

**The death in custody of a male prisoner
at HM Prison Swaleside on 14 June 2004**

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

March 2005

Contents

Part One	1. Introduction
	2. Summary
	3. Investigation methodology
	4. The deceased
	5. Swaleside prison
	6. Events leading to the prisoner's death
	7. Consideration of emergent issues
	8. Conclusions
	9. Recommendations
Annexes:	A. Terms of Reference
	B. Report of a Clinical Review

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HM Prison Swaleside on 14 June 2004. The prisoner was found dead in his cell at 6:50am that day.

The Coroner's inquest was held in the Council Chamber, County Hall, Maidstone, on 19 January 2005. The jury's verdict was that the prisoner died of natural causes. A post mortem examination had earlier shown that the cause of death was ischaemic heart disease.

The investigation was carried out on my behalf by a colleague. An independent clinical review was also commissioned into the management of the prisoner's health needs while he was at Swaleside. This was carried out by a representative of the Medway Primary Care Trust (PCT).

My thanks go to the PCT and to the Governor and staff at Swaleside whose ready co-operation with the investigation has been much appreciated.

This investigation has revealed significant causes for concern over the way the prisoner's health needs were managed on the night of his death.

I make four recommendations.

This published version does not include the original annexes.

Stephen Shaw CBE
Prisons and Probation Ombudsman

2. Summary

The deceased was born in Scotland on 13 October 1957.

On 24 July 2003 he was sentenced to a total of 10 years' imprisonment at Lewes Crown Court for robbery and firearms offences. He was transferred from Lewes prison to Swaleside on 15 August 2003.

During the night of 13/14 June 2004, the prisoner twice complained of chest pains, once at 10:45pm on 13 June and again at about 3:00am the next morning. He was seen on both occasions by healthcare staff who judged that it was not necessary to consult a doctor, or to admit him to the healthcare centre, or to carry out an ECG examination, or to call an ambulance. He was found dead in his bed at about 6:50am on 14 June 2004. A post mortem examination showed that he died of ischaemic heart disease.

The PCT has judged that the prisoner's death was potentially preventable. In the context of that judgement, I have made four important recommendations. One of those recommendations is that the Prison Service should consider whether two members of the healthcare staff on duty at Swaleside on the night the prisoner died should be subject to a disciplinary investigation.

3. Investigation methodology

The investigation was opened on Wednesday 16 June 2004 when my investigator met with the Governor, a representative of the local Independent Monitoring Board, and a representative of the local branch of the Prison Officers' Association. They were briefed on the nature and scope of the investigation. On the same day, notices to staff and to prisoners were issued. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.

An independent clinical review of the management of the prisoner's health needs whilst he was in custody at Swaleside was carried out by the Medway Primary Care Trust .

My family liaison officer spoke with the prisoner's partner over the telephone on a number of occasions. She expressed a wish to be reassured that the prisoner had received proper medical care, but did not identify any specific issues that she wanted the investigation to explore.

4. The deceased

The prisoner was born in Scotland on 13 October 1957. Little is known of his family, social and educational history. It is, however, known that he has a son and that, at the time of his arrest, he was employed as a carpenter.

In July 2003, he was sentenced to 10 years' imprisonment at Lewes Crown Court for robbery and firearms offences. Prior to his arrest, he had been living with his partner in Romford, Essex.

The prisoner was transferred to Swaleside on 15 August 2003. After an initial period of unsettled behaviour, he became known to staff as polite and well behaved. According to his partner, he was a big man who smoked heavily. Prior to his death, he had not displayed any significant symptoms of heart disease apart from high blood pressure.

5. Swaleside prison

Swaleside, which opened in 1988, is situated near Eastchurch on the Isle of Sheppey. It is a Category B training prison for up to 777 adult male sentenced prisoners. At the time of the investigation, the establishment held 750 prisoners.

The healthcare centre at Swaleside provides 24 hour nursing cover with in-patient facilities for up to 15 prisoners. All staff are currently employees of the Prison Service. An outside dentist provides three clinics per week and a psychiatrist visits once a week. The healthcare staff complement comprises:

- 1 Healthcare Principal Officer (Healthcare Manager)
- 1 F Grade nurse
- 2 Healthcare Senior Officers
- 5 Healthcare Officers
- 8 Nurses

One member of the healthcare staff is on duty at night. That person is responsible for attending to in-patients as well as for responding to events and emergencies elsewhere in the prison.

