# Investigation into the circumstances surrounding the death of a man in July 2011, at hospital while in the custody of HMP Gartree

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

**January 2013**

This is the report of the investigation into the death of a man at hospital, while in the custody of HMP Gartree. His death was noted to be of natural causes due to raised pressure in the brain causing a chronic subdural haematoma (brain haemorrhage). He was 45 years old. I extend my sincere condolences to his family and friends.

The investigation was undertaken by an investigator. A review of the man's medical care was undertaken by a clinical reviewer. I am grateful to the Governor of Gartree and his staff for assisting with this investigation. Additionally, the assistance from Leicestershire Constabulary was appreciated. I apologise for the delay in issuing this report.

In July 2011, a wing officer responded to the man's cell bell. He complained to the officer of a bad headache and said he felt unwell. He was seen to vomiting. A nurse was called and attended the cell. Following a brief examination, the nurse immediately requested an emergency ambulance be summoned. At 8.50pm, he was escorted to hospital. Following an assessment, he was placed on a life support machine. He died a few days later with family at his bedside.

The clinical review concludes that the man was generally well cared for during his time in custody. He received treatment for both his physical health and substance misuse issues. However, when he became seriously unwell there were delays in entering his cell, and delays in the ambulance staff reaching him. The investigation raises some concerns about the rigidity of Gartree's policy regarding the opening of a cell at night, particularly with regard to prisoners with known health problems. Recommendations are made to address these issues,

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** **January 2013**

## SUMMARY


1. The man was remanded to HMP Leeds in September 2010 and sentenced to life imprisonment on 17 December. He was addicted to heroin and, on arrival at Leeds, was treated on an Integrated Drug Treatment System (IDTS) prescription. (IDTS is a service to assist prisoners withdraw from their drug misuse through monitoring, assessing and reducing their addiction through treatments and medication.) His health problems were noted to include asthma.

2. In November 2010, following a heart attack, the man underwent heart surgery and was prescribed warfarin to reduce his blood clotting. He spent six months at HMP Leeds before transferring to G wing at Gartree on 23 March 2011. This was to progress his sentence by transferring to a prison where he could attend offending behaviour courses.

3. On arrival at Gartree, the man continued with the IDTS prescription and reduced his dosage of methadone in line with his treatment plan. He was referred to a hospital cardiologist to maintain his ongoing heart care. Furthermore, he was referred to a gastroenterologist for medical investigation into a bowel problem. He had regular blood tests to check his levels of warfarin and the dosage was adjusted accordingly.

4. During the afternoon of 5 July, the man used a G wing hairdryer which malfunctioned. He returned the hairdryer to an officer. It was later noted that his cell and three near to it had suffered an electrical power failure. A member of the work's department was called out to G wing and the power was re-set.

5. Around 6.00pm, a prisoner said he saw the man trying to attract an officer's attention. He told the prisoner he had a bad headache. A short while later, the prisoner said the man's speech was slurred and he swayed when walking. He told the prisoner that the officers had told him to put in an application for a healthcare appointment the next day.

6. Around 7.20pm, an officer responded to an alarm bell activated by the man. On arrival at the cell, the officer saw him vomiting through the cell door observation panel. The officer rang the healthcare unit for a nurse to come and see him. Seven minutes later, a nurse spoke to him through the observation panel and asked the officer to radio for the orderly officer to attend to cell. Following her arrival, the Senior Officer (SO) telephoned the duty manager for permission to open the cell door. By this time, he had fallen against the cell door.

7. Around ten minutes later, having got permission to unlock and gain access into the cell, the nurse and officer entered it and tended to the man. The nurse asked for an ambulance to be summoned. He was moved from his cell to the landing, where the nurse carried out medical observations and administered oxygen.

8. An ambulance arrived at around 8.20pm and paramedics carried out a medical assessment of the man. He was transferred to hospital at 8.50pm. He was admitted to the intensive care unit and was not restrained. He died two days later with his family at his bedside.

## THE INVESTIGATION PROCESS

9. The investigation into the man's death was opened on 12 July 2011, when the investigator visited Gartree. She was met by the prison's liaison officer and reviewed the man's prison file. She took copies of relevant documents from those files. Later, she met the healthcare primary care manager and visited G wing to see his cell. She also spoke to three of his friends on the wing.

