

**Investigation into the circumstances surrounding the
death of a man at HMP Kingston
In December 2009**

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

September 2012

This is the report of an investigation into the death from natural causes of a man, a prisoner at HMP Kingston, who died in December 2009. He was 49 years old. A post mortem recorded that he died of a heart attack. I offer my condolences to his family and to all those affected by his death.

The investigation was carried out by an investigator. A clinical reviewer was commissioned by the local Primary Care Trust to lead a clinical review panel into the man's medical care at Kingston.

After he died, the police began an investigation, which did not conclude until June 2011. In accordance with our agreement with the police, this investigation was postponed until their enquiries were complete. After the police enquiries finished there was an additional delay to allow a clinical review panel to consider his care. I apologise for the significant delay this has caused.

The morning before he died, the man had complained of pains in his chest. Instead of testing him immediately, nurses decided to run a routine clinic and see him later. Afterwards, he became upset and they said they were unable to complete the tests because of his agitation and what they regarded as his threatening behaviour. Although his solicitors contacted the prison to ask that an electrocardiogram test be completed, he had no further contact with healthcare staff that day and no one checked on his condition. The next morning he was found dead in his cell.

The clinical review concludes that the man's care was not satisfactory and I fully agree that he did not get the treatment he should have done. I understand that no criminal charges have arisen from the police investigation. The nurses involved have subsequently been suspended from duty and we have been told that they will not return to work prior to the conclusion of a full internal disciplinary investigation. Any potential disciplinary action is a matter for their employer, who has received the clinical review's findings and will also get a copy of this report.

The investigation also notes that, when the man's cell was unlocked on the day of his death, staff made no attempt to check on his condition, and his death was discovered by a fellow prisoner. We have criticised this situation in the investigation of a subsequent fatal incident at Kingston - remarkably, the same prisoner made both mournful discoveries. This is wholly unsatisfactory and staff should be required to make more efforts to check on the wellbeing of prisoners when unlocking cells. Sadly, I acknowledge that this would not have altered the outcome for the man. The recommendations made in the draft report have been accepted by HMP Kingston. I have included the prison's response to the recommendations at the end of this report.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was born in 1960. He was 49 years old when he died at HMP Kingston in December 2009. He died from natural causes as a consequence of abnormal heart rhythm caused by poor circulation of the blood to the heart.
2. He had been sentenced to life imprisonment at Court on 24 June 1999 for murder. He had been in custody on remand at HMP Brixton from 6 July 1998. He spent time at HMP Swaleside, HMP Lowdham Grange and HMP Wormwood Scrubs before moving to HMP Kingston on 25 October 2002.
3. When his cell was unlocked on the morning of 21 December 2009, the man said he was experiencing pains in his chest and his left arm. He asked if a member of healthcare staff could see him in his cell as he felt so unwell. The officer immediately went to the healthcare area and the lead nurse agreed to see him after she finished administering the morning's medication. The officer let him know.
4. No one from healthcare came to visit his cell so he went to the healthcare area, before the administration of medication had finished, and was seen by another nurse. He repeated his symptoms to her but said he had no pain at that time. The nurse informed him that she intended to take his blood pressure and carry out an electrocardiogram¹. However, the lead nurse asked if this could be delayed as the treatment room was going to be used for a routine clinic. The nurse asked him to return an hour later for his examination.
5. After the clinic finished, the nurses left the healthcare area to carry out some other duties. They returned at around 9.45am, and found the man sitting in the waiting area. He allegedly became verbally aggressive towards the lead nurse. She explained that the ECG would now have to be delayed further as he was too upset for a proper reading to be taken. As they were unable to resolve the situation the lead nurse asked prison officers to remove him from the healthcare area.
6. One of the officers who escorted him back to his cell subsequently checked with the nurses to find out when the ECG would be carried out but was not given a specific time. When informed of this, the man said that he had already contacted his solicitor to ask them to fax a request for the ECG to be carried out. The fax was sent at 12.37pm and received by the modern matron at around 1.45pm. She spoke to the nurses about what had happened and instructed them that his ECG should be carried out within 24 hours. Neither healthcare staff nor officers were approached by him with any further health concerns after he was escorted back to his cell.
7. During the afternoon of 21 December, a prisoner said he spoke to the lead nurse and asked her to see the man but she was dismissive and disrespectful.

¹ Electrocardiogram – an ECG is a graphical recording of the electrical activity of the heart.

