Investigation into the circumstances surrounding the death of a prisoner at HMP Wymott in June 2005

Report by the Prisons and Probation Ombudsman for England and Wales

December 2005

This is the report of an investigation into the circumstances of the death of a man who was a prisoner at HMP Wymott and who died at a nearby hospital in June 2005. The man had been suffering from severe coronary artery disease and died from coronary artery thrombosis.

This was the first time the man had been in custody. Although he was coping with life in prison, he was very much looking forward to his release and was making plans for his future.

I am grateful to the Governor of Wymott at the time of our investigation, and to the members of his staff who assisted us. I have found the prison's contact with the man's family to have been sensitive and respectful.

I am also grateful to the doctor from Chorley and South Ribble Primary Care Trust who carried out a review of the man's care whilst he was at Wymott.

The man's collapse and subsequent death could not have been predicted. The review of his clinical care concludes that the treatment he received was appropriate in the circumstances.

I make two formal recommendations alongside some other suggestions as to good practice.

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Prisons and Probation Ombudsman **December 2005**

Contents

Summary

The man who is the subject of this report was 40 years old when he arrived at Wymott on 22 October 2004. He was serving a sentence of two years and six months. He died on 8 June 2005.

A post mortem examination was carried out by a Consultant Pathologist and concluded that the man's death had been due to natural causes caused by left coronary artery thrombosis and severe coronary artery disease.

Beyond an initial health screening, the man had not had any contact with Wymott's healthcare staff during his time at the prison. He had been declared fit for labour and was working in the prison laundry.

The man collapsed with chest pains outside the servery on B7 landing just before 11.00pm on 7 June. He was found by a fellow prisoner who pressed the alarm bell to alert staff. The two staff on duty on the wing responded very quickly to the alarm; within a few minutes, the duty nurse had also arrived on the landing. The man was in pain but was conscious. His blood pressure and heart rate were normal. The man was given oxygen by the nurse for about 15 minutes which seemed to ease his pain. He then went back to his cell. After a few minutes, his condition began to deteriorate. The pain in his chest returned, he lost consciousness and suffered a seizure. An ambulance was called to attend at 11.35pm.

The nurse and two officers carried out Cardiopulmonary Resuscitation (CPR) on the man for 15 to 20 minutes until the paramedics arrived. The paramedics then continued CPR for approximately 30 minutes. The man was taken to a nearby hospital at approximately 00.30am on 8 June. He was pronounced dead shortly afterwards at 01.05am.

One of the officers who conducted CPR had had no first aid training at all. The other had received training but this was not up to date.

A clinical review into the man's care was carried out by a doctor from Chorley & South Ribble Primary Care Trust. The review concluded that the man's treatment by the medical staff at Wymott was appropriate in the circumstances but that healthcare staff may wish to consider if they should have called an ambulance sooner.

The man's family were informed of his death by Merseyside Police between 4.00am and 5.00am on 8 June. The prison's liaison with the man's family was conducted with sensitivity.

This report includes two recommendations and makes some other suggestions that the Governor of Wymott may wish to consider.

Investigation process

Two of my investigators visited Wymott. They met with the head of healthcare, a member of the Independent Monitoring Board and a representative of the Prison Officers' Association (POA). They also visited the wing where the man had lived.

The investigators issued notices to staff and prisoners informing them of the investigation and inviting comment.

Access to the man's prison records, including his medical records, was provided ahead of the Investigators' visit to Wymott. The Coroner provided the investigators with statements taken by the police and a copy of the post mortem report. Lancashire Ambulance Service also provided copies of their activation log.

The investigators conducted formal and informal interviews with several officers, members of healthcare staff and prisoners.

One of my family liaison officers contacted the man's family. The family liaison officer and an investigator went to visit them to explain the purpose of the Ombudsman's investigation and to discuss any questions the family might have had. The man's family did not feel they had any particular concerns about his time in Wymott. They felt that the prison staff, in particular the governor who had acted as their contact at the prison, had been helpful and sensitive.

