done. Any assessment available to medical staff to help inform a decision about the appropriate response should have been used. In retrospect, an ambulance should have been called, given the symptoms that he was presenting with.

The Head of Healthcare should ensure that all staff follow the UK wide protocol in relation to chest pain/presenting symptoms and request an ambulance without delay.

Response at unlock

71. The man was discovered in his bed 50 minutes after morning unlock. Following formal interviews and informal discussions with staff and prisoners, it would appear that eliciting a response from those located in each cell at unlock is not routine practice and I do not criticise any individual. I do not believe that it would have made a difference in this case, as it would appear that he had been dead for some time prior to 8.05am. However, the practice of gaining a response at unlock times is covered in the initial officer training. Further, Prison Service Instruction (PSI) 10/2011, paragraph 2.3 clarifies the responsibility of the unlocking officer:

> "Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

72. Following receipt of my initial feedback letter the Director responded:

> “We accept that we should have tried to elicit a response from the man.”

The Director of Wolds should ensure that all staff responsible for unlocking prisoners are reminded of the need to elicit a response from every prisoner at the point of unlock as stated in PSI 10/2011.

Use of emergency codes

73. It was apparent following my interviews and having informal discussions with other staff, that there is a systemic issue with regards to the use of radio emergency codes. There appeared to be no consistent use of codes, little awareness of what the codes meant and differing understanding of the use of the radio to contact the Control Room using a dedicated call button rather than a specific code. The advantage of a code system is that each code can alert staff to the specific type of emergency, enabling the appropriate equipment to be brought to the emergency and prompt calling of an ambulance. However, I am satisfied that in the case of the man, this issue would not have changed the outcome and I do not criticise any individual member of staff.

74. Following receipt of my initial feedback letter, the Director responded:

> “We accept the confusion about the codes used for calling Health Care in an emergency. A new system has now been introduced throughout the prison, using codes Red and Blue – red for any blood related problems and Blue for any breathing, unconscious or similar difficulties. Clear diagrams have been issued to all parts of the prison and a comprehensive briefing given to staff.”

75. In view of this change in practice I do not make a formal recommendation.

Resuscitation and defibrillation machines

76. Uniformed staff who found the man in his cell were first aid trained but radioed immediately for healthcare assistance, which quickly arrived. The healthcare nurses attending the scene did not attempt to resuscitate him. Under Prison Service policy, it is clear that resuscitation should not be attempted where there is clear evidence of rigor mortis. The clinical reviewer agrees that this decision not to resuscitate was the correct decision by the attending nurse. He had been dead for a period likely to have been of some hours, and attempting resuscitation would have compromised his dignity

77. Whilst in the case of the man it was not necessary to utilise emergency first aid equipment, during her visits, my investigator recognised that there was a lack of awareness about the accessibility of defibrillation machines (a portable electronic device that diagnoses heart rhythms after cardiac arrest). These

machines were not available on A & B Unit and it was only healthcare staff and managers that had been trained in their use.

78. Following receipt of my initial feedback letter, the Director responded:

> "I can confirm that resuscitation masks are now purchased for all operational staff and that additional defibrillators are to be purchased."

79. I am pleased by the response to my feedback. Defibrillator machines can save lives and are easy to use. Whilst it would not have saved the man, ready accessibility to such machines could prevent future deaths.

The Director of Wolds should ensure that all residential units have easy access to emergency defibrillation machines and that staff are trained in how to use them.

Liaison with the man's family

80. At the time of the man's death, Wolds had four prison family liaison officers available, none of which had received specific training. The appointment of these liaison officers was made some months ago and I understand there was an initial problem accessing this training. Without such training staff will be less prepared to provide a consistent service to bereaved families. The investigator discussed her concerns regarding the lack of training with the Director, and was assured that this would be accessed as soon as possible.

81. The family expressed disappointment to my family liaison officer that they were not advised on how to view their brother's body prior to the post mortem. My investigator was told by the Coroner's Officer that he had been formally identified by staff at Wolds and the post mortem was undertaken quickly after death, as a pathologist was available. The PSO 2700 Family Liaison Guidance notes that the Prisons Family Liaison Officer should:

> "[Arrange for the family] to view the body if they wish to do so, the family should be told of their right to have a medical representative present at the post mortem and that they should ask the Coroner's Officer about this. Giving or facilitating initial practical support for the family."

82. PSO 2710 makes clear the importance of prison family liaison officers being trained appropriately for this sensitive and difficult role. Whilst I appreciate the Directors plan to provide training, I make the following:

The Director of Wolds should ensure that family liaison officers receive the appropriate training as soon as possible.

Notification of next of kin when in hospital

83. The man submitted a complaint to the prison on 15 March because he was unhappy that his family were not notified when he was admitted to hospital on 7 March. The prison is only required to inform families of admittance to

outside hospital if a prisoner's condition is assessed as life threatening. This was not the case during the period that he was in hospital. The prison arranged for him to have money to use for telephone calls the day after his admittance, and he did have access to a telephone. There is no record that he specifically requested staff to inform his family. I am satisfied that he had the opportunity to contact his family at an early opportunity, had he wished to do so.