Swaleside was last visited by Her Majesty's Chief Inspector of Prisons in July 2002. A number of recommendations were made about healthcare but none are relevant in the context of this investigation.

Prior to the prisoner's death, 10 prisoners had died at Swaleside since it opened, four by their own hand and six from natural causes.

6. Events leading to the prisoner's death

When the prisoner was first remanded in custody at Pentonville prison in December 2002, no significant medical history was noted beyond addiction to alcohol. Following his initial reception health screen he was prescribed amitriptyline after complaining of insomnia.

After sentencing, he was transferred to Swaleside on 15 August 2003 and seen by the Medical Officer the next day. His blood pressure was higher than normal at 140/100. For this the doctor prescribed Felodipine 2.5mg daily. There were no other significant events until 27 May 2004 when the prisoner was further reviewed after reporting sick. The Felodipine prescription was continued and routine blood tests were ordered. There is no evidence in the Inmate Medical Record (IMR) to show that these were carried out.

On 13 June 2004 at about 10:10pm, the prisoner pressed his cell bell to attract the attention of the Night Patrol on duty in the wing. The prisoner was located in a single cell. When the Night Patrol responded, the prisoner told him that he had sharp pains in his chest and that he wanted to see a nurse. At interview, the Night Patrol reported that the prisoner was holding his chest as he spoke. The Night Patrol telephoned the healthcare centre to ask for assistance from the on duty staff.

The Night Patrol was told that, unless the prisoner's case was urgent, two other cases would be dealt with first. The Night Patrol therefore returned to the prisoner to re-assess the urgency of his case. The prisoner said that he was "really in pain" and so the Night Patrol called the healthcare centre again to relay this information.

It is normal for there to be only one member of the healthcare staff on duty at Swaleside by night. However, on the night of 13/14 June 2004 two healthcare staff were on duty: a Staff Nurse who was a permanent member of the Swaleside healthcare team, and a Healthcare Officer who was temporarily seconded to Swaleside from neighbouring Standford Hill prison. The Healthcare Officer's secondment was aimed at assisting him to gain NVQ qualifications that he could not achieve at Standford Hill.

Together, they re-prioritised their work and, at about 10:45pm, went to the prisoner's cell. The Healthcare Officer took the lead and examined the prisoner. He later wrote in the IMR:

"Called to the wing, chest pain, not consistent with MI (myocardial infarction), blood pressure 120 over 80 pulse 60, patient concerned, aspirin three hundred milligrams, stat dose given, told that he would see MO in the morning."

At interview, the Healthcare Officer emphasised that he found the prisoner's blood pressure to be normal, that he had no pain in his arms, was experiencing no tingling in his fingers, was not short of breath and was not cyanosed. The prisoner had told the Healthcare Officer that he had been in

pain for about an hour before he reported it. The Healthcare Officer went to the healthcare centre to fetch some aspirin tablets and then returned to the wing to give them to the prisoner for pain relief. The Healthcare Officer told my investigator that the prisoner "was fine" at that stage. He did not consult a doctor about the prisoner's condition. Neither did he decide to admit the prisoner to the healthcare centre for observation or to carry out an ECG test. Instead, he advised the prisoner to see the doctor the next morning. The Healthcare Officer then left the cell to continue his other duties with the Staff Nurse.

After the healthcare staff had left the prisoner's cell, the Night Patrol continued to check him through the observation panel in his cell door. At interview, the Night Patrol told my investigator that at about 1:00am on 14 June, the prisoner once again complained of chest pains. This time, according to the Night Patrol, he was sitting on his bed holding his chest. The Night Patrol said that he rang the healthcare centre and was told by one of the nurses that they had done everything they could and that they could not give the prisoner any more medication. He told my investigator that he was not sure whom he spoke to.

At about 2:30am, the prisoner again pressed his cell bell, and asked the Night Patrol to call for a nurse. According to the Night Patrol, the Healthcare Officer and the Staff Nurse arrived at the prisoner's cell at about 2:45am.