HMP Wymott

Wymott is a category C training prison with one half of the prison holding vulnerable prisoners. The prison was last inspected by HM Chief Inspector of Prisons in December 2003. A high percentage of prisoners reported that they felt safe (81%), and the inspection team found the prison to be well managed with evidence of respectful relationships between staff and prisoners. However, the inspection team considered that access to a doctor out of hours was problematic. Any prisoner in need of urgent medical attention was usually sent to an outside accident and emergency department.

Responsibility for healthcare at Wymott transferred to the local Primary Care Trust in April 2005. The healthcare department has a doctor available every weekday. Overnight and weekend cover is provided by local GPs who are on call. There is also a clinically qualified member of healthcare staff on duty at these times.

Nine prisoners have died at Wymott since April 2004. All but one of those deaths was due to natural causes. None of the deaths raised issues of specific relevance to the death of the man who is the subject of this report.

The man lived on a wing which consists of four spurs. Each spur accommodates between 11 and 13 prisoners in single cells. During the night, the gate at the end of each spur has a gate which is locked. There is no in-cell sanitation on the wing. Throughout the night, prisoners have free access to the landing where there is a toilet and a small servery where they can get hot water.

At night-time, each of the wings is patrolled by an Operational Support Grade (OSG) who is responsible for carrying out checks on the wing and answering any alarm bells. OSGs do not hold keys to enable them to access the spurs of each wing. These are held by the night duty officers. During the night there are six officers and a senior officer on duty throughout the prison, in addition to the OSG on each unit. On the night of 7 June, an officer had based himself in the wing office. In addition to that officer, an OSG was also located on the wing.

Two of the six officers on duty that night had left the prison earlier in the evening to escort a prisoner to outside hospital. The prison was therefore operating with a staff of four officers, a senior officer, eight OSGs and a nurse.

The events leading up to the man's death

The man underwent reception screening on first reception at HMP Forest Bank in July 2004. This indicated that he was a relatively fit man with no obvious health problems other than the consumption of round 10 units of alcohol per night.

An initial healthcare reception screening was also conducted at Wymott on his reception there on 22 October 2004. The assessment revealed no indication of ill health although it was noted that the man reported smoking 40 cigarettes a day. His age and height were noted on the reception screen, but neither his weight nor blood pressure was recorded. He was assessed as fit for labour and the gym. The form was dated but not signed. Following his assessment on 22 October, the man did not come to the attention of the healthcare staff at Wymott again until 7 June 2005.

7 June 2005

The man was visited by a member of his family on the afternoon of 7 June. He was in a good mood and seemed optimistic about the future after his release. The rest of day passed without any unusual events and the man did not give any indication that he was feeling unwell.

On the evening of 7 June at approximately 10.50pm, a prisoner on the man's landing left his cell in response to hearing someone shouting out. The prisoner found the man lying on the floor in the doorway to the servery. The man told the prisoner who found him that he had pains in his chest and arms and asked him to press the alarm bell. The prisoner who had found the man collapsed pressed the bell outside the servery. This sounds an alarm in the landing office a short distance away on the same floor.

The alarm system does not have a recording facility and so it has not been possible to confirm the exact time that the alarm bell was pressed. However, staff and prisoners who were on the wing at the time estimate it was between 10.55pm and 11.00pm.

The OSG who was responsible for patrolling the wing that night responded to the alarm bell on the landing. He arrived at the entrance to the landing within about a minute of the alarm bell being pressed and saw the man lying on the floor, surrounded by other prisoners. He was told that the man had collapsed with chest pains and he ran to the landing office to fetch the night duty officer. They returned to the landing together where the officer opened the gate to allow him and the OSG to attend to the man.

At 11.01pm the night duty officer radioed through to the communications room and requested that the on duty nurse (code sign Hotel Two) attend the wing. The man was rubbing his chest and was clearly in pain. For the few minutes it took for the duty nurse to arrive, the night duty officer, OSG and the prisoners on the wing tried to keep the man comfortable by placing a pillow

under his head and laying a blanket over him. They talked to the man to calm him and help him to stay conscious.

