Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Garth, at hospital in February 2010

Report by the Prisons and Probation Ombudsman for England and Wales

February 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Garth. He died in February 2010 at hospital in Lancashire. He was 48 years old. I offer my condolences to his family and friends for their loss.

This investigation was carried out by an investigator. I would like to thank the Governor and staff at HMP Garth for their contribution and assistance. In particular, I am grateful to the governor who acted as liaison officer.

A clinical reviewer carried out a thorough review of the man's clinical care on behalf of the local Primary Care Trust and as always in such cases I greatly appreciate her assistance.

When the man transferred to Garth in June 2008, he disclosed no personal or family history of heart disease. He first reported chest pains in October 2009 and alerted the doctor to a family history, but a specialist referral was not followed up. A few months later, on 20 February 2010, he told medical staff that he had continued to feel chest pains and he was taken to hospital two days later when his condition worsened. The hospital confirmed that he had suffered a heart attack. Although there was initially some improvement in his condition, on 28 February he had two further heart attacks and died.

The clinical reviewer has identified that there were missed opportunities to possibly diagnose and treat the man's condition. However, it is impossible to judge whether this would have led to a different outcome. Nevertheless, there are a number of areas for improvement in the clinical management of prisoners at Garth and I accordingly endorse the clinical reviewer's recommendations. These focus mainly on screening and referral to specialist services, as well as better management of patients reporting chest pain. There is also a need for care plans for those admitted to the prison's healthcare unit and submission of medical notes for those admitted to outside hospitals. It is further recommended that more permanent doctors are employed and that nursing staff should make use of the telemedicine service, particularly when there are no doctors in the prison. Finally, the Governor should ensure that emergency ambulances are able to pass through the prison quickly.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **February 2011**

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SUMMARY

The man was born in January 1962 and died in February 2010 at hospital of a heart attack. He was 48 years old. On reception at Garth in June 2008, he had a healthscreen. He did not reveal any chest or heart problems; neither did he declare any family history of such illness.

He had a long running disagreement with healthcare staff and often refused medical attention. I understand this was because at a previous prison some of his medication had been stopped. He first complained of chest pains on 12 October 2009. He was examined by a locum doctor who advised him have a follow up appointment with the cardiac nurse. This follow up appointment did not take place. During the following few months, he had consultations with several doctors who do not appear to have consulted his previous notes.

The man complained of further chest pains on 20 February 2010. He was examined by a different locum doctor who again appears not to have considered his previous medical history. He was treated with an angina spray. He continued to suffer from chest pains over the next day and was transferred to the healthcare inpatient department on the morning of 21 February. The nurse on duty telephoned the locum doctor and was instructed to keep observations on him and to send him to the emergency hospital should anything change.

In the early hours of 22 February, the man's blood pressure dropped so the nurse telephoned for an ambulance. There was a delay when the ambulance arrived whilst an appropriate escort was arranged. Staff used a closeting chain to restrain him. (A closeting chain is a length of chain which is attached to one wrist of the prisoner and an officer.) This was required because he would not complete any offending behaviour work and his risk to the public was assessed as high. As his offences were of a terrorist nature and there had been media attention and photographs had been published a three person escort was required. This was due to the potential risk of repercussions on him if he had been recognised.

When he arrived at hospital he was diagnosed as having had a heart attack. He later transferred to another hospital to have a stent fitted and returned to the first hospital after the procedure. (A stent is a tube which is inserted into narrow arteries to allow the normal flow of blood and oxygen to the heart.) When he was first admitted, the prison made arrangements for him to receive telephone calls from his family. Over the next few days his health seemed to improve. However, he had two further heart attacks in close succession and subsequently died.

After the man's death the prison chaplain attended the hospital to act as both the family liaison officer and duty care team member to support the escort staff. He also officiated at the funeral, which was paid for by the prison and held a memorial service in the prison chapel.

I am unable to judge whether earlier intervention in the man's case would have affected the outcome. However, the clinical reviewer has identified the need for a number of clinical improvements at Garth, which I endorse. These relate to specialist referrals, the management of chest pain, care plans for inpatients in the

healthcare unit, transfer of records to outside hospitals, employment of permanent doctors, use of the telemedicine service and enabling ambulances to pass urgently through the security system.