On this occasion, the Staff Nurse took the lead in order to provide a second opinion. At interview, he told my investigator that he found the prisoner lying down and settled, despite the fact that he had called for help only about a quarter of an hour earlier. The Staff Nurse sat the prisoner up, took his blood pressure and measured his pulse. He also asked the prisoner if he had any pain in his arms, if he felt sick and if he had any tingling in his fingers. The Staff Nurse said that the prisoner told him he had none of these symptoms but that he was worried about having a heart attack. The Staff Nurse said that he examined him and found his pulse to be 68 and regular and his blood pressure to be 120/80. He reassured the prisoner, advised him that he would arrange for him to undergo an ECG the following morning and gave him two paracetamol tablets. A note to this effect was entered into the Inmate Medical Record but there is some confusion as to what time the Staff Nurse did so. At interview, he admitted that he made a retrospective entry at about 4:30am. Once again, a doctor was not consulted, no ambulance was called and no decision was made to admit the prisoner to the healthcare centre for observation.

After about 30 minutes, the Staff Nurse and the Healthcare Officer left the prisoner's cell and returned to the healthcare centre. The Staff Nurse said that he rang the Night Patrol at about 4:30am to ask him to check on the prisoner's condition. According to the Staff Nurse, the Night Patrol told him that he had observed the prisoner and that in his opinion he was "settled" and "okay". The Staff Nurse also said that the Night Patrol indicated to him that he would check the prisoner again half an hour later. Neither member of staff returned again to the wing to check the prisoner's condition. However, at 6:00am, according to the Night Patrol, a nurse rang the wing to ask how the

prisoner was at that stage. The Night Patrol said that he advised the Staff Nurse that he had checked the prisoner at about 5:00am and that, although he could only observe him through the observation panel in the cell door, he was certain that the prisoner was alive but asleep.

The Night Patrol told my investigator that he was in the habit of doing a final round of checks on prisoners just before the end of his night shift. It was during this round that he saw the prisoner lying flat on his back in his bed at about 6:45am. The Night Patrol noticed that the prisoner's hand was outstretched. He saw no movement and so he tried to get a response from him. There was none. He therefore sent an urgent message over his radio to alert other staff to what he judged to be an emergency.

On receipt of the emergency call over the radio, a Prison Officer opened the cell door to find the prisoner apparently dead and, in his opinion, beyond the point at which first aid was appropriate. The Officer told my investigator that he placed two fingers on the prisoner's face and found his skin cold and discoloured. Although he did not know much about rigor mortis, he thought that the prisoner's body looked stiff, as his arms were self-supporting.

Within about three minutes, according to the Prison Officer, the Healthcare Officer and the Staff Nurse arrived at the prisoner's cell. The Healthcare Officer tried to find a pulse in the prisoner's arm. He told my investigator that he noticed that the prisoner's arm was cold and stiff. He took the view that the prisoner was dead and beyond the point where he could be resuscitated. In his notebook he wrote, "Arrived on scene 6:50am. Inmate appeared deceased, no breathing, no pulse." The Staff Nurse wrote in his notebook, "No sign of life, no breathing or pulse, cyanosed, eyes fixed." No attempt was made to resuscitate the prisoner.

The establishment's incident log records that an ambulance was called at 6:58am and that one arrived at 7:19am and another at 7:22am. Paramedics examined the prisoner as soon as they arrived at the cell. The prison Medical Officer formally pronounced death at approximately 8:05am.

7. Consideration of emergent issues

The main issues that have emerged from this investigation are:

- **Failure to ensure that routine blood tests were taken**

On 27 May 2004, as part of a review of his case, a doctor, whose signature in the IMR is illegible, ordered that the prisoner should be subject to routine blood tests. There is no clear evidence that this order was carried out. There is an entry in the IMR against the date of 1.6.04 which reads, "DNA. Rebooked." It is understood that these initials stand for "Did not attend". The entry is either not in chronological order, in that it rests between an entry made on 27.5.04 and another on 13.6.04, or the wrong date has been used and should have read 1.6.04. Whether the former or the latter, it is evidence of poor record keeping. One has to guess what the entry means. It may suggest that a blood test was due to be taken on 1 June 2004, five days after the order was given, but that the prisoner did not attend. However, there is still no evidence that any further blood tests were rebooked after 1 June. Apart from the issue of poor record keeping, this is suggestive of poor care.