The duty nurse received the call at 11.01pm asking for her to attend the wing as a prisoner had collapsed. She received the call whilst she was in the Healthcare Centre and made her way to the wing, arriving at approximately 11.05pm. The man was lying on the floor outside the servery. He was conscious and able to tell the nurse that he had experienced a sudden pain in his chest that had caused him to collapse.

The nurse decided to fetch the emergency equipment in order to carry out an initial assessment of his condition. The equipment is located in the treatment room, approximately 50-60 metres from where the man had collapsed. The nurse left the man with the night duty officer and the OSG while she went to the treatment room to collect the emergency equipment. In interview, she estimated that this would have taken her one or two minutes. When she returned to the man, the nurse asked him a series of questions. She discovered that he did not have any history of heart problems, was not on medication and had not experienced any similar pain before. She took the man's blood pressure and listened to his heart rate and, although the readings were not recorded anywhere, the nurse explained to the investigation team that both readings were normal.

The nurse gave the man oxygen at 15 litres per minute to relieve his pain. This was administered for between 12 and 15 minutes. In interview, the nurse was asked whether she considered calling an ambulance at this stage. She explained that, as the man was conscious, aware of his surroundings and his pain appeared to be being relieved by the oxygen, she did not consider that necessary at that time. She wanted to question the man once his pains had subsided before she made an assessment of what further treatment might be appropriate.

A second officer and a Senior Officer (SO) arrived onto the wing during the 12-15 minutes the man was lying on the floor outside the servery. The SO heard the call go out at 11.01pm that a prisoner had collapsed on the wing and, as duty SO, went to the wing to assist. The second officer was on the adjacent wing and so upon hearing the alarm made his way to the wing where the man had collapsed, arriving at approximately 11.05pm.

At approximately 11.25pm, the man began to get to his feet. It has not been possible to establish whether he did this of his own accord, or whether it was suggested to him by either the nurse or one of the officers that he might try to stand up. Once the man was standing up, the nurse asked him how his pain was. He answered this by saying "What pain?" and appeared to be somewhat confused about what had happened.

The man was unsteady on his feet but was helped by two of the officers to walk back to his cell, which was some five metres away. He sat down on his bed and asked for a drink of water which the OSG went to fetch for him. In interview the nurse said that she thought the man had been chatting and

sipping water for about five minutes when he said that the pain had returned and lay down. She gave him oxygen but his condition appeared to be deteriorating. She asked the OSG to fetch more oxygen from the treatment room, handing him her keys. She observed that the man's Glasgow Coma Scale (GCS) was dropping and he then appeared to have a seizure.

The nurse was unsure in interview whether she asked for an ambulance as soon as the man's GCS began to drop, or whether she did this after he began to have a seizure. She explained that the two things happened in very quick succession. A third officer had arrived on to the wing by this time and this officer responded to the nurse's instructions and made his way to the landing office to request an ambulance.

As the man had been returning to his cell, the SO had received a request from the communications room to provide an update on his condition. He went to the landing office and telephoned the control room. As he was talking to the communications room operator, the third officer appeared and said that an ambulance was needed. The SO informed the communications room of this and an ambulance was duly requested. The call to Lancashire Ambulance Service was made at 11.35pm.

The man had lost consciousness and the nurse instructed the officer who had arrived with the SO to roll the man onto his back on the bed and to commence Cardiopulmonary Resuscitation (CPR) whilst she prepared to use the defibrillator. The nurse used the defibrillator to shock the man and she and the night duty officer continued to carry out CPR on him, on his bed, for 15-20 minutes. The second officer then took over and continued CPR for a few minutes until the paramedics arrived in the man's cell.

In interview, the night duty officer explained that in his 17 years in the Prison Service he had never received official first aid training. The second officer stated that he had received first aid training whilst in the Prison Service, but he did not think this had taken place in the last few years. The OSG also said that he had not received any first aid training.

It has not been possible to establish exactly what time the paramedics first attended to the man. The Lancashire Ambulance Service records indicate that the first paramedic arrived at the prison at 11.42pm. A prisoner on the man's landing noted the time as being 11.47pm when the paramedic arrived on the wing. The Control Daily Log Sheet records that the ambulance entered the prison at 11.50pm.