THE INVESTIGATION PROCESS

1. The man died in February 2010. My investigator opened the investigation on 15 March when she visited HMP Garth. She received copies of his personal and medical records and met the deputy governor and the Coroner's officer. She also spoke informally to the nurse who was on duty the night the man was taken to hospital and visited the healthcare department.

2. HMP Garth issued notices to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. No one responded. My investigator returned to Garth on 4, 27 and 28 May to interview staff and prisoners.

3. The local Primary Care Trust (PCT) commissioned a clinical review of the healthcare provided to the man. The purpose of the review was to establish whether the care he received in prison was comparable to that which he would have received in the community. I am grateful to the clinical reviewer for her review, which is attached as an annex to this report. She comments on the standard of healthcare provided to him and highlights issues for consideration.

4. The investigator contacted the local Coroner's office to inform them of the nature and scope of the investigation. A copy of my report will be sent the Coroner. The post mortem concluded that the cause of the man's death was:

    1a Acute posterior myocardial infarction (heart attack)
    1b Coronary artery atherosclerosis

5. One of my family liaison officers contacted the man's family to explain the purpose of my investigation and to provide them with an opportunity to raise any questions or concerns for consideration. His family raised no issues of concern at the outset of my investigation. They were also offered the opportunity to receive and comment on the draft version of the report. However, to date, they have chosen not to do so. I hope that the findings of my investigation answer any questions they may have should they review the report in the future.

HMP GARTH

6. HMP Garth is a category B training prison which opened in 1988. Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. Garth accommodates male prisoners who have been sentenced to four years or more. This includes life sentenced prisoners. Additional units were built in 1997 and 2007. The current capacity is for 847 prisoners.

7. The commissioning of healthcare at Garth is the responsibility of the local primary Care Trust (PCT). The prison has 24 hour nursing cover, seven days a week and an inpatient facility comprising eight beds. The majority of healthcare staff work between 8.00am and 5.00pm during the week. Staffing is reduced from 5.00pm through the night. When the man was in healthcare, prior to his admission to hospital, there was one nurse covering the night shift.

8. Doctors hold surgeries at Garth on weekday mornings. A full-time nurse practitioner (who has more advanced training than a general nurse) is on site during the week. At other times, the local out of hours telephone service, Care UK, is consulted if nursing staff either require a doctor's advice or consider that emergency treatment is needed. This means that any one of a number of doctors can be called to the prison.

9. Since April 2004, this office has investigated five deaths from natural causes and one self-inflicted death at Garth. The investigations into two previous deaths invite comparison with some of the man's experiences. I recommended that the healthcare team should look at their communication and record keeping systems. There were also delays referring the previous prisoners to the relevant specialist departments, which occurred again in the case of the man. The prison previously accepted that further improvements needed to be made in these areas.

Independent Monitoring Board (IMB)

10. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the prison service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and any areas of concern.

The most recent annual report published by the IMB at Garth covers the year from 2008 to 2009. In relation to healthcare at Garth it comments,

"The introduction of telemedicine within the prison setting and prisoners having external hospital contact with a range of different consultants should improve the initial investigation of primary assessment and subsequent follow

on treatments necessary. There have been concerns regarding prisoners' hospital appointments being cancelled by the hospital authorities on multi occasions causing frustration and extension of waiting times for prisoners; this is being strictly monitored by the healthcare administration staff.

There are on-going issues with waiting lists for both the doctor and dentist. A rectification notice has been served on the holder of the GP contract who repeatedly did not attend. Following a needs assessment, the PCT have now declared the in-reach provision is unsafe.

The majority of the prisoners were pleased with the treatment given by the primary care team and the quality of professional care and respect shown in personal health care matters. The 8 bedded inpatient units provide 24 hour care to prisoners who need continuous monitoring for medical - post hospital treatment and mental health care. The majority of the prisoners on the unit are in need of mental health care provision and are complimentary of being well supported by the dedicated health care team."