10. The Ombudsman's notices of investigation and terms of reference were sent to the prison in advance of the investigator's visit. Up to the circulation of this report no responses have been received to the notices. The Independent Monitoring Board (IMB) and the Prison Officer's Association did not ask to see her, but her details were made available to them should they wish to contact her. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, its staff and prisoners. The POA is the prison officer's trade union.)

11. The local PCT appointed a clinical reviewer to carry out the review on their behalf. The clinical reviewer had to delay the completion of his review until an extended post mortem examination had taken place. The results of that examination were received into the Ombudsman's office on 4 December 2011. The investigator received the final clinical review on 14 February 2012.

12. The investigator contacted a Detective Constable (DC) of Leicestershire Constabulary. The DC agreed to share some police statements, taken from prison and ambulance service staff, with the investigator.

13. On 20 July, the investigator returned to Gartree and interviewed three prisoners on G wing and the man's personal officer. (A personal officer is assigned to a prisoner to give guidance, support and information on an individual basis.) On 17 August, she interviewed two members of the healthcare staff.

14. One of the Ombudsman's family liaison officers (FLO) contacted the man's brother as his nominated next of kin and invited him to raise any issues for consideration as part of the investigation. The man's brother requested a visit and, on 31 August, the FLO and investigator met with him to discuss his concerns. He raised the following questions for consideration:

    - Was the malfunctioning hairdryer used by his brother significant in relation to his death?
    - Had his brother waited an unacceptable length of time for staff to respond to him on evening of 5 July?

15. The investigator wrote to the Governor on 1 September to outline her initial findings of the investigation. No serious concerns were identified although she was unable to comment on the man's healthcare until the clinical review had been completed.

16. The FLO spoke to the man's mother and sister on 9 September and invited them to raise any concerns. The points they raised were similar to those of the man's brother. However, the man's sister told the FLO information relating to his time in hospital. However, the actions of staff working in a hospital are outside the remit of this investigation.

17. The family received a copy of this report in draft and were concerned to read of the delay in paramedics reaching the man's cell. The Prison Service responded to the recommendations, which we have reflected in the final section of the report.

## HMP GARTREE

18. HMP Gartree opened in 1965 as a category C training prison. It changed to become a high security prison before it changed again to a category B prison in 1992. Category B prisoners are those who are deemed to be held in a secure environment and escape from custody must be made difficult.

19. Gartree accepts adult male prisoners who have been sentenced to life imprisonment. The regime includes employment in gardens, education and offending behaviour programmes. It holds 677 men in single cells.

20. The local PCT are responsible for the delivery of health services in the prison. The prison healthcare facilities do not include in-patient treatment facilities although there is 24 hour nursing cover. Doctors provide daily medical cover.

21. Her Majesty's Deputy Chief Inspector of Prisons (at the time this was Mr Nigel Newcomen CBE) made a full announced inspection of Gartree in May 2010. In the report of the inspection, he said:

> "The Governor provided strong leadership and support to the health care team and was active in the development of health services. A new building due to open in June 2010 would provide much improved facilities. Primary care services were satisfactory and included a good GP service, life-long conditions management and visiting specialists."

22. In their latest annual report, covering the year ending 30 November 2009, Gartree's IMB said:

> "The Board is well aware that the prison is served by a very able healthcare team. We see and discuss healthcare provision with prisoners regularly, and also visit the centre on all our rota visits. There are few healthcare issues or complaints raised, as is reflected in the analysis of our applications. We are also pleased to see the centre working so well with the GP practice – and winning the Partnership Award, Leicestershire and Rutland Justice Award."

23. This was the first natural cause death at Gartree this year. There were two deaths from natural causes in 2010. Neither of the cases had any direct similarities to the death of the man.

### Integrated Drug Treatment System (IDTS)

24. IDTS is a Prison Service scheme which aims to increase the amount and quality of substance misuse treatment available to prisoners, with particular emphasis on the early days in custody. It is intended to improve the links between clinical and non-clinical services and

reinforce continuity of care from the community into prison, between prisons, and on release into the community. As part of the IDTS programme, prisoners can be prescribed methadone (a heroin substitute). The prisoners take part in a programme that gradually reduces the prescribed amount of methadone, with regular case reviews and consultations with trained healthcare staff.