Lancashire Ambulance Service's records indicate that they left the prison at 00.36am on 8 June. This would suggest that they had been attempting to resuscitate the man in his cell for approximately 30 minutes.

The man was taken to by ambulance to Chorley District Hospital where he was pronounced dead at 01.05am on 8 June. The man's family was informed of his death by the local police between 4.00am and 5.00am on 8 June. The

family was visited by Wymott's duty Governor and the Family Liaison Officer on the day following the man's death.

The prison kept in regular contact and ensured that the man's belongings were returned promptly and with sensitivity. The prison offered to help towards the cost of the man's funeral and offered the family the opportunity to visit the prison if they wanted to. A letter of condolence was sent by the Governor two days after the man's death.

Discussion of the issues

Chorley and South Ribble Primary Care Trust (PCT) carried out a review of the man's medical care whilst he was at Wymott. The review concluded that the man's treatment by the healthcare staff at Wymott was appropriate in the circumstances. The man's collapse first became apparent to staff at 11.01pm and the nurse arrived on the scene within a matter of minutes.

In medical emergencies, there is a term referred to as the "golden hour". During the first 60 minutes following the trauma or pain, it is crucial that a victim receives medical treatment. The importance of this initial hour is no different in a prison.

As noted, an ambulance was not called until 11.35pm, at least half an hour after the nurse began to assess the man who had collapsed. The clinical review of the man's treatment suggests that "in retrospect the healthcare staff may wish to consider whether the ambulance should have been called sooner".

The nurse's initial assessment of the man included taking his blood pressure and heart rate. Both of these were normal. Her initial treatment calmed the man down and relieved his pain.

On the night of 7 June, the nurse would have been the only medically qualified member of staff in the prison. Neither of the two officers or the OSG who were directly involved in attending to the man that night had up to date first aid training. Two of the three had received no training at all. Yet one of these untrained officers gave the man CPR for some considerable time. While I commend the officer for doing what he could to save the man, it is questionable whether officers who have not had CPR training can reasonably be expected to carry it out.

In interview, the nurse explained that she asked the night duty officer to carry out CPR on the man whilst he was lying on his bed because there was no room on the floor of his cell. She believed that vital minutes could have been lost by moving him to the corridor. The nurse has had the training to enable her to assess whether or not to move a patient to perform CPR. However, in interview, both of the officers who had carried out CPR on the man were unaware that CPR should ideally be carried out on a hard surface. This highlights the risks of staff not being properly first aid trained.

After arriving on the wing and briefly speaking to the man, the nurse momentarily left him to fetch the emergency equipment from the treatment room. Although she was gone for only one to two minutes, it was possible that the man's condition could have deteriorated during that time. When the oxygen cylinder began to run out some half an hour later, the nurse handed her keys to the OSG and asked him to fetch the equipment whilst she stayed with the man. It might help in any future emergency if other members of overnight staff, besides the single healthcare officer, have access to the

treatment room. This would enable them to collect equipment without it being necessary to hand over keys, or for the nurse to leave the patient.

The prison's contact with the man's family was sensitive, timely and well handled. The family have appreciated their efforts to make what is an extremely difficult experience as painless as possible.

My strong preference is that, wherever possible, a senior manager from the prison where a prisoner has died should break the news to the family. Where this is not possible (such as when the family live a long distance from the prison) then consideration should be given to asking a senior manager from a prison in the nearby area to visit the family and break the news.

The Prison Service has recently revised its guidance Liaison with Bereaved Families Following a Death in Custody (Prison Service Order 2710) with the updated version coming into force on 4 January 2006. I note that at the time of the man's death the new PSO would not have been available to staff.