When interviewed as part of this investigation, the nurse said she did not recall speaking to any prisoners or staff about him after he left the healthcare area.

8. The man's cell was unlocked at around 8.15am the following day. The officer who unlocked the cell thought that he was lying on his bed watching television. The officer did not speak to him and immediately moved on to unlock the next cell. Shortly afterwards, at around 8.18am, a prisoner informed an officer that he could not rouse him. The officer went to the cell and, as he was also unable to rouse him, he immediately informed the matron who attended and confirmed that he was dead.
9. After the man's death, Kingston activated its death in custody contingency plan and the police visited the prison. The coroner's officer told the person who was managing the prison's response following the death that he had died from natural causes.
10. The clinical review carried out by a clinical reviewer and a panel of his colleagues on behalf of the local Primary Care Trust, considered the care provided for the man. In the panel's view, the quality of care given to him was not equivalent to that he would have received in the general community.

THE INVESTIGATION PROCESS

11. The investigator was formally notified of the man's death on 22 December 2009. Notices were issued to staff and prisoners at HMP Kingston informing them of the investigation process and asking anyone who had relevant information to contact the investigator. No one came forward. He examined all the man's relevant prison records including his medical records.
12. The investigator visited HMP Kingston on 5 January 2010 and discussed aspects of the man's treatment with staff. Detectives from Hampshire Police had started an inquiry into the circumstances of his death and asked that the Ombudsman's investigation be suspended until their investigation, and any subsequent court proceedings, had been concluded. The police agreed to share the information they gathered during their investigation, including the witness statements. The police investigation was closed in June 2011.
13. The investigator returned to Kingston on three occasions during August, September and October 2011 to conduct a range of interviews with staff and prisoners. Initial feedback about emerging findings was given to the prison on 31 October, which was subsequently confirmed in writing.
14. The local Primary Care Trust Cluster commissioned a clinical reviewer to lead a panel of colleagues to review the man's medical care during his time in custody. The purpose of the review was to establish whether the care which he received in prison was comparable with that he would have been offered in the community and to identify any points of learning. The report was received on 23 March 2012. The consequent delay in the issue of this report is regretted.
15. The investigator contacted Her Majesty's Coroner to inform him of the investigation and to request a copy of the post mortem report. This report will be sent to the Coroner to assist in his enquiries.
16. One of our family liaison officers contacted the man's family to explain the investigation. The solicitors representing the family wanted clarification of the following issues:
 - Whether prescribed pain relief for his shoulder had been stopped. If so, the reasons why and whether there were any issues as a result.
 - Whether the healthcare staff responsible for his care on 21 December were appropriately trained.
 - The reasons why he did not receive an ECG and why there were no written records of his appointment.
 - Why he was not referred to an outside hospital if healthcare staff were unable to conduct an ECG.
 - Whether efforts were made to calm him and provide him with information about an ECG after he was removed from healthcare and whether his condition was kept under review.
 - The reasons why healthcare staff failed to respond to a notification from another prisoner that he was unwell on the afternoon of 21 December.

The family and their legal representative received a copy of the draft report. No further representations were made in response to the findings, their preference being to raise matters directly with the Coroner at inquest.

HMP KINGSTON

17. HMP Kingston, in Portsmouth, Hampshire was originally built in 1877 to the Victorian radial design. Accommodation in the Category C² prison is mostly single cells with some multi-occupancy rooms. The prison can hold a maximum of 200 men, all of them are serving indeterminate sentences for public protection or life sentences.
18. Healthcare services at HMP Kingston are commissioned by the local Primary Care Trust and provided by an independent healthcare company. The modern matron at Kingston was responsible for the delivery of healthcare, supported by two primary care nurses (both cardiac trained), a mental health nurse, an administrator and two Integrated Drug Treatment System (IDTS) nurses for prisoners with drug and alcohol problems.
19. Visiting General Practitioners hold surgeries on Mondays, Wednesdays and Fridays. The nursing staff work from 8.00am until 6.00pm on weekdays and from 8.30am until 1.00pm on weekends. At all other times, there are no healthcare staff on site and an out of hours service is used. Prisoners can collect their daily medication from the dispensary at 8.15am, midday and 4.30pm.
20. The investigator reviewed the Ombudsman's reports into other deaths at HMP Kingston. There were some similarities with the investigation of a subsequent death in June 2011, when a recommendation was made in relation to unlocking procedures. Both men were found by the same prisoner after their cells were unlocked in the morning. (He was offered support after the events.) Both had suffered heart attacks and in both cases the prison officer who unlocked the cells did not notice any problems. The other man was still alive when he was found but died in hospital. We made a recommendation in the June 2011 case about the need to gain a response from a prisoner when unlocking and make a similar recommendation in this report.

