PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Leyhill in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is a report into the death of a man, who was discovered in his room at HMP Leyhill on the morning in January 2012, collapsed on his bed. Despite an attempt to resuscitate him, it was clear that he had already died before staff had found him. Although he had diabetes, was otherwise in good health. His death came as a shock to his family and staff and prisoners at Leyhill. I offer my condolences to his family for their loss.

The investigation was carried out by one of my investigators with the full co-operation of Leyhill prison. A clinical reviewer was appointed to undertake a review of the man's clinical care.

A preliminary post mortem report found that the man's died of a heart attack. It also discovered that he had undiagnosed pancreatic cancer, although this was not the cause of the death. The clinical reviewer notes that it was unlikely that this cancer would have been identified as the man had not displayed any specific symptoms and the condition is difficult to diagnose. He also considers that the man's heart attack could not have been predicted from his history or known risk factors. So far as his general healthcare was concerned, the man received a good standard of care, particularly for his diabetes, although the clinical reviewer identifies a number of occasions when medical records were not complete.

I am satisfied that the man's death could not have been foreseen and nothing could reasonably have been done to prevent it. However, while it would have made no difference in the man's case, the investigation recommends that sufficient first aid trained staff are always on duty at Leyhill.

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 **November 2012**

CONTENTS

SUMMARY

1. The man was born in Newport, Gwent. In February 2010, he was sentenced to four years imprisonment and was initially held at Parc prison in Wales. He subsequently transferred to Gloucester prison, then to Channings Wood and, lastly, to Leyhill.

2. Throughout his time in custody, the man's medical condition was well documented. Healthcare staff were aware that the man had diabetes and suffered from pancreatitis. Occasionally he presented a confused account of his diagnoses, but staff ensured that he was monitored regularly through blood tests, ultrasounds and eye tests. His diabetic medication was frequently reviewed and for the most part his condition remained well controlled.

3. While at Leyhill, some blood tests indicated that the man was controlling his diabetes less effectively. A doctor suggested that he increase the dosage of his diabetic medication but the man was reluctant to do so, preferring to attempt to manage it by diet and exercise. The man began a low fat diet and signed up for an exercise programme.

4. On 2 December 2011, the man was seen by a nurse, and then by a doctor, complaining of abdominal pain. He was examined, diagnosed with 'a non specific pain' and prescribed paracetamol and an indigestion remedy.

5. Although the preliminary post mortem report recorded that the man appeared to have had a heart attack about this time, both the nurse and the doctor were sure that the symptoms the man presented with were not consistent with this. The clinical reviewer agreed that thorough and responsible examinations had been carried out. The man did not complain of any pains or of feeling unwell after that day.

6. On the morning of the man's death at approximately 5.30am, an officer working the night shift carried out a roll check (a check to ensure all prisoners are present in their rooms). The officer noted nothing unusual when he checked him.

7. Four hours later, another member of staff conducted a check of the condition of rooms. When she reached the man's room she saw that he was lying across his bed and appeared unresponsive. The officer immediately called for assistance from a nearby colleague and radioed for urgent assistance from healthcare and other prison staff.

8. Staff quickly responded to the emergency and, when the nurse arrived, she attempted to resuscitate the man. He was unresponsive and showed no signs of life, but the nurse continued to attempt resuscitation until the doctor arrived a few minutes later. He examined the man and confirmed that he had died. The time of death was recorded as 9.50am.

9. This report makes three recommendations. These relate to first aid training for staff, emergency equipment and record keeping.

THE INVESTIGATION PROCESS

10. The Ombudsman's office was notified of the man's death on 24 January 2012 and the case was allocated to one of my investigators. The investigator carried out an opening visit to the prison on 26 January 2012. During the visit she met with the Governor, the liaison officer for the prison, a member of the IMB, the Head of Healthcare and the officer who discovered the man on the morning of his death.

11. The investigator was given a copy of all of the relevant documentation covering the man's time in prison, including his medical record and prison policy documents.

12. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation and invited them to contact her with any relevant information. While there was no response to the notice, during the investigator's opening visit she met a prisoner who knew the man. He said that some prisoners had concerns relevant to the investigation:

- How thoroughly night checks were carried out on prisoners at 11.00pm and 6.00am
- How quickly the man was removed from the prison after he had died
- Because they were not locked in their cells, prisoners on the man's wing saw his body being removed from the prison and were distressed by this.

