

**Investigation into the circumstances surrounding the
death of a man at HMP Cardiff
in June 2007**

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

March 2008

This is a report of an investigation into death of a man at HMP Cardiff in June 2007. The man collapsed and died in his cell. He was serving a four month prison sentence.

The Coroner for Cardiff requested a post mortem and it noted that the man had died from natural causes. The Coroner sent a copy of the provisional post mortem report to my investigator, and agreed those findings could be passed to the clinical reviewer. The provisional cause of death was due to:

- 1a haemopericardium (an accumulation of blood around the heart)
- 1b myocardial infarction (heart attack)
- 1c coronary artery thrombosis (blood clot in an artery feeding the heart).

In February 2008, an inquest into the man's death was held. The cause of death was confirmed as natural causes due to a myocardial infarction. I extend my sincere condolences to his family and friends at the sudden loss of a partner, son and brother.

This investigation into the man's death was undertaken by one of my investigators. I would like to thank the Governor of HMP Cardiff and her staff for their help and assistance. I am particularly grateful to a principal officer and a senior officer.

A review of the man's healthcare was commissioned with Healthcare Inspectorate Wales. I must also thank the doctor who actually undertook the review into the man's medical care. In this final report the doctor has made some amendments to her review. The amended clinical review is annexed to the report.

It would appear that a delay in ensuring an ECG test may have had grave consequences for the man. The clinical reviewer says that it was a serious omission that no ECG was performed immediately upon the request of the prison's doctor, as it would almost certainly have shown evidence of a heart attack. The man would presumably then have been sent to hospital.

I make four recommendations, three for the Head of Healthcare and one for the attention of the Governor with reference to the Listener scheme. I commend three named members of staff in noting an example of good practice. In this final report, the prison service has replied to the draft report and the responses have been included. The man's family have also made some comments, which again are included in this report. In relation to the recommendations, the prison has replied to those raised and the actions have been included.

In this revised final report the prison service response to the recommendation of Listener confidentiality has been removed and this recommendation has been referred to the Samaritans national co-ordinator to share this with the Samaritans branch who train and support the Listeners at HMP Cardiff.

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

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Prisons and Probation Ombudsman

March 2008

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SUMMARY

The man was received in HMP Cardiff in early June 2007, having been sentenced to four months' imprisonment for driving offences. On reception, his first reception health screen document noted that he was a user of opiates and he tested positive for heroin and benzodiazepines. It was also recorded that the man had asthma. His clinical observations were taken, which included higher than normal blood pressure, although this may have been due to anxiety about his new surroundings. No other health problems were recorded.

The man was located on the prison's detoxification wing, and signed the compact to participate in the wing programme which included regular physical exercise in the gym. He was given medication for his asthma, as well as Zopiclone to help him sleep and painkillers.

The man saw a nurse on 10 June as he had been complaining of chest pain. Although no observations were recorded, the nurse recalled at interview that they were within normal limits. The nurse asked the man about any symptoms associated with heart problems, but excluded that as a possibility. He was seen by the nurse on two more occasions that day when he seemed to be feeling better.

Four days later, the man was examined by the doctor as he was still having chest pain. His observations were taken and were within normal limits, although his peak test flow was low for a grown man. The doctor thought that the man was suffering from asthma and requested confirmation from his doctor in the community. The doctor also requested an Electrocardiogram (ECG). (The average wait for an ECG at the prison is about two weeks.)

During the afternoon of 20 June, the man went to the gym as part of his detoxification regime. He asked the staff if he could sit out as he was feeling unwell. He returned to his cell at the end of the session, and lay down on his bed. He watched television and chatted to his cell mate. About 5.30pm, the cell mate heard the man 'snore' and turned round to look at him. He saw that the man had urinated. The cell mate tried to rouse the man, but could not wake him and immediately alerted wing staff.

