

**Investigation into the circumstances surrounding the
death of a man at Hull Royal Infirmary
while a prisoner at HMP Hull in January 2008**

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

August 2008

This is the report of an investigation into the circumstances of the sudden death of a man while a prisoner at HMP Hull, on 10 January 2008. The man collapsed in the B wing exercise yard while walking to the visits hall to see his wife and other members of his family. He was taken by ambulance to Hull Royal Infirmary, but sadly died there a short time later. He was 77 years old.

I would like to offer my sincere condolences to the man's family, not least given the circumstances in which he died.

My colleague conducted the investigation on my behalf. One of my family liaison officers spoke on a number of occasions with the man's daughter-in-law. She told my family liaison officer that the family was happy with the level of care given to the man who died, and they did not have any specific issues they wished my office to investigate.

An independent review into the man's medical care was undertaken by the Clinical Governance Manager at Hull Teaching Primary Care Trust Provider Services. I am grateful to her for her valuable contribution. I would also like to thank the Governor of Hull for his cooperation with the investigation. I am particularly grateful to a Principal Officer who provided a high standard of prison liaison.

I make one commendation in my report relating to the Principal Officer who accompanied the man who died in the ambulance to Hull Royal Infirmary. During the journey to hospital he carried out cardio pulmonary resuscitation (CPR) under the instruction of the paramedic in an attempt to revive the man. I also make two recommendations. The first relates to the confusion experienced by staff on hearing over the radio net about the emergency. The other concerns staff misunderstanding the codes for calling healthcare assistance.

Stephen Shaw CBE
Prisons and Probation Ombudsman

August 2008

CONTENTS

Summary	4
The investigation process	5
The man	6
HMP Hull	7
Key findings	8
Issues	13
Recommendations and good practice	15

Annexes

1. Clinical review
2. Transcript of an interview with an Officer
3. Transcript of an interview with a Principal Officer
4. Notes of debrief dated 11.1.08
5. Extract from Inmate Medical Record

SUMMARY

The man who died had been remanded in custody at HMP Hull. In August 2007, he was sentenced to four years' imprisonment. It was his first conviction. He died at the age of 77.

The man had a long term heart condition and had been fitted with a pacemaker around four months prior to his imprisonment. In addition, he had complained of pains in his feet and had high blood pressure which was poorly controlled. Hull had thoughtfully located him on the ground floor of I wing where food and medication hatches were located. This meant he did not have to exert himself unnecessarily in using stairs and getting his meals. The man also had access to a wheelchair if he needed it.

In January 2008, he had a cardiac arrest (heart attack) in B wing exercise yard. He had been making his way from I wing to see family members who were waiting for him in the visits hall. Staff attempted cardio pulmonary resuscitation and called an ambulance. The man was taken to Hull Royal Infirmary where staff also tried to resuscitate him, but he died shortly after his arrival.

I and J wings are designated vulnerable prisoner wings, housing a significant number of frail and elderly individuals. My investigator noted that it was a considerable distance to walk from I wing to the visits hall, an issue that had been previously identified by HM Chief Inspector of Prisons, Ms Anne Owers, in her Thematic Review of Older Prisoners.

My investigation found that, despite the initial confusion surrounding the location of the emergency, the response to the man's collapse was almost immediate. Nursing staff carried out cardio pulmonary resuscitation in appalling weather conditions. They were aided by a member of staff who attempted to shelter them with an umbrella. Other staff thoughtfully fetched blankets to keep the man warm.

Code amber was called over the radio net (code amber is used to indicate a medical emergency where the individual is collapsed but breathing). The clinical reviewer has found this to be unsatisfactory as it relies on staff diagnosing between a collapse and a cardiac arrest. The clinical reviewer has recommended that this policy be reviewed the better to inform healthcare as to the nature of the emergency. I agree. I also recommend that the call codes be limited to code red for blood-evident incidents and code blue for all other medical emergencies. This will ensure staff bring the correct equipment with them. In this case, the outcome would have not have been different, but it could well have a bearing on the outcome of emergency situations in the future.