- **Failure to call a doctor or an ambulance, or to transfer the prisoner to the healthcare centre, or to carry out an ECG test on the night of 13/14 June 2004**

Neither the Healthcare Officer nor the Staff Nurse discussed the prisoner's condition with a doctor after they had seen him first at 10:45pm on 13 June 2004 and then at 3:00am on 14 June 2004. No ambulance was called on either occasion. Despite the fact that on each occasion the prisoner complained of severe chest pains, the observations taken first by the Healthcare Officer and later by the Staff Nurse showed that the prisoner's blood pressure and pulse were normal. Their judgement that it was not necessary either to consult a doctor, or to admit the prisoner to the healthcare centre, or to call for an ambulance, or to carry out an ECG test, is questionable. Before making that judgement they should have taken into account the fact that the prisoner was already taking Felodipine for high blood pressure, had been in pain for about an hour before he first asked for help, and had been pacing up and down in his cell before he was seen for the second time.

- **Failure to examine the prisoner at 01:00 and at 05:00 on 14 June**

At 1:00am on 14 June 2004, the prisoner rang his cell bell again and told the Night Patrol that he was experiencing further chest pains. The Night Patrol rang the healthcare centre and said that he was told by a nurse (who he could not name) that nothing further could be done for the prisoner. As the Staff Nurse and the Healthcare Officer were the only members of staff on duty in the healthcare centre that night it must have been one of them who took the Night Patrol's call. One or both of them should have gone to the prisoner's cell to examine him.

After they had seen and examined the prisoner at 2:45am on 14 June, neither member of staff returned to the wing personally to check on his condition. Instead they asked the Night Patrol - an Operational Support Grade who was not allowed to unlock and enter the prisoner's cell - to observe him through the observation panel in the cell door.

At interview, the Staff Nurse confirmed that the night of 13/14 June was relatively quiet. This suggests that there were no other significant events to distract the nurses' attention away from the prisoner.

The failure of either the Healthcare Officer and the Staff Nurse personally to assess the prisoner's condition on these occasions is suggestive of poor care.

- **Failure to make contemporaneous notes**

The Staff Nurse did not make contemporaneous notes of his examination of the prisoner at 3:00am on 14 June. I understand that he and his colleague were busy with other events during the night the prisoner died and I acknowledge that it is not always possible to make an immediate log of each event. However, the fact that the Staff Nurse allowed 90 minutes to elapse before making an entry in the prisoner's IMR after seeing him at 3:00am on 14 June is a matter of concern.

- **Failure to attempt to resuscitate the prisoner**

No attempts were made to resuscitate the prisoner in his cell at 6:50am. However, the Healthcare Officer, the Staff Nurse and a Prison Officer have all testified that, when they found him, the prisoner was beyond the point at which he could have been resuscitated. The descriptions of the prisoner offered by the Prison Officer and the Healthcare Officer suggest that rigor mortis may have been present. The Staff Nurse has not offered any information on the matter. Despite the advice I have received from Prison Health that the observations made by these staff were not such as to justify their decision not to apply cardiopulmonary resuscitation techniques, I am not persuaded that this matter can or should be taken further.

- **Night staffing levels in the healthcare centre**

Only one member of the healthcare staff is normally on duty in the healthcare centre at Swaleside by night. That person is responsible for attending to in-patients as well for responding to events and emergencies elsewhere in the prison. If a prisoner in the main prison requires medical attention by night, an Operational Support Grade has to replace the person on duty in the healthcare centre for the period of the consultation.

8. Conclusion

I am concerned that the normal night staffing levels in the healthcare centre at Swaleside may be insufficient to enable healthcare staff to respond to events that occur in the main prison as well as to attend to inpatients.

I am especially concerned that neither the Healthcare Officer nor the Staff Nurse considered either calling a doctor, or admitting the prisoner to the healthcare centre, or calling an ambulance on either of the occasions they saw him on the night of 13/14 June 2004. I am also concerned that no decision was taken to give the prisoner an ECG examination, despite the fact that a machine is kept in the healthcare centre.

I am also concerned that, on two occasions during that night, neither the Healthcare Officer nor the Staff Nurse chose to see the prisoner in person to monitor his condition.