Three officers and nurse officers attended the man's cell together with a nurse. On opening the cell door, the officers radioed for urgent assistance as the man was unconscious. Two physical education officers heard the call for emergency aid and went to the man's cell. The officers performed Cardio Pulmonary Resuscitation (CPR) and were joined by members of healthcare staff with resuscitation equipment.

At 5.45pm, paramedics arrived at the cell and undertook cardiac and respiratory assessments on the man. At 5.55pm, they declared he had died. A Listener, who happened to be a distant relative of the man's, was asked to sit with his cell mate following his collapse. The Listener then telephoned the

man's family and told them of his death before prison staff were able to visit and officially inform them of the sad news.

THE INVESTIGATION PROCESS

The investigation into the man's death was opened by one of my investigators, on 4 July 2007 when she visited HMP Cardiff. She met a senior officer (SO) and the Deputy Governor. No representatives of the Independent Monitoring Board (IMB) or the Prison Officers' Association (POA) wished to see my investigator, because they were familiar with the process of death in custody investigations. Notices and terms of reference had already been sent to the prison by post.

My investigator reviewed the man's prison and medical file, and received photocopies of relevant details. My investigator also visited C Wing, which is the detoxification unit. She spoke to an officer who knew the man. My investigator also spoke to three prisoners including the man's cellmate, a Listener who coincidentally is a relative of the man, and the man's brother-in-law.

A clinical review of the man's medical care was commissioned from the Healthcare Inspectorate of Wales and a doctor carried it out. On 5 September, at the request of the doctor, my investigator interviewed two members of Cardiff's healthcare staff. My investigator later visited the gymnasium and spoke to a senior officer.

One of my family liaison officers spoke to the man's partner. She did not request a family visit, but raised several questions that she would like the investigation to consider. I hope I have addressed those questions in this report.

The man's partner raised two questions with my family liaison officer,

1. Why did he have to wait to see a doctor for the first time?
2. Why was he not taken straight to hospital with such worrying symptoms?

I have addressed those questions within the clinical review section of this report.

HMP CARDIFF

Cardiff prison is a category B prison taking remand and sentenced prisoners. It can hold up to 754 adult men. The prison has six residential units, one of which is a detoxification unit for up to 52 prisoners.

There is a healthcare centre that provides 24-hour nursing and medical cover and beds for up to 16 in-patients. Reception healthcare staff identify new prisoners who would benefit from coming off drugs under medical supervision. If a prisoner agrees to go to the detoxification unit, he is assessed by the duty detoxification nurse and put onto the appropriate treatment programme.

There are 14 double cells and 24 single cells in the detoxification unit. Men spend approximately three weeks in the unit until they have completed the programme. All prisoners sign a compact that sets out the rules for acceptable behaviour and for participation in the treatment.

In February 2005, Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, inspected Cardiff. The report of that inspection commented as follows:

“Two years ago we described Cardiff prison as being at a crossroads as it struggled with competing pressure, including the inexorable rise in population. This unannounced follow up inspection records that Cardiff had achieved a great deal despite these unpropitious circumstances. We found that most of our recommendations had been implemented and in some key areas, the prison had gone significantly further.”

KEY FINDINGS

The man was received into Cardiff in early June 2007 and a first reception health screen document was completed. He tested positive for heroin and benzodiazepines and the document noted that he suffered from asthma. The man was assessed by the detoxification staff and the relevant paperwork was completed that day. His blood pressure was recorded as 145 over 85 and pulse at 80 beats per minute. His blood pressure was higher than usual (120 over 70 is the average resting level), but was within normal limits for a person in new surroundings. The man signed the detoxification compact that day. This document sets out the interventions and help offered to prisoners who misuse drugs or alcohol.