My recommendations aside, I judge that the care the man received before his collapse and subsequently was entirely appropriate. I also commend the actions of a Principal Officer who assisted the paramedics with their resuscitation attempts during the journey to the hospital.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 10 January 2008. Terms of Reference and notices were issued to staff and prisoners at Hull telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of the man's core record, Inmate Medical Record (IMR), and other records relevant to his time in custody and his death.
2. My Investigator also contacted the Coroner to ask for a copy of the post mortem and toxicology reports. A second toxicology report was commissioned specifically to examine the levels of warfarin. This was to investigate an allegation made by a prisoner and friend of the man who died that the man had been given incorrect medication.
3. My investigator visited Hull on 21 and 22 February 2008. She met the Governor, Head of Residence and the Head of I and J wings, who also acted as prison liaison for this investigation. My Investigator visited I wing and spoke informally with staff and prisoners. The Head of I and J wings accompanied my investigator as she walked a similar journey taken by the man who died on 10 January. The journey started from I wing and proceeded to the visits hall via B wing exercise yard where the man had collapsed.
4. A clinical review of the man's medical care was commissioned from Hull Primary Care Teaching Trust (PCT). The Clinical Governance Manager conducted the clinical review which focussed on the medical care the man who died received at Hull. The review appears as an annex to this report.
5. One of my family liaison officers, contacted the man's daughter-in-law and maintained telephone contact with her throughout the investigation. She told my family liaison officer that the family did not have any concerns regarding the man's care at Hull. They were pleased with the care he received.
6. A copy of the draft report has been seen by the family and the prison service. The family do not have any comments and the prison service has accepted the recommendations I have made. The prison service response can be found on page 14 of my report.

HMP HULL

7. HMP Hull is located around two miles from Hull city centre. It opened in 1870 and was designed to hold both male and female prisoners. In 1939 it was used as a Military Prison and then as a Civil Defence Depot. In the 1950s it re-opened as a Closed Male Borstal. Following extensive security renovations in 1969, the prison became a maximum security dispersal prison.
8. In 1986, Hull ceased to be part of the dispersal system and commenced its current role as a male local and remand prison. The prison has a maximum operating capacity of 1,035 prisoners and is rarely below that level.
9. Expansion and refurbishment in 2002 included four new wings, a new healthcare centre, sports hall and improved kitchen, education and workshop facilities. There are eight wings in total.
10. Healthcare is provided by Hull Teaching Primary Care Trust Provider Services. The healthcare department is located on two floors. The first floor contains consulting rooms for visiting clinics such as psychiatry, dentistry, chiropody and opticians. The second level has an 18 bed unit that caters for prisoners with medical and mental health needs who require 24 hour care. The unit is currently undergoing refurbishment to enable the prison to give palliative care.
11. The most recent inspection report by HM Chief Inspector of Prisons acknowledged that Hull had risen to the challenges of a 'burgeoning population of often needy prisoners in inadequate conditions'. The prison had made a number of improvements since the previous inspection in 2004. The Quality of Prison Life Assessment rated the prison as a three star establishment indicating that it is a generally safe prison with a commitment to treating prisoners with decency.
12. The Independent Monitoring Board (IMB) in its latest report for Hull (2005 – 2006) says that overall the prison continues to be well managed. It praises an organised and dedicated staff. Initial difficulties with Hull Teaching Primary Care Trust taking over responsibility for healthcare provision were highlighted at the time of the IMB report.
13. Since 2004, I have been responsible as Ombudsman for investigating all deaths in custody, approved premises and immigration removal centres. This includes both deaths from natural causes and those that are self inflicted. Since 2004, my office has investigated nine deaths through natural causes at HMP Hull.