25. The expected benefits from IDTS are:

- Reduction in self-inflicted deaths and self-harm among those most at risk
- Reduction in post release deaths
- Fewer incidents of violent aggression
- Better engagement in prison regime
- Reduction in drug taking
- Reduction in injecting behaviour
- Reduction in offending

**KEY EVENTS**

26. The man was born in 1965. On 1 September 2010, he was remanded into HMP Leeds charged with murder. This was not his first time in prison.

27. On his arrival at Leeds, the man was seen in the reception area by a nurse. The nurse noted a history of asthma and he told her he was addicted to heroin. His blood pressure was within the normal range at 130/80 and his pulse rate was regular. Later, he was examined by a doctor and prescribed methadone of 100mls per day, to help with his drug withdrawal symptoms and Salbutamol for his asthma. Two days later, a doctor increased his methadone as he had missed a dose whilst at court.

28. He was placed on an Integrated Drug Treatment System (IDTS) plan to start to address his heroin dependency. He was referred to the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATs) team (The CARATs team specialise in assisting prisoners with substance misuse problems.)

29. A review of the man's breathing and medication was undertaken by a nurse in the asthma clinic on 10 September. It was noted that he was a smoker and the nurse gave him advice on how to stop smoking.

30. He attended the healthcare unit for several minor illnesses over the next few weeks and was prescribed antibiotics for a tooth abscess. He continued to attend the asthma clinic for regular reviews. On 16 November, healthcare staff were called to see him after he became ill in his cell. He was conscious but complained of chest pain. An emergency ambulance was summoned and he was escorted to hospital.

31. Medical notes show that the man had a heart attack and he underwent surgery to fit two stents (tubes) into his chest. It was further noted that he had heart disease and would remain in hospital for several days for observation and post-operative care.

32. He returned to Leeds on 23 November. His medication had been reviewed and he was prescribed drugs for his heart disease, including warfarin to thin his blood. (Patients receiving warfarin must have regular blood tests to optimise the exact dosage of this medication.) He remained on his methadone maintenance programme.

33. His blood was tested and his dosage of warfarin adjusted accordingly. He also was regularly seen by the doctor and nursing staff. On 3 December, a nurse discussed with him the after effects of his recent heart surgery and said that a specialist cardiac nurse would visit him within the next few weeks. The nurse again advised him to stop smoking.

34. The man was sentenced to life imprisonment with a tariff of 22 years at Crown Court on 17 December.

35. A cardiac nurse visited him on 30 December and advised him on diet and exercise. On examination, his blood pressure was low (90/60) so the nurse asked for this to be monitored weekly and his medication adjusted as necessary. The cardiac nurse visited him again on 6 January 2011. There was some improvement in his blood pressure but he was still experiencing some minor chest pain. The nurse advised him that this was normal following surgery, but he should ask for assistance from healthcare staff if the pain worsened.

36. A nurse examined him on 12 January and his blood pressure and pulse rate were within normal limits. The nurse saw him on three further occasions until his transfer to Gartree in March.

37. On 11 February, the man reported blood in his stools and, after an examination, the doctor was unable to find any abnormalities. However, he was referred to hospital for further investigation. He was seen at hospital for a cardiology out-patient appointment on 25 February.

38. On 23 March, he transferred to Gartree to continue his sentence and address his offending behaviour. On his arrival at Gartree, he was seen by a nurse. The nurse completed a full medical history and recorded that he was receiving methadone on a maintenance programme. His breathing flow rate was measured and his medication updated. The nurse arranged for him to be located on the ground floor of G and H wing. However, for the first night he would have to stay on the third floor of B wing until a cell on the ground floor of G and H wing became available. (G and H wing are newly built and the ground floor cells are used, in part, to house prisoners with physical disabilities or those vulnerable through age and poor health.)