13. A clinical reviewer was appointed to undertake a review of the clinical care the man received at Leyhill. The investigator and the clinical reviewer carried out eight interviews at the prison on 29 February. They also spoke informally to the man's cousin, who was a prisoner at Leyhill. The investigator provided written feedback to the Governor on 1 March. The clinical reviewer's report was received in this office on 9 March and is attached as the first annex to this report.

14. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation. A copy of this report will be sent to the Coroner to assist with his enquiries.

15. One of the Ombudman's family liaison officers contacted the man's family to invite them to be involved in the process. The family received a copy of the draft version of this report and have considered the findings. They said they still have some questions but feel these would be better dealt with at the Inquest.

HMP LEYHILL

16. HMP Leyhill is a category D prison in South Gloucestershire. Category D prisons are also referred to as open prisons and hold prisoners who require only minimum security. The prison has capacity to hold 532 prisoners.

17. 'A' unit, where the man lived, has mostly single rooms and each prisoner has a key to their own room. The unit allows free access to all prisoners until 11.00pm, after which they are expected to stay in their rooms till morning.

18. Healthcare cover is provided in Leyhill every weekday from 7.30am until 4.30pm. Doctors are in the prison on weekdays and run GP surgeries. A local surgery provides out of hours cover.

Her Majesty's Inspectorate of Prisons report (HMCIP)

19. The last report published on Leyhill by HMCIP followed an unannounced inspection in May 2010. The report noted that health services in the prison were good. At that time inspectors noted that prisoners complained that too frequent and noisy checks at night meant they lost sleep.

Independent Monitoring Board (IMB) report

20. Each prison in England and Wales has an independent Monitoring Board, made up of unpaid volunteers from the local community, responsible for ensuring that proper standards of decency and care are maintained. The annual report published by the IMB in January 2011 noted that despite some concerns during the first year of a new contract with healthcare providers, healthcare continued to deliver to a good standard.

Previous deaths at Leyhill

21. Since this office took over responsibility for investigating deaths in prison custody in 2004, there has been one previous death at Leyhill. The circumstances surrounding that prisoner's death were different to those of the man, as the prisoner had a terminal illness of which he was aware.

KEY EVENTS

22. On 12 February 2010, the man was sentenced to four years imprisonment at Cardiff Crown Court for conspiracy to supply drugs, and began his sentence at HMP Parc in Wales. During an assessment in the First Night Centre on 16 February, the man said that he needed a low fat diet because he had problems with his pancreas. The man said he felt OK and had no immediate concerns.

Gloucester prison

23. The man transferred to Gloucester prison on 16 September. During a health assessment that afternoon, the nurse recorded that the man had diabetes. It was also noted that his current medication included

- paracetamol
- naproxen for sciatica (nerve pain)
- tramadol (a painkiller)
- amoxicillin for a chest infection
- and metformin, to combat the effects of diabetes.

24. He was seen later that day by a prison GP. The doctor noted in the medical records that the man also had a history of pancreatitis[1]. This entry said that the man was taking metformin and gliclazide[2]. The doctor noted that the man was fit to attend the gym.

25. On 21 September, the man had a Hepatitis B vaccination and it was noted that he had no adverse reaction to this. Three days later, on 25 September, he was seen by the (noted as "other Community Health Service"). His current medication was recorded as metformin and gliclazide and that there was a family history of diabetes mellitus[3]. An additional note was made which said that the man had no concerns about his health at that time.

26. Over the next few weeks, the man was seen by healthcare for help with giving up smoking, to have a second Hepatitis B vaccination and to discuss reducing his use of tramadol[4] because he was worried he was becoming dependent on the medication.

27. It was noted on 24 November that, although the man had not been seen in healthcare, he had told staff on the wing that he had not smoked for four weeks. As he was due for transfer, replacement nicotine therapy was sent with the man's medical record.

Channings Wood

[1] Inflammation of the pancreas
[2] A diabetic drug
[3] A disease in which a person has high blood sugar because their body does not produce enough insulin
[4] An anti inflammatory drug

28. The man arrived at Channings Wood on 24 November. Later that day he attended a medical assessment with a nurse manager. It was noted that his current medication was tramadol, metformin, gliclazide and naproxen. The nurse noted that the man had diabetes.