KEY FINDINGS

14. The man who died was remanded into custody at Hull in 2007. He was convicted of serious offences following a trial at the Crown Court and later in 2007 a sentence of four years imprisonment was imposed. He was located in the vulnerable prisoner wing. There is very little information within wing records regarding the man's behaviour but his fellow prisoners and staff speak well of him as a pleasant, polite individual. Although he was retired from work in the prison, the man attended education classes. He complied with his sentence plan and was willing to be assessed for a place on an Offending Behaviour course specific to his offence.
15. There is a well documented medical history covering his period in custody and this is examined more fully in the clinical review. A note dated 18 May 2007 in his clinical records acknowledges that he was fitted with a pacemaker prior to imprisonment. He was prescribed warfarin (for the treatment and prevention of abnormal blood clotting) and digoxin (for irregular heartbeat).
16. A further entry on the same day records states that the man who died told the healthcare professional that he felt well with no problems. He said that he was awaiting surgery at a local hospital to 'clear the veins in his neck out as they are both blocked'. On 16 August, a telephone call was made by an unspecified member of healthcare staff to the hospital to check that there were follow up appointments at the hospital. The member of staff was informed that there were no follow up appointments for the man at that hospital. A subsequent letter dated early December 2007 from the hospital to the prison said that an appointment had been made for the man for early January 2008. A handwritten note on the letter stated that the man was to be referred to hospital by the local hospital. The referral was made because two days before the man's death, the prison was notified of a pacemaker check-up appointment. This appointment was due to be at the Cardiac Investigation Unit in February 2008. Sadly, the man died before the date of the appointment.
17. Medical records indicate that, in addition to his heart condition, the man said he had difficulty walking and complained of pain in both feet. He suffered from high blood pressure that prison medical professionals noted was poorly controlled.
18. The prison had placed the man on the ground floor of I wing. This enabled him to obtain his meals and medication from the ground level without unnecessary exertion. My investigator spoke to his friend who was permitted to assist him in everyday tasks. My investigator walked the distance from I wing to B wing exercise yard where the man who died collapsed and then onward to the visits hall. She noted the distance was considerable and unpleasant in poor weather as was the case on the day the man died. The frailty of a number of the prisoners on I and J wings, including the man, would have made the walk particularly difficult although wheelchairs were available. HM Chief Inspector of Prisons, Ms Anne Owers, had also raised a concern

regarding the distance between the vulnerable prisoner units and the visits hall in her Thematic Review of Elderly Prisoners published in 2004.

19. A fellow prisoner and friend of the man who died was with him when he collapsed on the exercise yard. The man's friend raised a concern to staff and my investigator that the man informed him that he had been given the wrong medication the day before he died. The friend stated that the man was very clear about the medication he should receive. On a number of occasions in the past he had complained to his friend that he was dealt with by different nursing staff who were not aware of his needs. Nursing staff had often sent the man back from the medication hatch on the wing. They told him that he was not due to receive medication and he should return either in the evening or on the following day.
20. In the light of concerns raised by the man's friend, a toxicology report was requested by the Coroner. The report did not show any adverse results that would indicate the wrong amount of medication had been administered. However, the clinical reviewer has identified that the drug which might have been administered incorrectly was warfarin. Accordingly, a further toxicology report has been requested with specific emphasis on levels of warfarin. The clinical reviewer investigated this matter in the light of the friend's concerns. She found that the man had been receiving the same dose of warfarin since mid-November 2007 and concludes that this was entirely in keeping with his needs. The toxicology report supports the clinical reviewer's findings as it concluded that, 'The Warfarin is at a level expected with low therapeutic range use.'

