Investigation into the death of a man at St Thomas' Hospital in August 2010, whilst in the custody of HMP Belmarsh

Report by the Prisons and Probation Ombudsman for England and Wales

May 2011

This is the report of the investigation into the death of a man. The man died at St Thomas' Hospital, London whilst on remand at HMP Belmarsh. The post mortem concluded that he died of a heart attack and related coronary problems. He was 57 years old when he died. I offer my sincere condolences to his family.

The investigation was carried out by one of my senior investigators. I would like to thank the prison Governor and his staff for their co-operation with the investigation. I am grateful to Governor A for his work as the establishment's investigation liaison officer and the member of staff who liaised with the clinical reviewers. I apologise for the delay issuing my report and any additional anxieties this may have caused.

NHS Greenwich commissioned three clinical reviewers to review the clinical care provided to the man by Belmarsh. I am grateful for their considered review.

The man arrived at Belmarsh two days earlier on 5 August and healthcare staff assessed him. They recorded that, as well as being dependent on heroin, he had existing health problems, including chest related issues for which he was due to attend hospital. The man was admitted to the inpatients ward at the prison to undergo a detoxification programme and for his physical problems.

In the early hours of 7 August, the man complained of feeling unwell and the ward was unlocked so that nursing staff could examine him. The man's blood pressure was very low and the nurses decided that he should be taken to hospital. After a delay, an ambulance was called. Sadly, the man suffered a heart attack at hospital and died following surgery later that day.

I am disappointed to find that the clinical review highlights a number of shortcomings in the clinical care offered to the man at the prison. The reviewers conclude that the standard of care offered to the man was not equitable to that he might have expected to receive had he been in the community. I make five recommendations as a result of this investigation and highlight one area of good practice.

This final version of the report includes the National Offender Management Service's response to the recommendations made.

The 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 **May 2011**

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SUMMARY

1. The man was remanded into the custody of HMP Belmarsh on 5 August 2010. On his arrival, he was assessed by a nurse in reception. The man said that he was dependent on heroin and had been prescribed methadone (a heroin substitute) in the past. He said that he often bought methadone from drug dealers. In addition, the man mentioned suffering with chest problems and said that he had a forthcoming hospital appointment. He did not specify what his chest problems were but said that he was prescribed medication for asthma and chronic obstructive pulmonary disease. The nurse recorded that the man appeared to be frail and weak.

2. Because of the nurse's concerns, the man was also seen by a locum doctor and detoxification nurse. The doctor did not make a thorough physical examination and could not read the man's blood pressure or pulse. However, he decided that the man should be admitted to the healthcare unit as an inpatient so that his physical condition could be monitored and he could undergo a detoxification programme. Nursing staff were given few instructions about the care that the man needed and no care management plan was detailed in the medical records.

3. Later that evening, a nurse working in the healthcare unit took a blood pressure reading. The reading was low but the nurse decided that, as the man was not in distress or complaining of any discomfort, he should be examined by a doctor the following day.

4. On 6 August, the man was assessed by a doctor from the detoxification team. The doctor concentrated on the man's substance misuse problems and did not carry out a detailed physical examination. He had not read the man's medical record beforehand. The doctor placed him on a detoxification programme. He was not examined by any other doctors that day and no basic clinical observations, such as his blood pressure or pulse readings, were taken or recorded.

5. At about 2.30am on 7 August, the man began banging on the window separating his ward from the staff office. He complained that he could not breathe and thought he was dying. The staff on duty called for the night manager to attend and unlock the ward. The two nurses on duty examined the man and found his blood pressure was very low. They agreed that an ambulance should be called. The night manager sought confirmation from the on call doctor and, when he could not be contacted, the on call clinical lead was telephoned. He agreed that the man needed to go to hospital and so an ambulance was called.

6. The man was taken to hospital but, later that morning, suffered a heart attack. Hospital staff resuscitated him and decided that he needed further treatment at another hospital nearby. He was transferred by ambulance and immediately taken to the operating theatre. Unfortunately, his condition deteriorated and he died at 12.50pm.

7. This investigation and the accompanying clinical review have highlighted shortcomings in the care provided to the man during his short time at Belmarsh.

In particular, the clinical reviewers concluded that his physical condition was not sufficiently explored and, other than his substance misuse, his health needs were not identified or managed. The reviewers also identified failings in the procedure for calling an ambulance. They conclude that the man did not receive an equitable standard of care in prison to what he might have expected had he been in the community. As a result I make five recommendations relating to healthcare provision at Belmarsh. I identify one area of good practice.

THE INVESTIGATION PROCESS

8. The Ombudsman was notified of the man's death on 7 August 2010. The investigation was allocated to one of my senior investigators who visited Belmarsh on 13 August to open the investigation.

9. My investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. There was no response to the notices. My investigator was provided with copies of the man's prison and medical records covering his brief time at Belmarsh.

10. NHS Greenwich commissioned three clinical reviewers to review the clinical care the man received at Belmarsh. My office only received the review in late January 2011, which has meant that my own report is delayed. The reviewers and my investigator carried out joint interviews with staff in December 2010. In addition, the reviewers interviewed other staff and provided to my investigator with transcripts of the interviews. The Governor of Belmarsh was given written feedback from the interviews in January 2011.