29. The next day the man was seen by a locum GP at the prison. The locum GP A reviewed the man's medication and decided to prescribe the co-codomol tablets (painkillers) but that the tramadol should be reduced with a view to stopping it. He also noted that the man had been prescribed nicotine patches as part of a course to give up smoking.

30. Over the next month, the man continued to be monitored as part of the smoking cessation programme and, on 7 December, it was noted in the medical records that he had successfully stopped smoking.

31. On 10 December, the man was seen by locum GP B in healthcare. The locum GP noted that:

> "Patient seems v young and v slim to be type 2. No strong family history. Says it is all due to pancreatitis but never had CT (scan) pancreas and usually needs to be on insulin not type 2 meds. This needs to be looked into bloods please ….and I will decide what best plan is, I feel should be seen in diabetes clinic and may well need CT to abdomen to establish pancreatic damage."

32. The man had a urine and blood test that day. A member of healthcare staff also contacted the man's community doctor for further information about his diabetes and pancreatitis.

33. The locum GP B recorded the results of the man's tests in the medical record three days later. She noted that the man had diabetes mellitus. The GP noted that the results of a urine test indicated that the man's kidneys might not be functioning correctly and that the urine test should be repeated. The blood test results showed that the levels of white blood cells and haemoglobin (iron) in the man's blood were abnormal and that he needed to be seen by a doctor.

34. On 17 December, the locum GP B made another entry in the medical record. She wrote that the man's blood tests were OK, his blood pressure reading was borderline and that he needed to be seen for a second opinion by the diabetes team.

35. On 23 December, healthcare received a response to their letter of 10 December from the man's doctor in the community. He said he did not have much information about the man, although he was admitted to the Royal Glamorgan hospital on 10 January 2010 and discharged two days later with a diagnosis of pancreatitis. The doctor added that the man was not a known diabetic.

36. On 30 December, the locum GP by recorded the results of the man's plasma viscosity[5]. She noted that this was normal but required him to have another test to check the levels of amylase (a protein produced by the pancreas which helps to digest carbohydrates) and calcium in his blood. This was carried out later that day.

37. Locum GP A made an entry in the medical record on 4 January 2011. He said that the man's serum amylase level report showed as abnormal and requested he make an appointment to see a doctor. A blood sample to repeat the tests was taken shortly afterwards.

38. On 21 January, locum GP C made a note in the medical records following an ultrasound. The GP said:

> "uniform echo and swelling of pancreas consistent with pancreatitis, scan done on 13/1/11 shown to me on 21/1/11. Unable to contact anyone to get info on patient. Last bloods 4 Jan. Not seen since then. Plan for urgent review next week".

There is nothing in the medical record to indicate that the man had the scan on 13 January.

39. Locum GP A saw the man on 23 January. He booked an appointment for him to be seen by a dietician and requested he be seen in the diabetic clinic at Torbay hospital.

40. On 15 February, the man attended the diabetic clinic at Torbay hospital. A consultant physician in diabetes and endocrinology wrote to locum GP B on 18 February and said that he suspected that the man had type two diabetes and that there may have been some pancreatic damage. He suggested that the man should continue with the medication he was taking as his condition seemed to be stable. He added that if the diabetes progressed then the man might require insulin in the future to manage it. No follow up was arranged.

41. On 11 March, the man had a blood test. The result indicated that his liver function was abnormal, possibly due to a fatty liver, and that the man needed to make an appointment to see a doctor.

42. Over the next few months, the man continued to be monitored and had regular blood tests. On 18 April, he attended Torbay hospital again for a diabetic retinopathy test (eye test). The results were normal. In May, his cholesterol[6] level was reported as abnormal and he was told to make an appointment to see a doctor.

43. On 19 May, the man saw locum GP C about his cholesterol levels. The man was reluctant to take more medication and said he would like to try to control his cholesterol by diet. The GP spoke about the risks of prolonged high

[5] This estimates the 'stickiness' of the blood produced by abnormal protein
[6] Cholesterol is a fat (lipid) which is produced by the liver and is concerned for normal body functioning

cholesterol in diabetic patients, but they agreed that the man would ask the prison kitchen to provide a low fat diet. The plan was to review the man in six months and a date was set for 19 November.