Events on 10 January 2008

21. An Operational Support Grade (OSG) member of staff, was standing by the gate on B wing exercise yard as part of a team of staff monitoring prisoner movements from the wing to the visits hall.
22. At approximately 1.50pm, the man who died, along with other prisoners, was walking to the visits centre for an afternoon visit with his wife and daughter-in-law. They passed through a gate supervised by the OSG. They had nearly reached the visits centre when the man suddenly collapsed in the exercise yard.
23. Movement is supervised by officers posted at various stages of the route prisoners take while moving together from one location to another. This was the case on the day the man collapsed. The OSG heard two prisoners call out to him that the man had collapsed. Officer A was present and was also supervising the line of prisoners on B wing exercise yard. He told my investigator that a prisoner collapsed in front of him. He thought at first that the man had slipped because of the wet conditions. Officer A approached the man and found him unconscious. He said that he put the man in the recovery position, at the same time calling a 'code amber' for healthcare assistance.

24. The OSG also radioed for assistance using the call sign 'code amber' to indicate to healthcare nursing staff that there was a medical emergency. The Orderly Officer, the senior uniformed officer in charge of the prison, was also supervising the line route when she heard the call over the radio net. She was one of the first on the scene, arriving with the OSG and Officer B. The Orderly Officer noted that the man had been placed in the recovery position and that he was 'turning blue'. She then asked the main Control Room to immediately cease all prisoner movement.
25. A Staff Nurse was detailed as Hotel 5 (Hotel 5 is the call sign given to the healthcare staff member who carries a radio and is detailed to attend all medical emergencies in the prison). She told my investigator that at 1.59pm she had received an unclear message over the radio net for Hotel 5 to attend D wing. On receipt of the message, she asked for confirmation of the area and was informed it was B wing exercise yard. The Staff Nurse attended with a Senior Staff Nurse. Using the radio net, the Senior Staff Nurse immediately requested a paramedic ambulance.
26. At the time the man collapsed, the Principal Officer was in the Stores selecting suitable clothing for the poor weather conditions. He was not wearing a radio but heard the code amber called over the storeman's radio. His initial understanding was that the incident was located on C or D wing as the phonetic alphabet had not been used. (In other words, in the first instance he misunderstood the location.) In interview, the Principal Officer confirmed that nursing staff were on the scene by 1.58pm when he arrived.
27. Hull operates a colour coded radio net call system to give medical staff an indication of the nature of the emergency. Code red is used if blood is evident; code amber is used if the person is collapsed but breathing; code blue is used if the individual is not breathing. My investigator found that medical staff considered the 'code amber' call unclear. The system is reliant upon an assessment by officers as to whether an individual is breathing or not. The OSG called 'code amber' over the radio net when asking for assistance from healthcare. However, my investigator found a lack of understanding of requirements between healthcare and prison staff. The Head of Healthcare, informed my investigator that her nursing staff needed to be accurately advised as to the nature of the emergency so that they could prepare for it and take the necessary equipment. In the man's case, healthcare staff arrived very swiftly to administer medical assistance.
28. The phonetic alphabet should be used by staff when using the radio net. It was evident from the Principal Officer's account and the notes of the debrief held at Hull on 11 January, that staff initially misheard attendance at B wing exercise yard as B or D wing. The Staff Nurse said she was initially unsure whether the call was for D or B wing. The notes of the debrief record as an action point: 'K D to brief control room staff to use phonetic alphabet.' It would be good practice to implement this immediately. While not critical in this case, as staff reached the man very swiftly, it might be so in future emergencies.