The next day, the man was given medication for his asthma and the day afterwards he was given Zopiclone of 7.5 mg at night to help him sleep. On 4 June, an entry in his medical record reads, 'Detoxing well, settled with no complaints.' He was transferred to C wing on the first floor landing and placed in a double cell with a cell mate. On 5 June, the man was given ibuprofen and paracetamol and on the following evening Zopiclone was prescribed. It was also noted that the man had provided a positive urine test for benzodiazepines. This was not unusual as benzodiazepines remain in the system for up to 14 days after they have been taken.

On 10 June, at 8.00am, an entry in the man's medical record noted that he complained to a nurse of chest pain and feeling breathless. A nurse asked about symptoms associated with heart pain and excluded that possibility. It was a hot day, so the man moved to a cooler area and used his inhaler. No observations were recorded in his notes, although at interview the nurse was able to recall that the man's observations were within normal limits. The nurse did not carry out a Peak Flow test as he was aware the man was an asthmatic. He declined to see the doctor.

At 10.00am, the nurse saw the man again to follow up the first assessment. He still had mild chest pain and felt a bit sick. The pain was reducing and the nurse's initial diagnosis was indigestion. The man was given Maalox (an indigestion remedy) to settle it. At lunchtime, the nurse checked how the man was feeling. He told the nurse that he had expelled some air, felt much better and the pain had gone. The nurse told the man that his name was on the doctor's list for an appointment on 12 June. The man failed to keep the appointment on 12 June and it was re-arranged for two days later. Nevertheless, on 11 June the man was given a dose of paracetamol in the morning and again at lunch time. It is not recorded why he asked for this. He was also given a dose of Zopiclone that night.

The man saw the doctor as arranged on 14 June, and told her that he had had some chest pain on 10 June and that he thought that the pain had spread down his left arm. He also mentioned that he had had chest discomfort all day on 10 June. The doctor examined the man and could find no problems with his lungs; his blood pressure was 130 over 85 and pulse 60 beats per minute. A peak flow test was performed and the flow was very low for a

grown man. The diagnosis was again asthma and the man was instructed how to use his medication. The doctor requested a routine, rather than an urgent, Electrocardiogram (ECG) to be performed. There is an average of two weeks wait for an ECG and specially trained healthcare nurses carry out the procedure. On 15 June, at the request of the doctor, the man's home doctor was contacted and it was confirmed that he did have asthma.

At 2.00pm on 20 June, the man went to the detoxification unit's gymnasium area to take part in the lifestyle group. (The lifestyle group is overseen by gym staff who promote exercise and positive healthy living to prisoners on the detoxification unit.) He did not participate in any physical exercise that afternoon and told the physical education officer that he felt unwell. The officer told the man to sit out in the gymnasium area. He sat on a window sill with another prisoner who was also not participating in exercise that afternoon. Later, the man returned to his cell with his cell mate who had also been to the lifestyle group.

About 5.30pm, the man was lying on his bed watching television and chatting with his cell mate. Soon afterwards, the cell mate heard the man make a snoring noise, and was concerned as they had been in the middle of a conversation. The cellmate then noticed that the man had urinated into his trousers. The cell mate moved towards the man, thinking that he was asleep. He tried to wake the man, who did not respond. The cell mate then pressed his cell bell, banged the door and returned to the man. He again tried to rouse him, turned him onto his side and saw blood running from his mouth.

At this stage the cell was opened by an officer who immediately called for assistance. A second officer heard the shout and he called to a nurse, who was nearby on the wing. They both went to the man's cell. A third officer joined them in the cell and saw the other two officers with the nurse who was trying to find the man's pulse. The cell mate was told to leave the cell and one of the officers called on his radio for a code blue assistance (a code blue alert informs the communications room that urgent medical attention is required).

Two physical education officers (PEOs) were on duty on D wing which is adjacent to C wing. They heard the code blue and went to the man's cell. Both PEOs are trained in first response first aid. (First responders are trained to carry out resuscitation techniques and in the use of resuscitation equipment). Three members of healthcare staff, also heard the code blue radio message from another wing in the prison. They collected the emergency bag and oxygen from the wing treatment room and made their way to the man's cell.