44. On 27 June, the man attended outside hospital for nasal surgery. There is little information about this, but he was due to attend hospital again three weeks later.

45. The man was examined on 21 October to determine whether he was fit enough to transfer to Leyhill prison. There were no concerns and he was noted as being fit and well and had sufficient medication.

Leyhill

46. The man was seen by practice nurse A, on his reception at Leyhill on 25 October. The nurse noted that the man had a history of type two diabetes which was well controlled. He was advised how he could order and collect medication and the nurse noted that he had enough medication (all of which were recorded) to last a month.

47. The man began Leyhill's 15 day induction programme and attended all sessions. He was initially given a job working in the prison shop.

48. On 31 October, the man was seen by Dr D. The doctor recorded that the man gave a slightly confusing account of his health problems, although the doctor had access to his electronic medical records from previous prisons. The man said that he had been diagnosed with type two diabetes in 2010 and that he had developed acute pancreatitis due to gallstones. He added that he had been told he had insulin dependent diabetes, but had been prescribed metformin and gliclazide. The doctor arranged for him to have a blood test and attend the diabetic clinic. The man also complained of a painful lump on his neck. On examination this was diagnosed as an inflamed sebaceous cyst and was prescribed flucloxacillin (an antibiotic).

49. Dr E examined the man on 9 November as he had complained of a chesty cough. The doctor noted that he was diabetic and had started smoking again. He was prescribed cefradine (an antibiotic). The doctor also reviewed the man's blood tests which were normal, apart from mild microcytosis[7] with eosinophilla[8] which he noted as not being urgent. However, the man's haemoglobin test was noted as being abnormal and the doctor advised that he should make an appointment to be seen for this.

50. On 11 November, the man was examined by practice Nurse A. She noted that he appeared, and said he was, fit and well.

51. Practice Nurse B, saw the man on 16 November and noted in the medical record that he should have had a diabetes review and not been given an

[7] A blood disorder
[8] Abnormally high white blood cell count

appointment with a general nurse She advised the man that he had a high HbA1c[9] level and said that healthcare would contact him with a new appointment (this was made with the Head of Healthcare for 23 December). She advised the man to ensure he controlled his diet in the meantime.

52. On 23 November, the cyst on the man's neck flared up again. He was prescribed another course of flucloxacillin.

53. Practice Nurse A saw the man on the morning of 2 December. He complained of upper abdominal pain on the left hand side which had started at 1.00am that morning. He said that it felt as if it were spreading to his right side and was experiencing a sharp shooting pain when he went to the toilet. The nurse noted that on examination the man had "soft mild guarding (sensitivity) on left side" and had loose stools. She thought this might be due to constipation, but made an appointment for him to see a doctor. During her interview with the investigator and the clinical reviewer she said that she had not been particularly concerned but she was aware he had pancreatitis.

54. The man saw Dr E just over an hour later. He examined him and noted that he had tenderness on his left side. The doctor noted that the man had a history of pancreatitis, that he had not been vomiting and had been able to pass bowel movements. Apart from the slight tenderness, the man appeared well and showed no signs of acute abdominal pain. The doctor prescribed Gaviscon[10] and paracetamol with a view to examining him again if he had not improved. During his interview with the investigator and the clinical reviewer, the doctor said that there was nothing to suggest that the pain the man was experiencing was from his heart. This is discussed later in this report.

55. Ten days later, 12 December, the man received a hospital appointment for an ultrasound on his neck. This was scheduled for 23 December but appeared to have been postponed until 12 January (there is no record that the man attended this appointment).

56. He also saw Dr D on 12 December. The doctor noted that the man's cyst had completely cleared. The doctor recorded that the man's HbA1c was 77 percent, which was not as good as it had been previously and the doctor suggested increasing the dose of his anti diabetic medication. However, the man attributed this to a change in diet since he had been at Leyhill and said he would aim to control his diet by doing most of his own cooking. He was reluctant to increase his medication at this stage. The man's cholesterol was described as excellent and his blood pressure was normal. The doctor was aware that the man had an appointment for a formal diabetic review the following week.