HM Inspectorate of Prisons

21. The last inspection of Kingston was in August 2010. The Chief Inspector made the following comments in his introduction:

“Kingston is a small specialist prison for life and other indeterminate-sentenced prisoners. This very positive report, of a full announced inspection, is testament to the benefits that can flow from having a small-scale niche prison, with a settled population. The inspection

² All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category D: open conditions, prisoners who can be trusted not to try and escape.

reaffirmed previous findings that Kingston is a safe and decent place, and also applauded the purposeful regime and sound focus on addressing the risks posed by the very serious offenders in the prison's care."

22. In relation to healthcare, inspectors noted that there was good partnership working between the prison and health providers, but there had been no recent health needs analysis and no prison health improvement plan. The healthcare environment was small but functional and clean. A reasonable range of clinics for primary care and lifelong conditions were run but inspectors were concerned that prisoners did not have the opportunity for confidential consultation with a doctor, without other staff present. There was appropriate access to secondary health services.

Independent Monitoring Board (IMB)

23. The IMB is made up of unpaid volunteers from the local community who monitor all aspects of prison life to ensure that proper standards of care and decency are maintained. The most recent annual report published by the Independent Monitoring Board at Kingston covers the year from January to December 2010.
24. In the IMB's report for the year ending December 2009 the IMB was positive about "the high quality healthcare with a full range of services".

KEY EVENTS

25. The man was born in 1960. On 6 July 1998, he was remanded into custody at HMP Brixton. It was not his first time in prison. On 24 June 1999, he was sentenced to life imprisonment for murder. He was later held at HMP Swaleside, HMP Lowdham Grange and HMP Wormwood Scrubs before he transferred to Kingston on 25 October 2002. At Kingston he lived on the ground floor of A wing in a single cell.
26. At his first reception health screen interview at Kingston it was recorded that he had no previously diagnosed conditions. He had been receiving medication to help him to give up smoking. He had also experienced shoulder pain for which he had been prescribed pain relief medication.
27. In July 2004, he was referred to hospital in response to the pain in his left shoulder. He was prescribed dihydrocodeine tablets (pain relief medication) for the pain. On 3 September 2008, it was recorded that he was trying to reduce his intake of pain relief medication and he was prescribed an alternative (pregabalin). However, due to the side effects of the new medication his dose was reduced, on 31 October, and he was prescribed tramadol (another pain relief medication but thought to be less addictive than dihydrocodeine).
28. On 12 January 2009, it was recorded that the man wished to stop taking the tramadol and it was reduced from 50 milligrams four times a day to three times a day. Just over a month later, the tramadol was increased again to four doses as it was recorded that at his request as he was experiencing break through pain (pain which does not respond to the current pain relief medication). However, two weeks later, on 27 February, he said that he was content to stop taking tramadol and to try acupan (a less powerful pain relief medication) instead. There were no further complaints recorded from him about his pain relief medication and it appears instead he engaged with staff in the efforts to reduce his dependence on strong pain relief medication.
29. Around 8.20am on 21 December 2009, the man told an officer, who unlocked his cell door, that he was having pains in his chest and his left arm. He asked the officer to see if a member of healthcare staff could visit him in his cell as he felt so unwell. The officer agreed to do so and immediately went to the healthcare area. He informed lead nurse about his condition. She agreed to see him after she had finished administering the morning's medication. The officer returned to the cell and told him what the nurse had said. However, ten minutes later he was found in the healthcare area waiting to be seen.
30. At around 8.45am, a nurse saw him. He explained that he had experienced pain in his chest and arm but was pain free at that time. She noted that his skin colour was good and that he was not short of breath. She said she would take his blood pressure and carry out an electrocardiogram (ECG). The lead nurse then asked her to delay this as the treatment room was needed for a clinic. The nurse asked him to return after an hour when she would carry out the ECG.