39. A senior healthcare manager spoke to a Senior Officer (SO), to ensure that the man would be transferred to a cell on the ground floor as soon as possible. B wing staff were advised of his health problems and told that they should contact the healthcare staff if they had any concerns for his health. (A few days later, he was allocated a ground floor cell on G wing and the staff were similarly made aware of his health problems.)

40. The following day, healthcare administration staff at Gartree made contact with the healthcare manager at Leeds. They asked for any of the man's outstanding hospital appointments and diagnostic results to be sent to them at Gartree. A doctor examined him and noted his medical history. The doctor recorded that he would need a referral to a cardiologist and a gastroenterologist (specialist in stomach and bowel problems) as soon as Leeds provided up to date information.

41. A substance misuse nurse saw the man and advised him of the support and IDTS regime at Gartree. Later, a nurse reviewed him in the hypertension clinic. His blood pressure was low (113/84). The nurse arranged for him to have a full blood test, and advised him of the help that healthcare staff could offer him. The following day, the blood tests indicated no abnormalities. His blood was regularly tested to check his warfarin levels and blood clotting.

42. A doctor noted on 15 April that the result of the man's blood test was abnormal, and he should be seen by the doctor if the re-test was abnormal again. The following day a nurse saw him, who complained to her of bleeding gums. The nurse contacted the out of hours doctor service (this was a Saturday and there is no doctor on duty at weekends). They advised that another blood test should be taken and sent to hospital for urgent analysis. He consented to the blood test and a taxi was despatched to take the blood to the hospital.

43. On 17 April, a nurse noted in the man's medical record that the blood tests results had been assessed by a doctor. The doctor advised that his warfarin dose should be adjusted by him not taking his dose for that day. A doctor reviewed the latest blood test results on 18 April. It was further noted that he had a vasculitic rash, (a rash caused through a bacterial infection from a blood vessel). The doctor examined him and recorded that he was felt better, his chest was clear and she arranged for a further blood test for the following day, before adjusting or prescribing further medication. A doctor saw him on 20 April and noted that his blood test results had improved and he reduced the dose of methadone. His warfarin was adjusted and he continued to have regular blood tests to ensure that he received the correct dosage of the medication.

44. A doctor saw the man on 11 May. He told the doctor he was struggling on the reduced amount of methadone although he would consider a further reduction because of his other medical problems. It was agreed between them to slightly reduce the dosage and review his progress in one week's time. On 18 May, a doctor again reduced the dosage of methadone and noted that he continued to receive support form the CARATs team. The following day, a doctor noted in the medical record that he must be unlocked during the day on the wing, as he needed to exercise for both his physical and mental health.

45. An occupational therapist saw him in a relaxation class and it was further noted that he was seen by a member of the prison mental health in-reach team. On 25 May, a doctor saw him and further reduced his methadone dose. He told the doctor he had an ache on the left side of his chest. On examination, the doctor noted that this might be muscular. He attended another relaxation class on 27 May.

46. The man saw a doctor in the IDTS clinic on 2 June, where it was agreed to another reduction in his methadone. It was also noted that his out-patient appointments with a cardiologist and gastroenterologist would take place within the month. Six days later, he was seen by the dentist who recorded that, due to his health problems, a referral to hospital would be made to address his dental issues.

47. On 26 June, he was abusive towards healthcare staff when he arrived late to collect his methadone. He was warned about his behaviour by wing staff. (Three days later the clinical team manager spoke to him to remind him of his responsibility to be on time for his methadone collection.)

48. A doctor assessed him on 27 June in the IDTS clinic. He told the doctor he had pain from his heart and, while he was concerned over the reduction of methadone, he wanted to maintain the reduced dosage. The doctor recorded that he had an appointment with a cardiologist in a few days time. His methadone dosage was now 21mls per day

**July**

49. One afternoon in July, the man and his friend, Prisoner A, socialised on the wing. The prisoner told the investigator that his friend said he had a headache while playing pool, but did not complain of any other symptoms.

50. An officer was on duty in the wing office at around 4.00pm that day. The man asked the officer if he could use the hairdryer. (A hairdryer is kept locked in a cupboard on the wing and an officer has to issue and 'book out' the hairdryer to a prisoner.) The officer handed the hairdryer to him.