57. The man had an appointment with the Head of Healthcare, on 23 December for this review, however he did not attend the appointment (a reason is not recorded) which was rescheduled for 30 December.

[9] HbA1c occurs when haemoglobin joins with glucose in the blood
[10] Medication for heartburn and indigestion

58. On 30 December, the head of healthcare carried out a diabetic annual review. They discussed his condition, how diet and exercise could help him and that his HbA1c had raised to 77 percent. The man said he had lost one stone in weight which he attributed to his diet. The head of healthcare made an appointment for the man to attend the gym, as part of the Fit for Life exercise programme. The man had no other issues aside from a cough and he was prescribed some cough linctus. A week later, the man completed the Fit for Life referral with a healthcare assistant.

59. There are no records to indicate that the man was assessed by healthcare after December 2011. There had been no mention from any staff, or from the man himself, that he had felt unwell or had experienced any chest pains.

60. At the man's request, he was granted a job change on 16 January 2012, and began working in the prison's clothing exchange store (CES)[11].

61. There is little else of note before 23 January. A prisoner told the investigator that he saw the man on the evening of 22 January. He recalled that the man looked well and had seemed fine. He did not complain of feeling unwell and they spent their time playing pool. Officer A recalled seeing the man that evening. She saw him use the telephone at approximately 9.30pm. She said the man had seemed fine and had given no cause for concern. A roll check was carried out at approximately 11.00pm, and again there were no concerns about the man.

The day the man died

62. On the morning of the day the man died, at approximately 5.30am, Officer B was working on A unit, where the man lived. The officer had a vague recollection of the man, but they had not engaged much. During his interview, the officer explained that between 5.30am and 5.45am staff are required to unlock prisoners rooms and check that they are present (there is no observation panel in the door). The officer added that there were mostly single rooms on A unit and the man lived in one of these. The officer said that the Local Security Strategy made it clear that staff should not try to get a response from the prisoner, but that the purpose of the check was a physical body count.

63. Officer B said that when he came to check the man's room he found nothing of concern, although he could not remember where in the room the man was. He added that he noticed nothing abnormal. The officer said that, during the checks, staff do not switch the light on as this would disturb the prisoner, although the landing light remains on.

64. The officer who discovered the man started her shift at 7.30am. Two hours later she began to carry out a check of the condition of each room. The officer said she would not have expected a prisoner to be present during this check,

[11] Where prison clothing (known as kit) is stored and supplied to living units.

as they would usually be expected to be at work during the day, unless they were unwell.

65. The officer who discovered the man and her colleague, Officer C began room checks, each working down one side of the corridor. The officer who discovered the man said the first room she checked was number 48, and she worked her way to number 43, which was the man's room. The door was closed and so she unlocked it. She immediately saw the man was lying half on the bed, face down, with his legs hanging over the side of the bed. They were not touching the floor. He was bare-chested and appeared to be holding his arms tight to his chest. His shoulders were drawn into his body and his hands were under his chin. The man was wearing a pair of grey jogging bottoms, but no shoes or socks. There was a grey, screwed up tee-shirt on the bed, just above his head.

66. The officer who discovered the man recalled that the room's single strip light was fully on, the curtains were drawn and all of the man's personal effects appeared to be in order. The officer called the man's name a couple of times and put her hand on his shoulder. He felt cold to the touch.

67. The officer who discovered the man immediately called for assistance from Officer C, who responded straight away. Officer C felt for a pulse on the man's left wrist, but could find none.

68. While he was doing this, the officer who discovered the man used her radio to contact the prison's communications room. She requested immediate assistance from healthcare (Hotel 1) the duty manager (Oscar 1) and asked for an ambulance to be called.

69. Approximately two minutes later, two senior officers (SO), SO A and SO B arrived to assist. SO A was one of the residential senior officers on duty that day and heard an emergency call over the radio for staff to attend. He confirmed that an ambulance was on its way and then checked the man's neck for a pulse, but could not find one.

70. At 9.45am, practice Nurse B arrived at the room after responding to the emergency call. On the way she had collected an emergency bag, a defibrillator and an oxygen cylinder. She asked that the man be turned over fully onto his bed so she could begin cardio-pulmonary resuscitation (CPR). Officer C noticed that the man's eyes were open and he had a small amount of blood by his nostrils. At this point SO A left the room to inform the duty governor of what was happening.