31. After the clinic finished, both nurses left the healthcare area to carry out other duties. When the nurses returned to the healthcare area, at around 9.45am, the man was waiting. As they approached him, the lead nurse said he became verbally aggressive towards her and accused her of being unprofessional for sending him away and not treating him. She explained that the ECG would now have to be delayed further as he was too upset for a proper reading to be taken. She also informed him that the ECG would not be done because of his poor behaviour. She asked prison officers to remove him from the healthcare area.
32. Two officers took him back to his cell and the nurses left healthcare and went to the staff room. When interviewed as part of this investigation, Prisoner A confirmed that the officers did not use any force when they removed him. After taking him back to his cell Officer A checked with the nurses to find out when the ECG would be carried out. He said he was told that "it would not happen at this time". When the officer returned to the cell, to let him know what the nurse had said, the man thanked him and said he would contact his solicitors to ask them to request that the ECG be carried out. Although he had clearly been upset, no further efforts were taken by healthcare staff to try to find out if he had calmed down or check how he was. His conduct on his return to his cell did not cause officers any concern and there is no evidence of any previous altercations with healthcare staff.
33. At around 10.30am, the man complained to Prisoner B of having chest pain and a "tingling in his hands". According to his statement to the police, the prisoner gave him his PIN³ code so that he could ring his solicitor. After he contacted the solicitors, they sent a fax to the prison expressing their concerns about him having "serious heart problems" and requesting that an ECG be carried out. The fax was sent at 12.37pm.
34. According to his police statement, when Prisoner B saw him at around 1.00pm "he looked terrible and I could see he was sweating". At the man's request the prisoner contacted his solicitors and they agreed to re-send their fax to the prison. This was sent at 2.00pm.
35. The Modern Matron received the original fax from the man's solicitor at around 1.45pm. She spoke to the nurses about what had happened but did not speak to him. She instructed the nurses that his ECG should be carried out within 24 hours. She then sent a fax to the solicitors to inform them that she had spoken to the nurses and they had not performed the ECG because of his agitated and aggressive state, which they felt indicated that he did not have a cardiac problem, and he would have an ECG within 24 hours.

³ Pin telephones are used in prisons and each prisoner is given a PIN number which they key in before making a call. Prisoners complete a form to select telephone numbers for their family, friends and legal contacts, which has to be agreed by the prison. The system works on a credit basis and prisoners buy credit from the prison shop, the cost of the calls being automatically deducted from their PIN account.

36. According to his statement to the police, the last time Officer A saw the man was around 4.00pm. As he was passing his cell he asked whether he had been seen yet by healthcare. He told him that he still not been seen but his solicitor had sent another fax. This was the last time he saw him.
37. In his statement to the police Prisoner B said that during the afternoon of 21 December, when he went to collect his medication he approached the lead nurse and asked her to see the man. He claimed that the nurse then put on a pair of novelty glasses (he thought they were Christmas glasses with reindeer on the top of red frames). He told her it was not funny and that the man needed to be seen. He then alleged said that the nurse twitched the glasses and said: "I'm Doctor Death don't you know" and she was laughing while she said this. He reiterated that it was not funny and that the man needed to be seen and he then returned to the wing. He assumed the reference to "Doctor Death" was in relation to one of the names the man told him, and other prisoners, he had called the nurse earlier in the morning.
38. When interviewed as part of this investigation, the lead nurse said she did not recall any prisoners or staff mentioning the man to her after he left the healthcare area. It is therefore not possible to corroborate the prisoner's account.
39. After the man left the healthcare area that morning there is no evidence of any further interaction between him and the healthcare staff. Although Officer A had asked them what their next steps would be, they took no further action in relation to him and made no written record of what had happened. He received no further care or support from healthcare staff that day. Both nurses finished their shifts at 6.00pm.
40. In his statement to the police, Prisoner A said that between 6.30pm and 6.45pm he trimmed the man's hair. According to him the man was still complaining of pains in his chest and arms. He said that he told him to go to bed and settle down, which he did.
41. There were no entries made about the man in the wing observation book on that day and he does not appear to have raised any further health concerns with staff after he was escorted back to his cell.
42. At around 8.15am the next morning, Officer B was carrying out morning unlock. She looked through the observation panel in the man's cell door and then unlocked it. In her statement to the police, she wrote that through the observation panel she saw him lying on his bed watching television (it was not clear from his statement whether his eyes were open). She did not speak to him and immediately moved on to unlock the next cell.
43. Shortly afterwards, at around 8.18am, Prisoner A told Officer C that he could not rouse the man. The officer went to the cell and observed that he was dressed had his bedcovers pulled up and he appeared to be watching television. He felt for a pulse on his neck but could not find one. As he was unable to rouse him, he immediately informed the Senior Officer (SO) and he

then went to healthcare to inform the Modern Matron. In her statement to the Governor, the Modern Matron wrote: "It was very clear that the man was dead in his bed. I felt for his pulse but there was no pulse". When interviewed as part of this investigation, she confirmed that rigor mortis⁴ was also present when she checked his vital signs. Paramedics were called, but they declined to attend as they were informed that he was dead. The prison arranged for a doctor to attend the cell and she certified death at 11.14am. The doctor was delayed due to other commitments and severe weather conditions as there was very heavy snowfall that day.