51. About five minutes later, the man returned the hairdryer and told the officer that it was not working and had gone 'pop' when he switched it on. The officer noted that he did not look any different from when he had collected the hairdryer and did not complain of any health problems.

52. About 4.30pm, a nurse was walking to the healthcare unit when he saw the man, who was going to collect his daily medication of warfarin. Both men walked together to the unit and chatted about his general health and how he felt. During his interview, the nurse told the investigator that the man was in good spirits but a little out of breath, which was normal for him as he had a heart condition. He did not complain to the nurse of a headache. The men left each other when they arrived at the healthcare unit.

53. Around 5.15pm, as prisoners were locked up for the evening meal, it was noted that the man's cell, and three others near to him, had no

electricity.  A member of the works department was called out to visit the cells and restore power.  At 5.45pm, the works department re-set the power to those cells.

54. Prisoner B on G wing was interviewed by the investigator.  He told the investigator that around 6.00pm, while the prisoners were on association, he and the man were at the gate next to the wing office. (Association is the free time for prisoners when they are out of the cells to socialise, make telephone calls and take their showers.)  He told the prisoner that he had a bad headache and wanted to attract the attention of officers sitting in the wing office.  The prisoner said that none of the officers responded to either his or the man's request for assistance.  He saw him walk away from the gate and noticed that he seemed to be swaying when he walked.

55. A short while later, the prisoner spoke to him again and he noticed that his speech was slurred and he did not look his usual self.  He asked him if he was okay and he told the prisoner that he had spoken to officers and was told, "to put in an app for triage in the morning".  (An app is a form for a prisoner to ask for a medical appointment and triage is a nurse-led appointment to measure the urgency of a medical condition.)

56. Later, another prisoner told the investigator that the man came to his cell during the association period and asked him if he had any paracetamol for a bad headache.  He did not have paracetamol and was unable to give him any tablets.  (Prisoners are risked assessed as to whether it is appropriate for them to have medication in their possession as opposed to collecting it from the healthcare unit.)

57. Around 6.45pm, the association period finished and the prisoners returned to their cells to be locked in for the night.  The prison then went into patrol state.  (Patrol state is the time when all prisoners are locked in their cells.  There are less staff on duty and a cell door can only be opened on authorisation of a senior manager.)

58. About 7.20pm, an officer responded to an alarm bell from the man's cell.  The officer spoke to him through the door observation hatch.  He told the officer he had a bad headache and was vomiting into his toilet. The officer returned to the wing office and telephoned the healthcare unit.  He spoke to a nurse, who told the officer that she would come down to wing within five to ten minutes.  She arrived at the cell at 7.27pm.

59. The nurse spoke to the man via the observation hatch and could see him standing near the door.  He told her he had a bad headache and had been sick.  She could see vomit on his clothes so she reassured him and advised him to sit down.  The officer radioed for the orderly officer to attend the cell.

60. The nurse went to the wing office to collect an emergency bag. (An emergency bag holds apparatus to deal with medical emergencies and includes oxygen.) When she returned to the cell, a few minutes later, she looked through the observation hatch and saw that he was slumped against the door. Her view of him was partially obscured and she was unable to get a response from him.

61. The orderly officer and two officers arrived at the cell and the nurse told her that she needed to get inside the man's cell to examine him. (It is the protocol at Gartree that the duty governor has to give authorisation to open a cell when the prison is in patrol state.) The orderly officer telephoned the duty governor and obtained permission to open the cell. The nurse told the investigator that this procedure only took a few minutes.

62. On receipt of permission to unlock the man's cell, the orderly officer spoke to him through the observation hatch in an attempt to see if he could move from the door as his body was slumped against it. She unlocked the door and officers pushed it open so that the nurse and officer were able to squeeze through a narrow gap into the cell. The nurse then asked for an officer to call for an ambulance. The orderly officer called the communications room to relay this message and a member of staff there made the 999 call. The time was 7.46pm. (This time was noted by the ambulance crew in a statement made to the police. However, they were not despatched by the ambulance service to attend Gartree until 8.02pm.)