KEY FINDINGS

11. The man was sentenced to six years imprisonment on 25 January 2008 for a serious offence. He transferred from HMP Manchester to Garth on 2 June 2008. At his first healthscreen during the reception process, he told healthcare staff that he was registered disabled after an injury to his ankle approximately ten years before.

12. All prisoners entering the prison complete a questionnaire regarding heart disease. In the questionnaire, the man said that he was unaware of any problems with his heart and was not taking in heart related medication. He also said that none of his family had any heart problems. He refused any preventative injections for hepatitis B and C, tuberculosis or HIV. He told staff he did not want to be referred to any support services and had never used drugs but had used alcohol for approximately five years before his imprisonment.

13. He said that he had previously had contact with psychiatric services and had been diagnosed with anxiety and depression. This was attributed to the tragic death of his youngest son who died in a car accident in 2004. He was therefore prescribed paroxetine (an antidepressant medication) and referred to the mental health in-reach team.

14. The man told staff he had no dependents and was single. Although he had two sons and a large number of siblings, he said he did not want family visits at that time. Healthcare staff did not carry out a secondary healthscreen as it is not necessary to do so for prisoners who transfer from other establishments. (A secondary healthscreen is completed some days after the first. It gives the prisoner an opportunity to discuss any remaining health concerns when they are more settled into the prison regime.)

15. During his time at Garth, he was seen by healthcare staff on various occasions, mainly for pain in his ankle from an old injury. He had previously made a complaint about healthcare at another prison, so had a mistrust of healthcare. This resulted in a long running disagreement with healthcare staff at Garth and he often refused medical attention. When he went on hunger strike in January 2009, he was monitored by healthcare staff but he refused any treatment. He did not appear to suffer any ill effects and he started to eat again in February 2009.

16. The man refused to take part in any offending behaviour work throughout his time at Garth. In March 2009, he continued to refuse to see his offender manager or to engage with his sentence plan in any way. He therefore remained a category B prisoner. On 4 July he said that he did not want early release and would complete his sentence by working in the prison workshops.

17. On 12 October, he told the locum general practitioner (GP) that he had suffered from chest pains intermittently for some time, with episodes every two to three weeks. He also told the GP that he had 12 siblings and that one

of them had heart problems. The medical records show that the GP advised him to book an appointment with the cardiac health nurse at the prison and smoking cessation information was given to him. There is no entry to say whether an appointment was ever made for him to see the cardiac health nurse.

18. When my investigator interviewed the GP, he told her that he was normally accompanied by a nurse when he examined prisoners and that he assumed the nurse would have made the follow up arrangements. There is no record of which nurse accompanied him on that date and he could not remember who it might have been.

19. An entry in the medical record on 7 January 2010 says that a medication review took place. It was also recorded that the man had seen four different doctors in the previous four months and his medication had been changed several times. He was upset that his repeat prescription for co-codamol had been reduced. (Co-codamol is a pain relief medication, which he had received for some time for his ankle injury.) The clinical reviewer drew attention to the fact that over a period of time, he was examined by several doctors who do not appear to have reviewed his previous medical consultations.

20. On 15 January, the man refused to have a blood test and refused to be re-listed. It remains unclear who referred him for these tests or why they were arranged.

21. Five days later, he told staff he had further chest pains which had been on and off for the last few months. A locum on call doctor examined him and booked blood tests for 22 February. He was unaware of the man's previous history and he did not mention it to him.

22. The locum on call doctor told the investigator that, in his clinical judgement, he did not think the man needed to go to hospital at that time because he had walked to the healthcare centre and was not displaying symptoms of severe pain such sweating or difficulty breathing. It appeared to be more like discomfort. He thought it was muscular pain and prescribed co-codamol for pain relief. He noted that his chest was clear, there were normal heart sounds and that his abdomen was soft and not tender. An electrocardiogram (ECG) (a device which measures the electrical impulses within the heart) was taken and the reading was normal. The doctor's notes were typed electronically by a nurse. He said that he was unable to access the electronic system as he had not been trained or authorised to log into the system. The man complained of further chest pains that same evening.