71. Practice Nurse B found the man stiff and cyanosed[12] and his pupils were fixed and dilated. She attached defibrillator pads[13] to his chest but the machine indicated that he should not be shocked, so Nurse B began to administer chest compressions. She asked whether any of the officers

[12] Blue in colour, a sign that oxygen is not circulating round the body as it should.
[13] A defibrillator is a machine used to detect whether the heart can be shocked into a rhythm.

present were first aid trained and could assist her, but none were. She continued CPR unaided until Dr D arrived just after 9.45am.

72. Dr D carried out his own assessment of the man. He also found him to be cold, stiff and his pupils were fixed and dilated. There was no pulse and no respiratory effort. In view of the rigor mortis[14] which had clearly set in, Dr D assessed that further resuscitation attempts would be futile. At 9.50 am he recorded that the man had died.

73. At 11.35am, the Imam conducted prayers over the man, in his room. (A note in prison records show that the coroner's ambulance arrived at 3.44pm, that prisoners were advised that the man would be moved from the prison and he left at 4.10pm.)

Contact with the man's family

74. The Imam, knew that the man had a relative at Leyhill (later discovered to be his cousin). The Imam and SO C went to see the man's cousin so they could break the news of his death, but he had already heard this from another prisoner who had been informed by a member of the chaplaincy when they visited prisoners at their workplaces. His cousin had contacted his wife to let her know and it appears that she, in turn, had contacted the man's family.

75. SO C was appointed as the family liaison officer. She was assisted by the Imam. At 11.45am, SO C telephoned the man's wife. Normally she would have gone to see her personally but the prison decided to speak by telephone as the family had already learnt of the man's death through his cousin. The man's wife was very distressed and so the Imam spoke to her. The Imam telephoned the man's wife again at 12.40pm and gave her the direct telephone number to reach him at the prison chaplaincy. He told her that he and SO C would be travelling to Newport to see her family later that day.

76. The Imam and SO C arrived at the family home at 4.00pm. The man's family and friends were present. The Imaml explained the circumstances of the man's death in Urdu. The Imam gave the family details of the Coroner's office and confirmed that the family could arrange the funeral (they were concerned that this would be controlled by the prison).

77. The man's wife said she had spoken to her husband at approximately 9.30pm the night before, and he gave her no indication that anything was wrong. The Imam informed the family that they would be able to visit the prison and see the room where he lived, if they wished to do so. The family said they were desperate to see the man, but understood this was a matter for the Coroner.

78. SO C spoke to another family member on the telephone the next day. She was told that they were trying to arrange his funeral. SO C said that the prison would contribute towards the cost. SO C mentioned that a memorial

[14] Rigor mortis is a process by which muscles stiffen after death

service would be held in the prison the following week, and as soon as the police had released the cell, a visit to the prison could be arranged.

79. The same day, the Governor wrote a letter of condolence to the man's family. He reiterated that the prison would contribute towards funeral expenses, that a memorial service could be held on the same day they visited the prison and gave then information about the support available to them.

80. The man's funeral was held. His cousin was able to attend and was escorted by one prison officer. SO C had offered to attend the funeral but this was politely refused and she was thanked for her consideration.

81. The man's family visited the prison on 3 February. They viewed the room where the man lived and were able to speak to staff who knew him. The man's cousin attended too. Prisoners had created a condolences board which was shown to the family. Staff took photographs of the messages on the board and had the images laminated for the family to take away. His family did not wish to attend the prison's memorial service.

Support for prisoners and staff

82. After the man's death members of the chaplaincy visited A unit to speak to prisoners and also visited the CES store where the man worked. They also went to see prisoners working in other parts of the prison, to break the news to them and offer support. They reminded prisoners of the support services available to them.

83. The Governor wrote a notice to all prisoners, informing them of the man's death. Prisoners were reminded of the services of Listeners[15] and had ongoing support from the chaplaincy. They were all reminded that they could also speak in confidence to the Samaritans. There were no prisoners subject to suicide monitoring procedures to review.

84. The man's cousin spoke to the investigator and the clinical reviewer. He said that he had been treated well and appreciated being able to attend the funeral and that his family had been allowed access to the prison. He said that the man had never mentioned an illness and that he had seemed perfectly well. He explained that he had learnt of his death from another prisoner working in the laundry, before he could be told formally.