63. The nurse and the officer moved the man away from the cell door. The officer noted that the man was wearing track suit bottoms only and that they had vomit on them. Another officer was then able to enter the cell and between them they were able to lift him from his cell out onto the landing floor. The nurse placed him in the recovery position (on his side) as he was unresponsive and took his medical observations of blood pressure at 160/100 (an average is 130/80) and a pulse rate at 48 beats per minute (bpm) (an average is between 60 to 100bpm). On examination, the nurse noted that his right eye pupil was fixed which often indicates a serious medical condition.

64. The nurse remained at the man's side to monitor his condition and administered oxygen via a face mask. The ambulance arrived at G wing at 8.20pm. The nurse gave the ambulance crew a handover and left the man in their care while she returned to the healthcare unit and printed his medical history from the electronic record system. She then handed the history to the ambulance crew.

65. An escort of two officers was arranged to accompany the man to hospital, but he was not restrained. The ambulance left Gartree at 8.50pm to take him to hospital. On arrival at hospital, the staff assessed his condition and he was placed on a life support machine in the intensive care unit.

66. Later that evening, prison staff telephoned the man's nominated next of kin, his brother, who lived in the north of England. Staff arranged for a taxi to drive him down to the hospital to be at his brother's bedside. An escort of two officers remained near to his bed side. He was not restrained during this period.

67. The man's life support machine was switched off a few days later. A prison manager and family liaison officer liaised with his family and attended the funeral service. A contribution towards funeral expenses was offered to the family.

68. Prisoners and staff on G wing were told of the man's death the following morning and members of the IMB and chaplaincy visited G wing to offer their support. Prisoners arranged a collection and sent flowers for the service. A memorial service was held in the prison chapel.

## ISSUES

### Clinical care

69. A review of the man's healthcare was commissioned by the local PCT. A clinical reviewer undertook the review on their behalf. The doctor took the evidence for his review from the man's medical record, transcripts of interviews from healthcare staff and statements from prison staff.

70. The post mortem examination of the man found his cause of death to be of natural causes from:

> "1a Raised intracranial pressure due to
> 1b Acute on chronic subdural haematoma (rasied skull pressure due to collection of blood and blood breakdown products between the surface of the brain and its outermost covering).
> 2 warfarin therapy for ischaemic heart disease. (medication taken for heart disease)."

71. The clinical reviewer outlines the man's health issues. He had asthma and heart disease, which led to a heart attack in November 2010. He was a smoker and had been prescribed a methadone maintenance programme for his substance misuse. To reduce the risk of blood clotting, he was prescribed warfarin and he was waiting for a specialist hospital appointment for investigation into a bowel problem. The clinical reviewer writes:

> "His care with regard to his heart and bowel problems were managed well and his warfarin control was reviewed appropriately."

### Events leading up to the incident

72. The man told his friend, Prisoner A, as they played pool during the afternoon of 5 July that he had a headache. Later, he used the wing hairdryer which apparently malfunctioned when he switched it on. He returned the hairdryer to the wing office and did not report any ill effects from the faulty hairdryer.

73. Around 30 minutes later, he had a short conversation with a nurse as he was walked to the healthcare unit to collect his medication. He did not complain to the nurse of a headache or any other health problems.

74. Prisoner B, who saw the man on that afternoon, told the investigator that they were unable to attract the attention of officers during the association period. He saw the man walk away from the gate, next to the wing office and said he seem to sway as he walked. Later, he told the prisoner that he had spoken to officers and was told to put in an

application to see healthcare staff the following day. The prisoner noticed that his speech was slurred.

75. The investigator made enquires with the G wing manager to ask if any of the officers on duty during the association period had contact, saw or spoke to the man. The manager replied that none of the officers on duty that evening could recall him speaking to them or asking for assistance. Due to this, it is not possible to determine if officers failed to respond to his request for help. There were no entries in the wing observation book to show that he had asked for medical assistance or had complained of a headache.

76. Association periods are busy times on a prison wing when all prisoners may be out of their cells. However, should a prisoner need medical assistance, officers can make a request for a nurse to come down to the wing. Nurses are on duty until 8.00pm and available to attend to a prisoner should they need urgent medical attention.