On arrival in the cell, the PEOs saw the man lying on his back on the bed. His face was blue and his eyes were open with his pupils dilated. The PEOs also saw blood coming from his mouth. One of the PEOs instructed the officers to move the man onto the cell floor in order to carry out Cardio Pulmonary Resuscitation (CPR). The other PEO commenced chest compressions, whilst the third officer administered mouth to mouth resuscitation. The nurse left the

cell and returned with a crash bag (a crash bag contains an oxygen mask and bag plus equipment for serious medical emergencies). One of the PEOs then relieved the officer and used a bag and mask. The other PEO continued to carry out chest compressions.

At one point it seemed that the man was starting to recover and he was placed into the recovery position. A senior nurse could not find his pulse and he was returned to lie on his back so that the PEOs could continue CPR.

At approximately 5.45pm, the paramedics arrived at the man's cell. The senior nurse and a colleague, assisted the paramedics attending to the man. The PEOs then left the call. The paramedics performed cardiac and respiratory assessments on the man, and at 5.55pm they declared that he had died. At 6.48pm, a doctor attended and the man's death was confirmed.

A Listener trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress, was called to sit with the man's cell mate after the man's death. The Listener and cell mate were moved to another cell on the wing. The Listener was a distant relative of the man and, after leaving the cell mate, he telephoned his family to tell them of his death. Later that evening, a Governor and a principal officer (PO) visited the man's family to inform them of his death, and discovered that the family had already been told.

The prison offered financial assistance towards the man's funeral expenses which was gratefully accepted.

ISSUES

Clinical Review

A review of the man's medical care was commissioned with Healthcare Inspectorate Wales. The review was carried out by a doctor. Following responses from the prison service, the doctor made some amendments to the clinic review for the final report.

The doctor reviewed the man's medical notes and interventions by healthcare staff at Cardiff. The man's partner raised two questions with my family liaison officer that are pertinent to the man's medical care, and I will include those questions in this part of the report.

Reception

When the man came into prison, he mentioned that he suffered from asthma, but did not have his inhaler with him. He did not mention any other physical problems or psychiatric problems. He was located on the detoxification wing and received appropriate medication for pain relief. On 2 June, the man was prescribed medication to treat his asthma, but there is no evidence that his GP was contacted to confirm his treatment at this time.

A prisoner's doctor should be contacted to confirm any prescription medication they may need on reception, or as soon as possible after, and a record should be kept of that contact.

The man's first appointment with the doctor

On 10 June, the man was seen by a nurse who examined him, took his observations and questioned him about his symptoms. The nurse excluded any possibility of heart disease and checked him twice more in the morning. At the last consultation, the man told the nurse he felt better after receiving medication for indigestion. The man did not want to see a doctor that day, and that his pain had settled. An appointment was made for the man to see the doctor on 12 June but he did not keep it and it was rescheduled for two days later.

The man failed to keep the doctor's appointment as he had a prison visit on 12 June. It was unfortunate that he did not see a doctor, as the symptoms of an inferior myocardial infarction (MI), a heart attack of the lower artery, are similar to indigestion. It could be that the man had an MI on the morning of 10 June. He attended the rescheduled appointment two days later, when the doctor undertook a full examination, and a routine ECG was ordered.

Admission to hospital

The man saw the doctor on 14 June, and said that the pain had also spread down his left arm and lasted all day on 12 June, but he had not noticed any breathing difficulties. A doctor examined him and could find no problems with

his lungs, his blood pressure and pulse. The doctor confirmed the diagnosis of asthma and the man was advised how to use his asthma medication. Crucially, the doctor asked for a routine Electrocardiogram (ECG) to be performed and the man was placed on a waiting list for this procedure.