85. The Governor issued a notice informing all staff that the man had died. They were reminded of the services of the Care Team if they felt affected by the man's death. At 1.00pm that afternoon, the Governor held an incident debrief. All staff who had been involved in the discovery and resuscitation as well as senior managers, the chaplain and the Imam. The role of the Care Team was explained and the availability of counselling, should it be needed. A critical incident debrief was held on 23 February which was run by the Staff Care and Welfare Service.

[15] Prisoners trained to speak in confidence to others who may be in distress

Post mortem report

86. The preliminary post mortem report showed evidence that the man had chronic heart disease, had experienced a heart attack approximately seven weeks prior to his death (which appeared to go undetected) and a further heart attack which was the cause of death. He was also found to have pancreatic cancer. The complete post mortem report is still awaited.

ISSUES

Clinical care

87. The man received on-going monitoring and medication for diabetes at both Channings Wood and Leyhill prison. The clinical reviewer notes that the diabetes was well controlled and, in 2010, his HbA1c level (a measure of long term diabetes control) was at 6.3 percent, which indicated a good level of control.

88. The man had a full diabetes check in 2011 and no complications relating to his diabetes were noted. In April 2011, he had his eyes checked for signs of complications from diabetes and no problems were found. He also had an ultrasound of his pancreas in January 2011 which, although appearing consistent with pancreatitis, indicated no other abnormalities.

89. There is a well established Chronic Disease Management programme for diabetes at Leyhill, which the man attended. The clinical reviewer notes that this is the standard which would be expected for a patient in the community.

90. The man's diabetes control appeared to become less effective from 2011, and he underwent a number of tests to ascertain the effects of his condition. He was advised by a doctor at Leyhill to increase his diabetic medication, but the man was reluctant to do so. Instead, it was agreed that he would try to control his condition with diet and exercise. Again, he had a full diabetes check on 30 December 2011, and no abnormalities were found.

91. On 2 December 2011, the man complained of left upper abdominal pain and was examined by a nurse and then a doctor at the prison. He was diagnosed with having non specific abdominal pain (pain without any discernible cause) and was prescribed paracetamol and Gaviscon. The clinical reviewer notes that, given the preliminary post mortem findings, the man appears to have experienced a heart attack around this time (six to seven weeks before he died).

92. During interviews with medical staff, the clinical reviewer asked whether, with hindsight, the symptoms the man presented with on 2 December, could have been an indication that he was suffering a heart attack. Dr D said he had given that some thought since he had died and thought this extremely unlikely. He said that, as an experienced doctor, he had seen a very large number of patients with heart disease and thought that it was clearly abdominal pain about which the man was complaining. The doctor was well aware of the man's diabetes and pancreatitis.

93. The clinical reviewer agrees that the chances of the man's pain being related to his heart were negligible and that the doctor performed a thorough and reasonable examination, came to a reasonable conclusion and offered the man reasonable treatment.

94. The clinical reviewer also says that there was no evidence of pancreatic cancer when the man had an ultrasound in January 2011. In the absence of any symptoms, there would be no indication that a further scan was necessary. He added that pancreatic cancer is notoriously difficult to diagnose and in this case was unlikely to have contributed significantly to the man's death. The clinical reviewer also notes that the man died from a heart attack that could not have been predicted from his history or known risk factors.

95. The clinical reviewer concludes that the emergency procedures were undertaken in an entirely appropriate manner, the outcome would not have been different for the man had this happened in the community and the standard of care the man received was "of the standard expected in a good general practice."

Medical record keeping

96. There are a number of omissions in the man's medical record. There is often no explanation about why an appointment was missed or what the outcome of a referral or consultation was.

97. In is important to record a patient's diagnosis, care needs and follow up appointments so that all other healthcare colleagues involved in a patient's care are aware of it.

The Head of Healthcare should ensure that all healthcare staff follow the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Night roll checks

98. The officer who conducted the roll check at approximately 5.30am on the morning of 23 January said he did not notice anything out of the ordinary when he checked the man's room. He said that staff are not required to get a response from a prisoner, but just to ensure that they are present.