Healthy food options

84. The man's family were concerned about the food available to him while in custody. He made a number of informal complaints to uniformed staff on his unit about the choice of food available and raised the issue with healthcare staff on a number of occasions. He made formal complaints about food on three separate occasions. On 4 July 2009, he believed that he had suffered discrimination, as he felt that he had less menu choice than Muslim prisoners. The kitchen manager responded three days later, and agreed to introduce two additional menu options available to all prisoners.

85. On 30 March 2010, the man submitted a complaint to say that there was too much spicy food on the menu and he wanted a 'choice of English food'. The catering manager responded two days later, advising that apart from two days in a four week menu cycle, there were alternative food options that were not spicy. The menu for the two identified days where this was not the case had consequently been changed to avoid a similar problem.

86. Finally, on 8 February 2011, the man submitted a complaint stating that the available meat dishes too often contained mince and not 'proper' meat, and food was often cold. The catering manager responded two days later advising him that the core temperature of all food was checked prior to leaving the kitchen and suggested that he contact the unit catering representative as he would welcome menu suggestions. There is no evidence that he did this and he did not make any complaint to the PPO.

87. My investigator was able to view some of the menu option forms which the man had completed. There were a variety of foods and meals available, including healthy options, but he had not opted for these. He was given healthy lifestyle advice following his stroke in November 2009, and prescribed medication to help lower his cholesterol. However, I have concluded that despite this advice, he continued to select a less healthy diet.

Recording

88. The notes in the man's electronic medical record falls below that which would be expected. There are gaps in recording and the clinical reviewer highlights in the clinical review that there are some discrepancies with the medication that he had been prescribed, and that which was in his possession.

The Head of Healthcare should ensure that all healthcare staff, irrespective of status, comply fully with the requirements for accurate

and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

CONCLUSION

89. The man was treated fairly during the time he was at Wolds. Despite the positive response by the Director of Wolds to my initial findings in this investigation, I have drawn attention to several issues in this report. The most serious of this, was the response of the on call doctor on 6 March.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all prisoners returning from outside hospital have a full initial assessment of their needs, a plan on the co-ordination of further care is completed and ensuring as well as possible that compliance to the plan including medication is undertaken.

   Accepted - *All offenders who attend an external hospital appointment, or who have been an in-patient are escorted to the Health Care Centre on their return to the prison. They are initially seen by the Duty Nurse to carry out an initial assessment of their needs. This initial assessment will inform the subsequent Care Plan. Offenders with more complex needs will be seen by the prison doctor the following day, who will carry a review of the Care Plan and medication requirements. Completed 31 March 2011 - This system is now embedded into the normal routine for offenders returning from hospital*

2. The local PCT may wish to consider a separate investigation into the decision not to request an ambulance.

   Accepted - *This is a matter for the local PCT to consider. HMP Wolds will fully cooperate with any decision to carry such an investigation.*

3. The Head of Healthcare should ensure that all staff follow the UK wide protocol in relation to chest pain/presenting symptoms and request an ambulance without delay.

   Accepted - *The Health Care Manager will ensure that all HCC Staff are aware of the UK wide protocol in relation to chest pain, and the requirement to request an ambulance without delay. Once completed this will be recorded in staff training records. Completed 30 September 2011.*

4. The Director of Wolds should ensure that all staff responsible for unlocking prisoners are reminded of the need to elicit a response from every prisoner at the point of unlock as stated in PSI 10/2011.

   Accepted - *All staff have been reminded of the Prison Service Instruction and Operational Instruction requiring staff that "At unlock staff must satisfy themselves of the offenders wellbeing by making a physical check of the offenders and where possible physically speaking to them". A Staff Notice to support this was issued on 14th May 2011. Completed 14 May 2011, pending review.*

5. The Director of Wolds should ensure that all residential units have easy access to emergency defibrillation machines and that staff are trained in how to use them.

   Accepted - *At the time of the man's death there were 3 Defibrillators located within the prison; C/D Centre Office, Duty Managers Office, and The HCC Emergency Response Bag. Two further Defibrillators have been purchased and located in A/B Centre Office, and E/F Centre Office. The current*

provision now positions a Defibrillator in the centre office of each House Block, The Duty Managers Office, and the HCC Emergency Bag. To ensure that staff and offenders are aware of the location of the nearest Defibrillator each Unit/Department has signs displayed in prominent areas identifying this. In addition to this all front line staff have been issued with a personal Ventilation Mask, which is carried on their belt. Completed 22 July 2011, pending review.

6. The Director of Wolds should ensure that family liaison officers receive the appropriate training as soon as possible.

   Accepted - *Four staff were selected to take up the role of Family Liaison Officer within HMP Wolds in January 2011. Training for Family Liaison Officers is provided by National Offender Management Service (NOMS). Access to this course has proven to be difficult however Prison Service College, Newbold Revell have advised that they will list our staff for places on the November 2011 course.*

7. The Head of Healthcare should ensure that all healthcare staff, irrespective of status, comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   Accepted - *All Health Care Staff in post have been re-briefed on the professional standard required when completing medical notes. Registered nurses have been issued with and signed NMC Guidance. Due to staff turnover this action point will remain ongoing and all new staff in post will be given guidance on taking up post. Completed 15 May 2011, pending review.*