77. The investigator and the clinical reviewer were concerned that officers might have ignored the man's request for assistance had they seen him. Prisoner B told the investigator that the man's speech was slurred and he swayed when walking. The combination of those symptoms should have alerted officers that he was in need of medical attention. While none of the officers on duty that evening could recall speaking to him, his physical appearance might well have indicated there was a problem.

78. The clinical reviewer writes:

> "The severity of the man's symptoms does not seem to have been appreciated when he spoke to staff early in the evening. The combination of a severe headache, visual disturbance and unsteady walking would indicate the possibility of a brain problem such as a stroke and early treatment for this condition can be both life and function saving. However in his case he had two bleeds around his brain and the delay may have made no difference to the outcome."

79. Had the officers saw or spoke to him, then his presenting symptoms as described by Prisoner B, should have raised concerns that he was unwell and a request for healthcare staff to attend to him should have made. It is unfortunate that no-one realised the serious of his illness at this time, although it has not been possible to ascertain if any staff did speak to him at this time. However, the clinical reviewer acknowledges that quicker treatment may not have made any difference to the outcome, given the severity of his condition.

### *The response to the man's collapse*

80. The man rang his cell bell at around 7.20pm, which was answered by an officer. The officer looked through the observation hatch and saw him vomit into his toilet. He also told the officer he had a bad headache. The officer returned to the wing office and telephoned a nurse to ask her to come to the wing. The nurse was in the healthcare unit and arrived at the cell at 7.27pm.

81. The nurse made a brief physical examination of the man when she was able to enter his cell around 7.45pm and asked for an emergency ambulance to be summoned. In their police statements, the ambulance service crew confirmed that the incoming call to the ambulance service was logged at 7.46pm. The crew received their instructions to attend Gartree at 8.02pm and arrived at the prison around 8.10pm. It took a further ten minutes for the ambulance to pass through security and arrive at the cell at 8.20pm.

82. Another prisoner told the investigator that it was shortly after 7.00pm when he heard a 'moan' from the man's cell. He looked through a crack in his cell door and could see a nurse and officers outside of his cell. He told the investigator it seemed about an hour before he thought the cell door had been opened. However, it is noted from the ambulance crew that the ambulance service received the emergency call at 7.46pm.

83. The clinical reviewer is concerned that there was a noticeable time lapse between when the nurse arrived at the man's cell and her gaining entry so she could physically examine him. Part of the delay was due to gaining permission for the cell to be unlocked. It is the protocol of Gartree that when the prison is in patrol state the orderly officer must telephone the duty governor for permission to unlock a cell. Whilst this only took a few minutes, the staff also had to manoeuvre him from the cell door. In total, around 15 minutes were lost.

84. In a case of a medical emergency, access to the patient is crucial so that appropriate assessments and treatments can be undertaken. However, the urgency of emergency situations needs to be balanced against the security of the prison. The clinical reviewer writes:

> "The delay in accessing the man's cell is a concern as the sooner someone who is seriously ill and has collapsed can be assessed the sooner appropriate treatment can be initiated."

85. We endorse the recommendation made by the clinical reviewer for the attention of the Governor with consideration to the prisoners in relative poor health on G wing.

**The Governor should formally review the policy about unlocking cells when the prison is in patrol state to ensure an appropriate**

**balance between prisoner care and security, particularly with regard to prisoners with known health problems.**

86. The call to the ambulance service was made at 7.46pm although a crew was not despatched to Gartree until 8.02pm. The investigator asked the clinical reviewer to make enquires with the relevant services to clarify why there was a delay in despatching an ambulance. The clinical reviewer spoke to the East Midlands Ambulance Service and was told:

> "There was no ambulance with a suitably trained crew available immediately and Health Care Staff were on scene at the prison so Ambulance Control contacted the next available ambulance in the area at 20:02 standing them down from another 999 call which was deemed less urgent and diverted them to this call. This is standard practice at times when there are pressures on the service to respond to emergencies."
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> "The ambulance crew who were at Lubenham (some 1.5 miles from HMP Gartree) then proceeded under blue lights to HMP Gartree main gate at 20:05. Clearing the security systems to get to the wing took approximately 10 minutes and they arrived at G wing at approximately 20:15 arrived at G wing."