99. The prison's local instruction (13.7) refers to roll checks being conducted at night. It states that roll checks are to ensure that every prisoner is accounted for. It also states that these checks should be carried out in a way which causes as little disruption as possible to the prisoner. However, the officer said that he would have noticed if the man had been in the position he was found in a few hours later.

100. This seems to agree with the time of the man's death being estimated at approximately 6.30am (in the preliminary post mortem report) shortly after the roll check conducted by Officer B..

First aid training

101. Neither of the two officers who discovered the man were first aid trained and they were unable to assist the nurse who attended the emergency call. As a result, the nurse had to conduct CPR on her own. The clinical reviewer also notes this point and suggests that this training should be made widely available and that staff should be trained in basic CPR techniques.

102. A letter written by the Chief Executive Officer of the National Offender Management Service in 2010 reinforces the importance of ensuring that prisons have effective first aid arrangements in place to respond to prisoner related incidents. He wrote that:

> "A first aid needs assessment is the first stage in determining the number of first aiders that might be required to ensure sufficient cover at all times and requires a number of factors to be taken into account. "

103. These factors include: the shift patterns of staff, including those on night duty and those working at weekends, and the travelling distance between healthcare and other areas of the prison where first aid might be required.

104. Each prison was required to review their first aid arrangements for prisoner related incidents (in accordance with Health and Safety Guidance Note 3/2010 – First Aid provision) and, where inadequacies were identified, for action to be taken in response. It is unsatisfactory that neither of the two officers on A wing that morning were able to help with CPR or had any first aid training.

The Governor should ensure that there are sufficient first aid trained staff on duty at all times and provide a programme of first aid and CPR training for all staff, particularly those in regular contact with prisoners.

Provision of emergency medical equipment

105. During interview, practice Nurse B said that healthcare had only one emergency bag and shortly after she attended the man's cell another emergency incident occurred. As a result, she had to leave the cell to take the bag to the other incident (this did not affect the man's care as he had already died).

The Head of Healthcare should undertake a risk assessment to ensure there is sufficient emergency equipment in the prison.

Prisoners' concerns

106. The investigator spoke to a prisoner who knew the man and who identified some concerns on behalf of other prisoners. One concern was the roll checks and their purpose and whether a more thorough roll check would have found the man earlier. We are satisfied that the purpose of these checks is to ensure a prisoner is present in his room, not to gain a response from them. It

appears likely, in any case, that the man was still alive when the 5.30am roll check was conducted.

107. Some prisoners expressed concern that they saw the man being moved from his room to the Coroner's ambulance. The prison said that they had tried to ensure that the man's body was taken away as quickly and discretely as possible. They cordoned off a staircase to avoid causing prisoners unnecessary distress. We accept that in a prison setting, especially an open prison such as Leyhill, it would be difficult to avoid this without confining all prisoners to their rooms.

CONCLUSION

108. The man was diabetic and his condition was well monitored by prison healthcare staff. He attended a clinic for prisoners who had diabetes and his medication was regularly reviewed. The man also received regular blood tests to check the effectiveness of his medication and how well his diabetes was being controlled. On occasion the blood test showed some abnormalities which were appropriately responded to. The man also attended ultrasound appointments and an eye check at outside hospital to ensure that his condition had not deteriorated. Otherwise, the man appeared to be well and only visited healthcare for minor ailments.

109. The man's sudden death from a heart attack could not reasonably have been predicted. Understandably, his family and the staff and prisoners who knew him were distressed and shocked. The care given to staff and prisoners was of a good standard and the liaison between the prison and the man's family was handled professionally and respectfully.

RECOMMENDATIONS

To the Governor:

1. The Governor should ensure that there are sufficient first aid trained staff on duty at all times and provide a programme of first aid and CPR training for all staff, particularly those in regular contact with prisoners.

The prison partially accepted this recommendation. They said "HMP Leyhill will ensure that there are sufficient first aid trained staff on duty. Our training of these staff is comprehensive. However, it would not be feasible to train all staff in first aid, but rather have them situated to respond in all areas."

To the Head of Healthcare:

2. The Head of Healthcare should ensure that all healthcare staff follow the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

The prison accepted this recommendation and completed the action.

3. The Head of Healthcare should undertake a risk assessment to ensure there is sufficient emergency equipment in the prison.

The prison accepted this recommendation and completed the action.