29. The Principal Officer said that the Senior Nurse confirmed that an ambulance had been called. She asked him to go to B wing for the emergency medical bag (staff refer to it as the 'grab bag') as she specifically wanted the oxygen bottle with a mask that would be in the bag. The Principal Officer said he went on to B wing and asked an officer to collect the grab bag as he did not know where it was on B wing.
30. The OSG said that the Orderly Officer arrived with Officer B. Officer B instructed the OSG to go to B wing and fetch blankets to keep the man warm. Around the time the man collapsed, the weather had deteriorated significantly. Resuscitation attempts had to be conducted in high winds and torrential rain. Officer B held an umbrella over the man while the Staff Nurse and the Senior Nurse carried out cardio pulmonary resuscitation (CPR). Upon his return, the OSG saw two healthcare nurses attending the man.
31. The Staff Nurse examined the man and noted no signs of life. She could not detect a pulse, and observed that the man's pupils were fixed and dilated, his lips were blue and his heart had stopped. The Senior Nurse applied CPR for approximately 12 to 15 minutes but the man did not respond.
32. The communications room log noted that at 1.59pm there was a call for an emergency ambulance. At 2.03pm, Senior Staff Nurse 2 arrived, having been asked to attend the incident to assist the Staff Nurse and Senior Staff Nurse with CPR. The ambulance arrived at 2.10pm and went to the exercise yard. The paramedics took over care of the man. They assessed the gravity of the situation and immediately placed the man on a stretcher and into the ambulance.
33. The Principal Officer asked Officer C if he would travel in the ambulance with the man. The Principal Officer said that at the point the ambulance set off, the paramedic asked him to assist in giving CPR. The Principal Officer said that he knew the procedure but he had not used it since training some 20 years before. The paramedic quickly instructed the Principal Officer in the method of CPR and then asked him to continue for as long as possible. The Principal Officer described to my investigator how, under the paramedic's instruction, he and the paramedic carried out CPR while being 'thrown about at the back of the ambulance' as it was travelling at great speed.
34. The Principal Officer and Officer C went with the man into the resuscitation area at the hospital. The Principal Officer described strenuous attempts by medical staff at the hospital to save the man. Sadly, he was pronounced dead at 2.30pm. The Principal Officer confirmed that the time between the man's collapse and the pronouncement of his death in hospital was approximately 35 minutes.
35. Poignantly, at the time of his collapse, the man's wife and daughter-in-law had already arrived in the prison visits hall. At that point, the Head of Resettlement received a radio message for him to attend B wing exercise yard. The Head of Resettlement arrived at 1.59pm where he witnessed the man lying on the ground and two members of healthcare attempting to

resuscitate him. The Head of Resettlement told my investigator that, when the ambulance arrived, he telephoned the wing principal officer and asked for the man's cell to be secured. He further asked for copies of the man's prison records to be sent to the Command Suite. When the Head of Resettlement arrived at the Command Suite, he was told that the man's family had arrived for their visit. The Head of Resettlement went downstairs to meet the family. He took them to the Care Suite where he told them what had happened.

36. The Principal Officer telephoned from the hospital to say that the man had died. The Deputy Governor together with a member each of the chaplaincy team and of the Independent Monitoring Board, went to the Care Suite. The chaplain informed the family of the sad news. The family were very distressed and the prison ordered a taxi to take them to the hospital. Staff and the chaplain remained with the family until the taxi arrived.

ISSUES

Clinical Review

37. The Clinical Review was undertaken by the Clinical Governance Manager, Hull Teaching Primary Care Trust (PCT). She concludes that the care the man received was broadly similar to that which he would have received in the community.
38. The man was due to attend an outpatient appointment at local hospital. However, he died before the date of his appointment on 21 February. The clinical reviewer consulted the Consultant Cardiologist, who originally treated the man who died. They discussed whether, if the appointment had been brought forward, it would have made a difference to the outcome. In the consultant's opinion, it would have made no difference as appointments are set at six-monthly and sometimes annual intervals.
39. The reviewer considers that the response to the man's collapse was in line with local and European resuscitation policy. The initial confusion over the location of the incident did not result in a significant delay that would have affected the final outcome. The response of nursing staff to the incident was very swift and the time from collapse to pronouncement of death was around 30 minutes. The clinical reviewer has reiterated my investigator's finding that the phonetic alphabet should be used to reduce the risk of misunderstanding over the radio net.
40. The reviewer and my investigator spoke to the Head of Healthcare, regarding the use of the red, blue and amber colour coding system to indicate the type of medical emergency. As noted, 'code red' is used when blood is evident, and 'code blue' is used when it is clear that a prisoner is not breathing. Code amber is used to indicate that a prisoner is unconscious but breathing. The Head of Healthcare was of the view that the 'code amber' is of little value to nursing staff as it is not specific in advising nursing staff as to the type of emergency they are called to attend. It also relies upon prison staff being equipped to diagnose whether a person is breathing or not. The OSG used the 'code amber' call sign as did the Orderly Officer. This did not truly reflect the circumstances as the man had stopped breathing in the very short time it took staff to reach him. Had a code blue been called, medical staff might have had the opportunity to gain access to emergency medical bags before arriving. In the man's case, not carrying the correct medical equipment may not have altered the outcome, but it might be a crucial factor in another emergency in the future.
41. The reviewer has also highlighted the need for clarity regarding the use of code amber. She says it is probable that the member of staff using the code will not be healthcare trained. As a result, they may be unable to diagnose the difference between collapse and a cardiac arrest. The reviewer's recommendation is for Healthcare to respond to both code blue and code amber with the same urgency and equipment.