44. Prisoners on A wing were informed of the man's death during that morning. They were asked whether they required anything or wanted to speak to a Listener. (Listeners are selected and trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.) All prisoners who were on an Assessment, Care in Custody and Teamwork (ACCT) self-harm and suicide observation and support regime were reviewed. (ACCT is the Prison Service's procedure for supporting and monitoring prisoners believed to be at risk of suicide or self-harm.) Prison managers also held a "hot debrief" for staff immediately involved to share information and provide reassurance and support. Around lunchtime a number of prisoners stood outside the man's cell for a moment of reflection.
45. The Security Manager was appointed as the prison's Family Liaison Officer. Because of the severe weather conditions, he arranged for staff at HMP Holloway to inform the man's family of his death, and they did this during the afternoon. After they were informed of the death his family contacted Kingston and spoke to the Security Manager. He assisted with the funeral arrangements and arranged for the man's belongings to be returned to his family.
46. The post mortem report records death as being due to natural causes, as a consequence of cardiac dysrhythmia (abnormal heart rhythm) resulting from angina pectoris (poor circulation of the blood to the heart).

⁴ Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death making it virtually impossible to bend the wrists, elbows or knees.

ISSUES

Clinical care

47. A review of the man's medical care was undertaken by a panel led by a clinical reviewer. From the medical records, it was apparent that he was seen regularly by healthcare staff and, when necessary, referred to secondary care services. In relation to the events leading up to his death, the clinical reviewer states that in his opinion, when the lead nurse was informed by Officer A that the man was seriously unwell she should have immediately "abandoned whatever task she was engaged in and made an immediate assessment of the man in his cell". As she did not take this course of action, when he appeared in the healthcare area he "should have been referred to hospital as an emergency".
48. The decision to hold a routine clinic rather than treat the man in what was possibly a life threatening situation was not satisfactory. Action should have been taken to assess him, but instead an unwell man was sent away from the healthcare area.
49. The clinical reviewer feels that, although it might have been reasonable to have refused to deal with the man on the second occasion he came to healthcare until he calmed down, he should have been informed of what the next steps would be. Neither nurses made any provision for officers to inform them when he had calmed down or made any attempts to review his situation. They made no efforts to enquire as to his wellbeing after he was escorted from the healthcare area. In his opinion, not making any arrangements to follow up the man, despite his presentation of possible heart related problems, was "not an acceptable standard of care". He states that the two nurses assumed responsibility for his care after he presented himself at the healthcare area and they had a continuing responsibility to provide appropriate medical care.

The Head of Healthcare should ensure that prisoners presenting with symptoms of chest pain are assessed urgently, in line with NICE guidelines on the diagnosis of chest pain (Clinical Guidelines CG95 Issued: March 2010) and where indicated referred to hospital for emergency treatment.

Both the clinical reviewer and the investigator were surprised that following the incident in the healthcare area neither of the nurses made a record of what had happened. As they had made a decision not to provide treatment we would have expected them to record the decision process.

The Head of Healthcare should ensure that staff accurately record interactions with prisoners. Entries in medical and nursing records should be timely, prompt, and legible in accordance with the standards set out in the Nursing and Midwifery Council Guide to Record Keeping.

50. After the Modern Matron received the fax from the man's solicitors she asked both nurses for their assessment of him and what had happened. The clinical

reviewer draws attention to the fact that, although there was a conflict between the information in the fax (he having serious heart problems) and the assessment by the nurses (his behavior contradicting this), she saw no reason to make a personal assessment of his condition. He writes:

“The Modern Matron is the senior clinician in HMP Kingston and as such has an overall responsibility for the care of prisoners. I consider it a serious failing in her clinical responsibilities that she did not carry out a personal assessment of the man’s condition at that time”.

51. It has not been possible to verify the account that a prisoner approached healthcare staff with concerns about the man’s continuing pain and whether a flippant response was given by the lead nurse. If this did happen then the actions taken by healthcare staff were wholly inappropriate and the information given by prisoners should have triggered a review of the man’s condition.