23. His pains continued on 21 February, when at 3.00pm, he reported pain across the centre of his chest, radiating to the left side and tingling in his left arm. Staff Nurse A, a registered general nurse (RGN), assessed his condition and took his blood pressure, which was within the normal range. He was slightly pale and on breathing had a slightly prolonged expiratory (breathing out) phase. He was able to talk in sentences. He was given a

glyceryl trinitrate (GTN) spray twice and this relieved the pain. (GTN is a spray which is used for relief of pain from angina.)

24. At 8.23pm on the same day, the man complained of further chest pain when he was sitting up but said it eased when he was lying down. He was assessed by Staff Nurse B (RGN) in his cell. He did not have tingling in his arms on this occasion and had no shortness of breath. She said she thought that he was not using his GTN spray correctly and subsequently helped him to use it properly. She also took his blood pressure. It had dropped slightly in comparison to the reading taken at 3pm. As she was the only member of healthcare staff on duty, she decided to admit him to the healthcare centre for a 24 hour observation and arranged for him to be seen by the doctor the morning after. He was accommodated in a gated cell. (A gated cell has a locked gate which staff can easily see through, rather than a solid door.)

25. Nurse B did not complete a nursing assessment or care plan. Nor did she use a pain assessment tool. In interview, she said that as she was the only nurse on duty she did not have time to complete them and because she was aware of his situation she did not consider it a priority.

26. Throughout that night the man's pains worsened, so Nurse B telephoned the locum on call doctor. He advised that the man continue to use the GTN spray and if anything changed to send him to hospital. The nurse kept hourly observations on him. The observations consisted of blood pressure and temperature checks. He complained of a dull ache which was relieved by the spray.

27. At 2.17am on 22 February, the man's blood pressure dropped. Nurse B contacted control to call an ambulance. According to ambulance records, the call was received at 2.21am but there was an unexplained delay of ten minutes before it started towards Garth. On arrival at Garth, there was another nine minute delay before the ambulance arrived at healthcare. A governor said this was because the risk assessment for the man was revised and three escorts were needed instead of the planned two.

28. The paramedics took another ECG, which indicated that he had suffered a heart attack. They gave him morphine (a strong painkilling medication) for chest pain relief. The clinical review notes that the paramedics did not thrombolyse him. (Thrombolysis is when a drug is administered to dissolve blood clots and restore blood flow to the heart following a heart attack.) However, in his case it was deemed too late for this procedure because he had been suffering chest pain for too long.

29. A full risk assessment was carried out with regard to the man being taken to hospital. His offences were political and terrorist related and took place in the North West of England. At the time of his arrest, many photographs were produced in the local and national press. The extra escort was required to ensure his safety should there be repercussions from anyone who recognised him as well as to protect the public. It was also assessed as

necessary to use a closeting chain. This is a chain which is attached by a handcuff to one wrist only and allows treatment to be given.

30. The man was taken to hospital. At 3.54am, the hospital staff told Nurse B that he had experienced a heart attack but he was stable and would be staying in hospital for at least the next three days. They also asked for a copy of his ECG taken on 20 February and his recent medical notes. She had given paramedics a short note about his recent medical history but no 'Transfer of Care' document was completed, nor were his medical records transferred to hospital with him.

31. Later that morning, 22 February, officers recorded in the bedwatch log at 10.25am that the man wanted to discharge himself and return to prison because he was unable to have a cigarette. (A bedwatch log is a history, recorded by escort officers, of time and events which take place while a prisoner is out of the prison as an inpatient at hospital.) The doctor told him he had suffered a "massive heart attack" and that the first 48 hours after this were crucial to his survival. This shocked him and the record says he then began to co-operate better with staff.

32. The governor contacted the man's family and told them that he was in hospital and could receive telephone calls. Garth's protocol for visiting prisoners in hospital is that no visits will be authorised for the first seven days and then must be booked through the prison and authorised by the deputy governor. The only exception would be urgent compassionate visits, again authorised by the deputy governor. The next day, he received a telephone call from his brother and he was able to tell him how he was feeling.