When taken individually, each of the above issues gives cause for concern about the way the prisoner was managed on the night he died. When taken together, they suggest a poor standard of care that might have adversely affected his chances of survival.

9. Recommendations

To the Prison Service

- The Prison Service should establish a protocol to guide nursing staff in the management of potentially life threatening medical problems such as chest pain to include the appropriate use of ECG machines.
- Notes made in prisoners' medical records must be contemporaneous whenever possible.
- Routine blood tests should be performed within five working days of the request.

To the Governor of Swaleside

- The Governor should consider whether a disciplinary investigation should be conducted in view of the failure of either the Healthcare Officer or the Staff Nurse
 - to consult a doctor, or to call an ambulance, or to transfer the prisoner to the healthcare centre, after they had examined him on two occasions during the night of 13/14 June 2004;
 - to return to the prisoner's cell after they had examined him at 3:00am on 14 June in order personally to satisfy themselves as to his condition;
 - (the Staff Nurse only) to make contemporaneous notes after his examination of the prisoner at about 3:00am on 14 June 2004;

and in view of the Night Patrol's allegation that in response to his telephone call to the healthcare centre at approximately 1:00am neither the Healthcare Officer nor the Staff Nurse chose to assess the prisoner's condition in person.

Stephen Shaw CBE
Prisons and Probation Ombudsman

Annex A

Terms of Reference

The investigation was conducted under the following terms of reference:

You are to investigate the circumstances surrounding the death of a male prisoner at HM Prison Swaleside on 14 June 2004.

You are asked to:

- establish the circumstances surrounding the prisoner's death, including the care provided by the Prison Service and relevant outside factors.
- to examine any relevant healthcare issues and assess clinical care, in conjunction with the National Health Service.
- to examine whether any change in operational methods, policy, practice or management arrangements would help prevent a similar death in future.
- to ensure the prisoner's family have the opportunity to raise any concerns they may have and that these are taken into account in the investigation and in the report.
- to assist the Coroner's inquest.

You act on my behalf in conducting this investigation.

Timescales

You are to present me a report of your findings, together with any recommendations you may wish to make, by 24 August 2004.

Stephen Shaw CBE
Prisons and Probation Ombudsman for England and Wales
16 June 2004

Annex B

REPORT OF A CLINICAL REVIEW

REPORT SUMMARY

This report details the medical care of a male prisoner who died in custody on 14/06/2004.

Summary

- (1) The prisoner's death was potentially preventable
- (2) Adequate steps should be taken to establish a protocol to guide nursing staff in the management of potentially life threatening medical problems

The opinions expressed in this report are supported by information gained from perusal of the client's clinical records and interviewing the two staff members involved in his care during his last illness.

1.0 INTRODUCTION

This medical report is addressed to The Prisons Ombudsman and is prepared in accordance with the requirements of the civil procedure rules. I understand my duty to the court and I have complied with that duty.

1.1 Qualifications

- (1) I am a General Practitioner with 11 years experience in General Practice.
- (2) In addition I have worked for two years as a Medical Adviser to the Department of Health for Prison Health. During the course of my duties I was required to investigate and produce reports on deaths occurring in custody in addition to facilitating the re-appraisal process on doctors working in prisons.

1.2 Summary of Instructions

- (1) I have been instructed by the Prisons Ombudsman Team to report on the treatment received and the subsequent outcome of the prisoner who died in custody at HMP Swaleside on 14/06/2004.

1.3 Methodology

- (1) My report is based on my pre-examination of the medical records and subsequent interview of a Healthcare Officer and a Staff Nurse on 25/06/04
- (2) In preparing this report I have read the prisoner's medical notes and my opinion takes into account his pre-morbid medical history.