Healthcare staff at Kingston

52. After the man’s death an initial investigation was undertaken by the independent healthcare company to ensure “safe service” but they took no further action at that time as the police investigation took primacy. However, a full internal investigation was carried out by them after they received the clinical review from this investigation in January 2012. As a result of the internal investigation the three nursing staff involved were suspended in February 2012. We have been told they will not return to work prior to the conclusion of the internal investigation. A police enquiry was undertaken but we understand that no criminal charges were brought. Any further disciplinary action is a matter for the employer.
53. However both ourselves and the clinical reviewer were surprised that a local internal investigation by the employer was not carried out sooner, in line with the serious incident policy of the NHS. We therefore make the following recommendation:

The Head of Healthcare in conjunction with the employer should ensure that a prompt local investigation is carried out following any serious incident involving healthcare (in keeping with normal NHS Serious Incident policy) and must ensure that the report is shared with the commissioner of healthcare in the establishment, so that any lessons can be learned at the earliest opportunity.

The discovery of the man’s death

54. While we could find no written requirement in Kingston’s local roll check procedures that staff should check prisoners for signs of life when they unlock the cell, we believe that they should ensure the wellbeing of prisoners when they do so. Had a fellow prisoner not gone into the man’s cell and raised concerns, it is possible that his death would not have been discovered for a considerable amount of time. While recognising that such a check would not

have changed the outcome for him, this is clearly unacceptable. In other circumstances a more active check could save a life.

55. The Prison Officer Entry Level Training (POELT) manual states:

“Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.”

The Governor of HMP Kingston should review the procedures for unlocking prisoners and ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention

CONCLUSION

56. During the morning the man complained of pains in his chest. He was seen by healthcare staff in the healthcare area who asked him to return after an hour for tests to be carried out. However, when he was later seen by staff he became agitated and they decided not to carry out the agreed tests that day, despite a request from his solicitors. There was no further interaction between him and healthcare staff at Kingston and he was found dead in his cell the next morning.
57. Following the man's death, the police carried out an investigation. This investigation was suspended while the police carried out their enquiries. The police investigation concluded in June 2011 without further action. The independent healthcare company suspended the three nursing staff involved, although not until after the receipt of the clinical review in January 2012.
58. In light of the findings of our own investigation, and the clinical review, we conclude that the man's medical care was not satisfactory. In his review, the clinical reviewer concludes that his care:

“... fell far short of an acceptable standard, and might have contributed to his death. The clinical care was not equitable with the wider community as he was dependent on a member of the healthcare team to determine that an ambulance was required and to arrange for his transfer to hospital whereas in the community he would have been in a position to call an ambulance himself.”
60. The report also recommends that the Governor of Kingston ensures checks are made on the wellbeing of prisoners when cells are unlocked.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendation. That response is included in italics below the recommendation.

1. The Head of Healthcare should ensure that staff accurately record interactions with prisoners. Entries in medical and nursing records should be timely, prompt, and legible in accordance with the standards set out in the Nursing and Midwifery Council Guide to Record Keeping.

Accepted - TPP System 1 is now being used and training on the system is included in the induction programme. Notice has been served on practice GP and plan to recruit in-house.

2. The Head of Healthcare should ensure that prisoners presenting with symptoms of chest pain are assessed urgently, in line with NICE guidelines on the diagnosis of chest pain (Clinical Guidelines CG95 Issued: March 2010) and where indicated referred to hospital for emergency treatment.

Accepted - This is being picked up as part of the pathways work with clinical lead involvement. Triage templates have been created by the clinical staff. Other medical emergencies to be considered as well as slow deteriorating patients – bespoke training being organised.

3. The Governor should review the procedures for unlocking prisoners and ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Accepted - All staff have been reminded of the requirement to physically check the presence of the occupants in every cell and ensure they receive a positive response from them. This has been actioned via notice to staff and daily reminders at morning briefings. Regular management checks are carried out to ensure that staff are adhering to these requirements.

4. The Head of Healthcare in conjunction with the independent healthcare company should ensure that a prompt local investigation is carried out following any serious incident involving healthcare (in keeping with normal NHS Serious Incident policy) and must ensure that the report is shared with the commissioner of healthcare in the establishment, so that any lessons can be learned at the earliest opportunity.

Accepted - Online incident reporting in all establishments. Quality and Risk team assist with this. Already implemented therefore no further action required.