33. As part of his treatment, staff at the hospital arranged for him to be transferred to another hospital, to have an angiogram and, depending on the results, possibly to have a stent fitted. (An angiogram is an x-ray of blood vessels.)

34. That night, he asked for his drip to be removed as it was making him feel sick and bloated. He agreed to go back on it in the morning. At 8.30am the following morning, medical staff instructed 'nil by mouth', prior to his angiogram. A nurse attempted to carry out blood tests but he refused to let her do this. Records say that he was not happy that he could not have breakfast but he then calmed down after staff spoke to him.

35. In the operating theatre, the man was escorted by just one officer, with two outside the room. He remained handcuffed to this officer. After the procedure, he was informed that he had a blockage and that a stent would be fitted into his heart. This took place immediately and at 1.25pm, he was told that if everything was alright there was a possibility he could return to Garth, the next day.

36. At 9.15pm, he wanted to use the toilet but was told that he had to use the commode because he was attached to monitors. He unplugged the machinery and went to the toilet. Later that night, he refused to have his drip

changed and became very agitated with the doctor and nurse. Two hours later, he agreed to have the drip re-fitted. He also told doctors that he would not co-operate with any further blood tests, although later that morning he agreed to one, when he was reminded that if it was okay he could return to Garth.

37. At 11.35am blood samples were taken, as well as a further ECG and an x-ray. After this, the man was told by the nurse that they wanted to keep him in hospital over the weekend, because he had an irregular heart beat. Records show that he had an unsettled night, but chatted with prison staff and watched television.

38. On 28 February, he refused his breakfast but had a cup of tea. He took his medication and was sitting on his bed reading the newspaper at 10.10am when he started to have a seizure. His restraints were removed but were re-applied 30 minutes later after he had been given medication. Nursing staff approved this re-application of restraints.

39. At 10.55am, the man started to deteriorate and again had a seizure, requiring the defibrillator to be used. The restraints were removed. He remained unresponsive on this occasion. Nursing staff then telephoned his brother and a visit was authorised by the governor.

40. At 11.40am, he had another cardiac arrest and staff continued resuscitation attempts. At 11.45am, nursing staff contacted his son to inform him of his father's deterioration. At 11.55am, his death was confirmed by the doctor.

41. The man's family arrived at the hospital at 12.55pm and the prison chaplain spoke to them in his capacity as the prison's family liaison officer. In interview, he told my investigator that he had not received formal family liaison officer training. He fulfilled a dual role at the hospital as he also supported staff in his role as a member of the care team.

42. The chaplain gave the man's family his address book from his personal belongings and then he arranged to see them again to make plans for the funeral. He presided at the funeral which had been paid for in full by the prison. A memorial service was also held in the prison chapel and most of the prisoners on his wing attended.

ISSUES

Clinical care

43. The man attended the healthcare centre on 15 October 2009, complaining of chest pains. The locum GP examined him and advised him to book an appointment with the cardiac health nurse. He does not appear to have made an appointment and this was not followed up by a referral or any further appointment with healthcare staff. The GP said that he assumed that the nurse would make the arrangements for follow up. There were no notes by the nurse and it is unclear who that nurse might have been. The clinical reviewer suggests this was a missed opportunity for diagnosis and treatment of his heart problems. She adds that locum doctors do not all undertake an induction programme and are therefore not familiar with usual prison healthcare practices. She comments that this can lead to a failure in referral to the appropriate professionals. There is clearly confusion regarding the responsibility for arranging follow up referrals and I have drawn attention to this in a previous case at Garth, where follow up appointments did not take place.

The Head of Healthcare should ensure that all staff are clear about who is responsible for arranging follow up referrals and appointments and that action taken should be clearly recorded. Prisoners should be encouraged and reminded to attend.

44. Garth does not have a permanent doctor and when one is needed, a locum doctor is called. This means that any one of a number of doctors might attend the prison. The clinical reviewer comments that this results in a lack of consistency and leadership and overview of care, by lead medical practitioners. Also, it seems that doctors did not always review the previous medical consultations.