The new guidance provides a recommended option for delivering the news of a prisoner's death and explores the issues to be considered when taking the decision on how to do this (paragraphs 4.7 to 4.14). The Prison Service Order (PSO) recommends that the news is broken to a family as soon as possible after the death, face to face, by a dedicated Family Liaison Officer along with the Chaplain, Governor or most senior individual available. The PSO indicates that asking the police to break the news of a death is, generally speaking, poor practice although it does explain that in certain circumstances this may be necessary. In deciding on whether the police should be asked to break the news of a prisoner's death, the PSO encourages Governors to consider the following (paragraph 4.12):

- the prison should demonstrate its duty of care and show that it is taking the death seriously by making a personal visit
- failure to make a personal visit can sour the prison's entire future relationship with the family
- families who have experienced deaths in custody say they prefer a personal visit and regard anything less as a shirking of responsibility
- the police officer deployed to speak to the family may not be trained in breaking bad news or know anything about prisons. Many police forces have dedicated trained family liaison officers but it is likely that an untrained local police constable will be tasked with visiting the family, especially at night
- the police officer will have limited information about the incident and it is frustrating for families not to have access to all the information they want.

The Prison Service explained to the investigation team that, due to the time of night, the decision to ask another prison to send a member of staff to visit the man's family would have necessitated a member of staff being woken in the night to visit the family. Neither the Night Orderly Officer nor the duty Governor from another prison would have been able to visit the man's family in case there was an incident at their

establishment during that time. It was decided by the staff at Wymott that it was preferable to ask the police to visit the man's family rather than ask this of another establishment. The visit to the man's family the following day by a senior manager and Family Liaison Officer from Wymott ensured that there was an opportunity for the family to ask questions and learn more of the details of his death. In view of these factors, I consider that the decision taken was a reasonable one.

I remain of the opinion that the police should only be asked to break the news of the death, without prison staff in attendance, when distance and the time of night make this truly necessary. In addition to assessing the practical difficulties of asking staff from another prison to deliver the news of a death, the decision over whether to ask police to break the news of the death should take into account the way this may be perceived by the family.

Findings and Conclusions

1. The man who this report is about had not given anyone cause for concern about his health. However, the documentation relating to his healthcare reception screening on arrival at Wymott was not completed as fully as it might have been.

I recommend that the Governor and PCT remind healthcare staff of the importance of completing each assessment required on the Healthcare Reception Screening form.

(As a housekeeping point, all healthcare staff should also be reminded of the importance of fully completing their own details on Healthcare Reception Screening forms after carrying out an assessment.)

2. Following the man's collapse, the OSG, night duty officer and second officer acted promptly and appropriately. The prisoners on the landing also endeavoured to keep the man calm and to make him comfortable. The Governor will wish to consider if all three officers deserve some form of commendation.

3. Although he appeared to be in severe pain when he first collapsed outside the servery on the landing, the nurse's initial treatment eased the man's pain and calmed him considerably. Her initial assessment of the man included taking his blood pressure and heart rate. Both of these were normal.

The nurse treated the man for approximately half an hour before an ambulance was called. The clinical review concludes that the man's treatment by healthcare staff was appropriate in the circumstances. In retrospect, it might well have been better had an ambulance been called sooner. However, it is clear that the man was responding well to the treatment he was being given. This is evidenced by his getting to his feet and saying that he was not in pain.

4. The nurse attempted to revive the man for approximately 20 minutes. She did this with the assistance of two officers, one of whom had never had first aid training in the Prison Service and one whom was out of date with his training.

I recommend that the Prison Service considers whether there should be a requirement for all officers to be up to date with their first aid training.

5. The nurse left the man in the care of officers, albeit briefly, whilst she went to collect the emergency equipment from the treatment room. His condition could have changed during that time. The Governor may wish to consider whether there is a practical way for night staff to have access to the treatment room without medical staff needing to leave the patient or hand over their keys to other staff.

6. The prison's family liaison arrangements were very good. Where the family are some distance away, consideration should always be given as to whether it is better to ask a nearby prison rather than the police to break the news.

List of Recommendations

I recommend that the Governor and PCT remind healthcare staff of the importance of completing each assessment required on the Healthcare Reception Screening form.

I recommend that the Prison Service considers whether there should be a requirement for all officers to be up to date with their first aid training.