87. The clinical reviewer comments that the time to get the ambulance through the security gates to G wing and the man's cell took 10 minutes. Furthermore, there were difficulties getting the ambulance through the gates on its departure from Gartree, which added to the delay in transferring him to hospital. The clinical reviewer writes:

> "The crew made a provisional diagnosis of a brain bleed and at 20:39 transfer to hospital commenced. The process to get back out of the prison meant that the ambulance left the main gate at 20:59 and at 21:10 arrived at the hospital's Resuscitation Room in A+E."

88. The clinical reviewer is of the opinion that the delays for the ambulance to enter and leave Gartree are a cause for concern. He considers that this could be improved without affecting the security of the prison. We endorse the clinical reviewer's recommendation for the attention of the Governor.

**The Governor should ensure that emergency ambulances are given expeditious access in and out of the prison**

89. The clinical reviewer concludes his report as follows:

> "The man suffered a known complication of his treatment and this unfortunately led to his death. Although there were delays in recognising that he had a problem I am not able to say that

the outcome would have been any different had the problem been recognised when he first developed the headache and unsteadiness."

**Family issues**

90. The man's family raised two questions for the report to consider.

- Was the malfunctioning hairdryer used by him significant in relation to his death?
- Had he waited an unacceptable length of time for staff to respond to him that evening?

***Faulty hairdryer***

91. The man's family were concerned that the hairdryer he used on the afternoon of his death, which cut out when he switched it on, could be connected to his death.

92. An officer booked out the wing hairdryer to the man around 4.00pm. Five minutes later, he returned the hairdryer to the officer saying it had gone 'pop' when he used it. The officer noted that he did not look any different from when he collected the hairdryer. Later, it was noted that in three cells adjacent to the man's the electrical power failed. Other than the lack of electricity, no damage was noted to his or neighbouring cells. A member of the works department was called out to re-set the power supply. It is unclear if the faulty hairdryer caused the problem with the electricity supply.

93. The investigator asked for a comment from the work's department with reference to the call out to G wing and subsequent actions. In an email a member of Gartree's works department wrote:

> "As far as we recollect, and with the information on Planet, [a database], the hairdryer was used but was faulty (smell of burning) this would trip the power to the cell instantly. It would be very unlikely there would be any electric shock as power would be cut instantly."

94. The hairdryer was deemed to be faulty and disposed of.

95. Following the initial post mortem examination, the Coroner ordered an examination of the man's brain to be carried out by a brain specialist. The clinical reviewer read the full post mortem examination document and writes:

> "The Post Mortem Examination showed that the man had suffered two episodes of bleeding inside his skull but outside his brain. The second episode was only 1-2 days old and may have been associated with a jerk of his head when the hair dryer

failed. This would have been unusual in anyone not on warfarin but is a recognised complication of this treatment even when it is the therapeutic range."

96. We are unable to say categorically whether the faulty hairdryer had any impact on the man's death.

## CONCLUSION

97. The man had serious health problems including asthma and heart disease. Additionally, he was trying to address his substance misuse through a methadone prescription. The clinical reviewer concludes that he was generally well cared for and that there was good practice in controlling his medication.

98. The unfortunate incident of the malfunctioning hairdryer caused power to be cut from the man's cell and that of his neighbours. From the work department's call out report it seems the hairdryer would have cut out and it was unlikely that this would cause an electric shock. However, we are unable to say to what extent this incident may have had on his health.

99. The response to the man's collapse and the events that followed were subject to delays. Those delays started from entering his cell to him leaving Gartree for hospital. It is imperative that delays in staff and emergency services reaching prisoners with serious health problems are kept to a minimum. Recommendations are made to address these issues.

## RECOMMENDATIONS

### For the attention of the Governor

1. The Governor should formally review the policy about unlocking cells when the prison is in patrol state to ensure an appropriate balance between prisoner care and security, particularly with regard to prisoners with known health problems.

   **Accepted.** *The prison said that a full review would be undertaken. Upon completion of the review, appropriate and proportionate procedures will be implemented to ensure the requested balance is achieved.*

2. The Governor should ensure that emergency ambulances are given expeditious access in and out of the prison

   **Accepted.** *The prison said that they had already reviewed the procedures and introduced a new protocol at the time of their response.*

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