45. The man had a medication review in the healthcare centre on 7 January. He complained that he had been assessed by four different doctors over the previous four months and his medication changed frequently dependent on which doctor assessed him. The clinical reviewer makes a recommendation to the PCT and Head of Healthcare, which I endorse.

There should be less reliance on the employment of locum general practitioners and NHS Central Lancashire should work with the Head of Healthcare to employ permanent general practitioners at the prison.

46. Some of the man's medical records were handwritten. However, subsequent notes were recorded electronically. The locum on call doctor had to ask a nurse to log into the electronic system under their own log in details, to record electronically. He told my investigator that he did not have his own log in details and did not know how to use the system at that time.

47. A nurse told the investigator that since the man's death all records are now completed electronically and all doctors should be able to log in on their own

account. I am satisfied that records are now managed appropriately and are available to all medical staff. However, I would suggest that the Head of Healthcare and the Governor satisfy themselves that all medical staff, including locum GPs are trained to use the electronic system as part of their induction process at the prison.

48. When the locum on call doctor assessed and examined the man on 20 February, his clinical judgement was that he did not need to go to hospital. He arranged for him to have an ECG at the prison. The clinical reviewer commented on this practice in her root cause analysis:

> "The healthcare unit have not followed the local pathway or NICE recommendations for treatment of acute chest pain. It was stated that the unit used a 10 lead ECG machine this should be a 12 lead machine. This should be addressed at the earliest opportunity."

(NICE is an abbreviated term for the National Institute for Health and Clinical Excellence. It is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.)

49. The clinical reviewer comments:

> "It is very unfortunate that the GP did not refer him for early treatment to the acute hospital. This resulted in him being a late presentation for treatment for an acute myocardial infarction."

However, I note that he did not appear to staff to be in a great deal of pain, nor did he complain of intense chest pains. The clinical reviewer makes two recommendations in respect of the treatment of chest pain, which I endorse.

The Head of Healthcare should ensure that all staff follow the NICE guidance for acute chest pain and develop a robust pathway for patients who are complaining of chest pain.

The Head of Healthcare should ensure that the healthcare unit has a 12 lead ECG machine as recommended in the NICE guidance for acute chest pain.

50. When the man was admitted to the healthcare unit on 21 February, staff did not complete a nursing needs assessment or care plan, nor was a pain assessment tool utilised. When he subsequently transferred to hospital, staff wrote a short note regarding his recent medical history. There was no evidence of a "Transfer of Care" document. In the circumstances, as the nurse was the only member of clinical staff in the healthcare centre it is reasonable that she would not have had time to complete a full document. She ensured that information was sent to the hospital with him in the form of a written note. Nevertheless, the clinical reviewer makes two recommendations in respect of this, which I have slightly amended and endorse.

The Head of Healthcare should ensure there is a robust nursing needs assessment and individual care plans for all inpatients when they are admitted to the healthcare unit.

The Head of Healthcare should ensure that when prisoners transfer to an outside hospital a copy of their recent electronic medical record is sent with them or follows at the earliest opportunity.

51. Healthcare staff called an emergency ambulance at 2.17am on 22 February. The ambulance control recorded the call as being received at 2.21am and the paramedics recorded being with the man at 2.45am. Ambulance control said that there was a delay getting through the security gate at Garth. When the investigator asked the governor why that had happened, she was told that there had been a last minute adjustment of his risk assessment. This was related to the nature of his offences and the potential risk to him should it be publicised that he was out of prison. Instead of two escorts three were required and it took some time to arrange for a third person. The clinical reviewer comments that although this may have caused a delay leaving the prison, it should not have delayed the emergency paramedics attending to him. I agree with the clinical reviewer's comments and endorse her recommendation, slightly recast.

The Governor, in consultation with the Head of Healthcare should develop a protocol to enable emergency ambulances to pass rapidly through the security system.

52. The clinical reviewer makes one further recommendation about the use of a telemedicine service, which enables staff to obtain guidance and support from skilled Accident and Emergency (A&E) consultants, when there is no GP within the prison. This may have impacted on the length of time it took to transfer him to an emergency department.