Electrocardiogram

The doctor ordered a routine ECG rather than an urgent one, for the man following her examination of his physical symptoms. The ECG was not carried out immediately and the man was placed on a waiting list for the procedure. The clinical reviewer comments that it was a serious omission that an urgent ECG was not seen as appropriate on either on 10 June, or immediately upon the request of the doctor on 14 June, with the symptoms the man had presented. It may have shown evidence of a heart attack, had the ECG shown evidence of heart problems then it is assumed that the man would then have been sent to hospital.

Nursing staff should be trained to perform an ECG as soon as possible when a prisoner complains of chest pain indicative of heart disease.

Record keeping

The clinical reviewer also comments that records in this case were not up to standard. For example, doctors' instructions should be clearer when writing the prescribed dose and method of administering medication. Nurses need to ensure that all observations they perform are recorded in the medical notes after medication.

Healthcare staff should take steps to ensure they adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.

Lifestyle Group

The man wrote a letter to his partner a few days before he died. He told her that he was having chest pain, but was still being told to attend exercise class in the gym. The detoxification compact, which the man signed, sets out certain requirements that prisoners agreed to participate in whilst on the detoxification wing. One of the requirements is to join activities that help the withdrawal process, including physical exercise.

A nurse told my investigator that if a prisoner did not feel well, through withdrawal symptoms or other medical conditions, they were able to see a nurse and ask to be excluded from exercise for that day. The man's medical file did not note any requests to be excluded from exercise and so he was expected to participate in the lifestyle group. It was noted on the group's attendance list on 20 June that the man did not take part in the class as he felt unwell.

Staff reaction to the man's collapse

The man's cell mate alerted staff immediately that he found that he could not be roused. Officers went straightaway to the cell and called for urgent medical assistance. An officer and the two PEOs performed CPR on the man until the paramedics arrived. Although the officers' actions were unsuccessful, they should be commended for their attempts to revive the man.

I commend the actions of the officer, and the two physical education officers , for their efforts to save the man by the use of CPR.

Informing the family of the man's death

A family relative, was a prisoner in Cardiff at the same time as the man. He had spoken to him the day before he died. He was a trained Listener and, coincidentally, was asked to support the man's cell mate. On hearing of the man's death via his conversation with the cell mate, the Listener telephoned the man's family to tell them the sad news. Later that evening, the Governor and principal officer went to the man's family home, to inform them of the death in person. The man's partner has confirmed with my family liaison officer, that the Listener called the man's cousin, a close friend of the man's partner, and told them of his death. The cousin telephoned the man's partner, she then telephoned the prison and spoke to the chaplain.

It is unfortunate that the family heard the news before the prison could make the family visit, although the man's partner told my family liaison officer that hearing the news from a family member seemed more appropriate.

The importance of Listeners' duty of confidentiality should be emphasised to those participating in Listener training.

RECOMMENDATIONS

- 1. A prisoner's doctor should be contacted to confirm any prescription medication they may need on reception, or as soon as possible after, and a record should be kept of that contact.**

Response – Staff will continue to make every effort to contact the prisoner's home doctor with reference to medications if the prisoner states accordingly on reception.

- 2. Nursing staff should be trained to perform an ECG as soon as possible when a prisoner complains of chest pain indicative of heart disease.**

Response – The prison will continue to train healthcare staff in ECG procedures so that a test can be carried out as and when requested by the prison doctor. Furthermore, a protocol is now in force which aims to ensure consistency of practice across the healthcare centre and the detox unit.

- 3. Healthcare staff should take steps to ensure they adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.**

Response – The prison will continue to demand the highest standards in record keeping as required by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society.

- 4. The importance of Listeners' duty of confidentiality should be emphasised to those participating in Listener training.**

Response – The prison has already taken steps to reinforce the boundaries and implications of confidentiality to all those participating in, or delivering, Listener training.

GOOD PRACTICE

I commend the actions of the officer, and the two physical education officers, for their efforts to save the man by the use of CPR.

Response – The prison appreciated the investigation's commendation of the actions of the three officers involved and they will be recognised appropriately.