I recommend that the Governor and the Primary Care Trust review the coding policy with a view to restricting the use of Code Red for blood-evident incidents and Code Blue for all other medical emergencies, to provide medical staff with accurate information regarding the nature of the emergency.

The radio net

42. Staff initially misunderstood the location where the man collapsed. The Principal Officer was in the stores when he heard the Storeman's radio. He thought he heard that the incident occurred on either C or D wing. He quickly found the location because, 'I could see the incident occurring in front of me.' The Senior Nurse was located on A wing when she heard the radio call for nursing assistance. It was not immediately clear to her whether the call was for B or D wing although this was quickly clarified. In the staff debrief held on 11 January 2008, it was noted that 'several other members of staff also commented on this'. It is good practice for staff to use the phonetic alphabet over the radio net. This serves to reduce the likelihood of misunderstandings and ensure effective communication and prompt action if necessary.

I recommend that the Governor reviews the policy and procedures governing the use of the radio net and reminds all staff equipped with radios to use the phonetic alphabet when directing other staff to locations.

43. The Principal Officer is to be commended for his actions in assisting the paramedic with CPR. The Principal Officer had not practised this procedure since his training around 20 years before. On the paramedic's instructions, he assisted with medical procedures in extremely difficult circumstances. Although the outcome was unsuccessful, the Principal Officer's behaviour was exemplary.

The Governor should commend the Principal Officer by way of a letter for his actions in assisting with first aid under particularly difficult circumstances.

Conclusion

44. The man's death was sudden and unexpected. It occurred in particularly poignant circumstances as his family were actually in the prison awaiting a visit. In adverse conditions, every effort was made to save his life, but sadly without success.
45. The investigation has found that the man received regular and appropriate healthcare comparable to that in the community, with up to date records and appropriate referrals to secondary care. Although I have made recommendations concerning the use of call signs and coding, I have concluded that the shortcomings identified would have made no difference to the man's chances of survival.

RECOMMENDATIONS AND GOOD PRACTICE

1. **I recommend that the Governor and the Primary Care Trust review the coding policy with a view to restricting the use of Code Red for blood evident incidents and Code Blue for all other medical emergencies, to provide medical staff with accurate information regarding the nature of the emergency.**

Accepted. The prison service action plan response states 'completed and implemented 30th April 2008'.

2. **I recommend that the Governor reviews the policy and procedures governing the use of the radio net and reminds all staff equipped with radios to use the phonetic alphabet when directing other staff to locations.**

Accepted. The prison service action plan response says that 'An email has been sent to all control room operators regarding the use of phonetic alphabet, and an email has been sent to all staff regarding the use of the phonetic alphabet'.

3. **The Governor should commend the Principal Officer by way of a letter for his actions in assisting with first aid under particularly difficult circumstances.**

Accepted. The prison service action plan response has said that 'Letter to be drafted' to the Principal Officer.