The Head of Healthcare should encourage staff to make use of the telemedicine service, particularly at times when there is no GP within the prison. Telemedicine enables the medical and nursing team to receive prompt advice from skilled A&E consultants in acute medical situations. It also gives support and advice in managing and confirming the diagnosis based on the 'expert assessment' within a remote video based consultation.

Family liaison

53. When the man was admitted to hospital and it became clear that he was staying, the governor contacted his family and arranged for him to receive a telephone call from his brother. At this stage, although he had suffered from a heart attack his health seemed to improve, giving no indication of his imminent death. Indeed, the governor told my investigator that when he visited the prison on 28 February at around 8.00am the man was complaining that he hadn't received his address book, which he had

requested a few days earlier. According to the governor he became quite rude and argumentative but when he left the hospital at around 8.15am the man said “I’m alright, you know, the usual”.

54. When the governor received a telephone call around 10.15am, from an escorting officer to tell him of the man’s cardiac arrest, he was very shocked. He told the IMB and also gave authorisation for his family to visit. He received another call to say that he had rallied after this attack and was ok and up in bed having a cup of tea and was chatting normally. He was again shocked when he received the call to say he had died. The hospital staff contacted the family around 10.55am. Unfortunately, by the time they could get to the hospital he had died. I am satisfied that the prison did all they could to inform the family of his medical situation, whilst abiding by their own security protocol.

55. When the man was pronounced dead, the prison chaplain went to the hospital to see staff and the family. He was acting as both family liaison officer and as part of the duty care team. He told my investigator that he had not received formal family liaison officer (FLO) training and used his pastoral skills. I am concerned that he had to fulfil two complex emotive roles simultaneously. He appears to have handled this well. I therefore make no formal recommendation on these points, but the Governor might wish to consider ensuring the roles are conducted separately in the event of future incidents and that whoever undertakes family liaison is appropriately trained.

CONCLUSION

56. When the man transferred to Garth he did not initially declare any family history of heart disease. A further opportunity to explore his vulnerability to heart disease and a possible diagnosis was missed when he went to the healthcare unit reporting chest pains in October 2009. At this point, he also revealed the family history of heart problems. This episode was not followed up with any subsequent specialist appointments.

57. It is difficult to say whether earlier intervention and treatment would have changed the outcome for him. However, when he had further chest pains in February 2010, I am satisfied that healthcare staff acted appropriately, given the information that he gave them.

58. The investigation has revealed a number of shortcomings and areas for improvement in the provision of clinical care at Garth. I endorse and repeat the clinical reviewer's recommendations.

RECOMMENDATIONS

To the Head of Healthcare

1. The Head of Healthcare should ensure that all staff are clear about who is responsible for arranging follow up referrals and appointments and that action taken should be clearly recorded. Prisoners should be encouraged and reminded to attend.

2. There should be less reliance on the employment of locum general practitioners and NHS Central Lancashire should work with the Head of Healthcare to employ permanent general practitioners at the prison.

3. The Head of Healthcare should ensure that all staff follow the NICE guidance for acute chest pain and develop a robust pathway for patients who are complaining of chest pain.

4. The Head of Healthcare should ensure that the healthcare unit has a 12 lead ECG machine as recommended in the NICE guidance for acute chest pain.

5. The Head of Healthcare should ensure there is a robust nursing needs assessment and individual care plans for all inpatients when they are admitted to the healthcare unit.

6. The Head of Healthcare should ensure that when prisoners transfer to an outside hospital a copy of their recent electronic medical record is sent with them or follows at the earliest opportunity.

7. The Head of Healthcare should encourage staff to make use of the telemedicine service, particularly at times when there is no GP within the prison. Telemedicine enables the medical and nursing team to receive prompt advice from skilled A&E consultants in acute medical situations. It also gives support and advice in managing and confirming the diagnosis based on the 'expert assessment' within a remote video based consultation.

To the Governor and Head of Healthcare

9. The Governor, in consultation with the Head of Healthcare should develop a protocol to enable emergency ambulances to pass rapidly through the security system.

Response to draft report

In response to feedback from the prison, one recommendation regarding secondary healthscreens has been removed. There has been no formal response from either the family or the prison in respect of the other recommendations made in this report.