2.0 Examination of Medical Records

The following details emerged from examination of the IMR (inmate medical record):

- (1) On 19/12/2002 the prisoner was received at HMP Pentonville having been charged with armed robbery. During the Reception screen the form F2169 records he was noted to be a heavy drinker. The F2169 otherwise noted no significant past medical history. Following the prisoner's assessment for substance misuse he was commenced on an 11 day diazepam detoxification programme.
- (2) On 11/06/2004 the prisoner complained of insomnia and was prescribed Amitriptylline 50mg nocte. The dose of Amitriptylline was increased to 100mg nocte on 27/06/2003 due to pervading low mood.
- (3) On 24/03 /2003 the prisoner was sentenced to 10 years imprisonment. He was seen by a healthcare worker on return from sentencing and not considered to be a suicide risk. His medication of Amitriptylline 100mg was continued.
- (4) On 15/08/2003 the prisoner was received at Swaleside and seen by a Healthcare worker. No action plan was completed.
- (5) On 16/08/2003 the prisoner was seen by the Medical Officer for medical reception assessment
- (6) On 15/03/2004 the prisoner was seen on sick parade when his BP was noted to be slightly elevated at 140/100. Treatment was commenced with Felodipine 2.5mg daily.
- (7) On 27/05/2004 the prisoner was reviewed on sick parade. His medication of Felodipine continued and routine blood tests were ordered.
- (8) On 13/06/2004 the prisoner complained of chest pain and was seen on F wing at 10.45pm by a Healthcare Officer.

- (9) On 14/06/2004 the prisoner complained of chest pain again and was seen on F wing at 3:00am by a Staff Nurse.
- (10) On 14/06/2004 at 8:00am the prisoner was certified dead by the medical officer.

3.0 Interview of staff

- (1) Interviewee: The Healthcare Officer on duty on the night the prisoner died. Date of interview 25/06/04
Time 4:49pm

Method

The interview took place in a private room following my explanation to the interviewee the purpose of the interview. His responses were written down contemporaneously. The following account is a paraphrase of the interviewee's responses to my questions aimed at establishing an accurate chronology of events.

Interview

The Healthcare Officer has worked in the Prison Service since 1987 and qualified as a health care officer (HCO) in 1989. The date of 13 June 2004 was The Healthcare Officer's first time working nights at Swaleside HMP having hitherto worked at Stanford Hill HMP. He attended a call to 'F' wing made by the then Night Patrol. The Healthcare Officer was accompanying his colleague, an experienced and longstanding Staff Nurse at Swaleside HMP. The Healthcare Officer collected the emergency equipment from the outpatients and an oxygen bag together with the prisoner's medical record from the inpatients area on his way to 'F' wing.

He briefly studied the medical records en-route to 'F' wing. On the way to 'F' wing the Healthcare Officer and the Staff Nurse were accompanied by two Prison Officers. On arrival at 'F' wing the Healthcare Officer and the Staff Nurse were greeted by the Night Patrol. The Healthcare Officer entered the cell while his colleague stood outside. The Healthcare Officer established that the prisoner was complaining of chest pain in the upper sternal area. He noted that the prisoner was on treatment for hypertension. When asked how long he had the pain the prisoner replied an hour. The Healthcare Officer checked the prisoner's blood pressure twice and found it to be 120/80. His pulse was noted to be 60/min and steady. The Healthcare Officer asked if the prisoner noticed radiation of the pain to his neck or arms. The prisoner replied 'no just my chest'. The Healthcare Officer noted that the prisoner was not sweating or showing any sign of distress. The Healthcare Officer noted that the prisoner was interacting and co-operative throughout the

consultation. The Healthcare Officer returned to the outpatients department to fetch Aspirin and water. When he returned to administer the medication to the prisoner he appeared well and in no pain. Nevertheless, he administered the Aspirin. At 3:00am the Healthcare Officer and the Staff Nurse received another call from the Night Patrol stating that the prisoner was not improving. Both healthcare staff attended 'F' wing again accompanied by Prison Officers. On this occasion, the Healthcare Officer remained outside the cell. In the cell with the prisoner was the Staff Nurse, an assistant orderly officer and two escorting prison officers. The Healthcare Officer noted that the Staff Nurse took a history and recorded his observations. On exiting the cell the Staff Nurse remarked to the Healthcare Officer that the prisoner was not distressed and his observations were within normal limits. The Staff Nurse arranged for the prisoner to have two Paracetamol tablets. He advised the Night Patrol that he would call again later to check on the prisoner's progress. At approximately 6.45 am on 14 June 2004 the Healthcare Officer was in the gents toilet when he heard the Staff Nurse rushing through the corridor calling for him. The Staff Nurse told the Healthcare Officer that there had been an incident on 'F' wing. They both went to 'F' wing where the Healthcare Officer entered the cell to find that the prisoner's lips were blue with no sign of life. The Healthcare Officer stated that the prisoner felt stone cold. The duty doctor and flying paramedic were informed at 6.50 am. The doctor was called 2-3 times. The next doctor on duty, who arrived prior to the on-call doctor, confirmed death. The Healthcare Officer was unaware whether there is an ECG machine at Swaleside HMP. At Stanford HMP an ECG would only be done at the request of a doctor.

- (2) Interviewee: The Staff Nurse on duty the night the prisoner died.
Date of interview 25/06/04
Time 5:30pm

3.0 Interview of staff continued

Method

The interview took place in a private room following my explanation to the interviewee the purpose of the interview. His responses were written down contemporaneously. The following account is a paraphrase of the interviewees responses to my questions aimed at establishing an accurate chronology of events.

Interview

On the night of 13 June 2004 the Staff Nurse was on duty and accompanied by a Healthcare Officer. The Healthcare Officer was a new staff member from Stanford Hill and never before worked nights at this establishment. During their duty they were called to another block where an inmate was having an asthma attack. The Staff Nurse administered a Salbutamol nebuliser while the Healthcare Officer contacted the duty doctor. During this incident another call arrived requesting their attendance at 'F' wing from the Night Patrol where the prisoner who later died was experiencing chest pain. The Staff Nurse and the Healthcare Officer attended 'F' wing escorted by two Prison Officers. The Staff Nurse states that the Healthcare Officer entered the cell and examined the prisoner. The Staff Nurse noted that the prisoner was anxious. He stated that the Healthcare Officer examined the prisoner, took his blood pressure, reassured him and returned to administer Aspirin.

At 3:00am on 14 June 2004 the Staff Nurse and the Healthcare Officer were called to 'F' wing by the Night Patrol who reported that the prisoner was still in pain. When they arrived at the wing the prisoner had to be awakened. The Staff Nurse enquired of the prisoner whether he had experienced any sweating, tingling fingers. He noted that the prisoner showed no sign of cyanosis. The Staff Nurse noted that the prisoner appeared more settled compared with his initial visit. The prisoner asked for pain relief and the Staff Nurse administered Paracetamol taken from outpatient stock. The prisoner requested to see a doctor in the morning and the Staff Nurse recorded his request. The Staff Nurse subsequently telephoned the Night Patrol at approximately 4:00 am to check on the progress of the prisoner. The Staff Nurse was unable to detail what check the Night Patrol made of the prisoner. The Night Patrol reported that the prisoner was ok. The Staff Nurse stated that it was standard practice to check on patients in this manner.

At 6.45 am on 14/6/04 the Staff Nurse received a code 1 call for 'F' wing suggesting the occurrence of a serious incident. He and the Healthcare Officer attended 'F' wing escorted by a Prison Officer. The Healthcare Officer entered the cell first and noted there were no signs of life.

In response to further questions the Staff Nurse commented that he was unaware of any existing protocol to deal with potentially life-threatening medical emergencies. He remarked that inmates' complaints with chest pains occurred almost weekly. Had he been concerned that the prisoner was having a heart attack he would have arranged for hospital admission without reference to the duty doctor. He expressed concern regarding this incident stating that he is now more likely to send anyone complaining of chest pain to the hospital. He confirmed that the Healthcare Unit is equipped with a self diagnosing ECG machine.

4.0 OPINION & RECOMMENDATIONS

Following full review of the above details it is my opinion that

- (1)** The death of the prisoner was potentially preventable
- (2)** Adequate steps should be taken to establish a protocol to guide nursing staff in the management of potentially life threatening medical problems such as chest pain to include the appropriate use of ECG machines. Such details may be compiled from existing protocols operating NHS hospitals and be compiled by the medical officer
- (3)** The Staff Nurse be criticised for not returning personally to check on the prisoner's progress
- (4)** Every effort should be made to ensure each entry into a patient's notes be contemporaneous
- (5)** Routine blood tests should be performed within 5 working days of the request

STATEMENT OF TRUTH

I believe the facts I have stated in this report are true and that the opinions I expressed are correct.