11. One of the interviewees, the Head of Healthcare, was interviewed in relation to strategic issues relevant to this investigation and the investigation into the recent death of another prisoner at Belmarsh. The transcript of that interview has been redacted to remove the references to the other prisoner and specific details relating to that investigation and it is annexed to this report. The transcripts of other interviews conducted by my investigator are also attached as annexes to this report.

12. The doctor who assessed the man at reception no longer works at Belmarsh and could not be traced so that he could be interviewed for this investigation.

13. HM Coroner for the Inner South London district was notified of the investigation and provided the results of the post mortem. The Coroner will receive a copy of this report to assist with his enquiries.

14. One of my family liaison officers contacted the man's sister to explain the purpose of my investigation and invite her to raise any questions or concerns. The man's sister raised no specific concerns about her brother's death.

15. The man is the 11th prisoner to die of natural causes at Belmarsh since the Ombudsman began investigating all deaths in prison in 2004. In two investigation reports relating to deaths in 2005, the Ombudsman raised similar concerns about the thoroughness of physical examinations and the identification of prisoners' physical needs by healthcare staff.

HMP BELMARSH

16. HMP Belmarsh is a local prison in south London serving the Central Criminal Court and other courts in the surrounding area. It can hold up to 910 adult male prisoners, predominantly those on remand from court. It also accommodates category A prisoners and so is part of the high security estate. There is a separate high secure unit, holding high and exceptional risk category A prisoners. (The man was not a category A prisoner and he was not held in the high secure unit.)

17. The National Offender Management Service (NOMS) publishes quarterly performance ratings for all prisons in England and Wales. The ratings are based on a set framework and prisons can be rated from one to four (with four indicating 'exceptional' performance). Belmarsh has achieved a rating of three ('good' performance) for the last four published quarters.

HM Chief Inspector of Prisons (HMCIP)

18. The prison last underwent an unannounced full follow up inspection by HMCIP in April 2009. The inspection report acknowledged that Belmarsh is a "large and complex" prison, having to meet high security standards while supporting the majority of low risk prisoners.

19. The Inspectorate reported that the reception area was "unwelcoming and intimidating", but that prisoners were quickly moved to the much brighter first night unit. Substance misusing prisoners received a "good level of care" however there had been "no progress" in health services. Although first night screening was found to be good, clinical records were poor and prisoners experienced long delays in seeing doctors. Not all staff had received annual resuscitation training and training records were poorly maintained.

20. At the time of the last inspection, healthcare services were provided by NHS Greenwich. In the course of this investigation, the Head of Healthcare confirmed that the service would be run by a private company, Harmony for Healthcare, from early 2011.

Independent Monitoring Board (IMB)

21. Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community. Board members have full access to every part of the prison and all prisoners held there. The Board must produce an annual report, with the latest available for Belmarsh covering July 2008 to June 2009.

22. The Board noted the complex task of managing the prison but concluded that "security … can, on occasions, be used as a cover for unreasonableness or lack of information". However, the primary concern was the "unsatisfactory state of healthcare", although some of their concerns may have been addressed by the introduction of the electronic medical system in October 2009. The Board also noted "generally increasing clarity" over the relative roles of prison and

healthcare staff. They were “optimistic” that their concerns had been taken seriously and a way forward would be developed.

KEY EVENTS

23. On 5 August, the man and his three co-defendants appeared at Bexley Magistrates' Court charged with conspiracy to supply Class A drugs, having been arrested by the police on 3 August. The Person Escort Record (PER) which accompanied him from the police station to the court noted that he suffered with asthma and was a heroin user. (The PER Part A highlights any risks the escorted prisoner may pose to themselves and others. Part B serves as an ongoing record of the prisoner's time whilst being escorted and should be updated by escort staff during the day.) Escort staff checked him at regular intervals during the day and recorded that he was "ok". There is no record of the man having complained of feeling unwell. Following his court appearance, he and his co-defendants were remanded into custody and arrived at Belmarsh at 4.15pm.

24. Shortly after his arrival at the prison, staff completed a Security Information Report (SIR) which reported that the man's co-defendants had "problems" with him. (SIRs must be completed by anyone working in a prison who has concerns about or knowledge of activities which potentially compromise the security of the establishment or the safety of prisoners or members of the public.) As a result, staff directed that the man should be placed in a single cell, for his own safety.

25. Officer A completed the Cell Sharing Risk Assessment (which assesses the risk a prisoner poses to other prisoners and whether they are suitable for sharing a cell). The officer noted that the man was dependent on heroin but posed a low risk to other prisoners. The man said he had no concerns about sharing a cell. The officer wrote, however, that he was a Rule 45 prisoner "due to conflict with his co-defendants". (Rule 45 prisoners, also known as vulnerable prisoners, are usually kept separately from the general prison population. They may be deemed vulnerable because of the nature of their offence, or because they are less able to cope with prison life.)

26. At 5.15pm, the man was assessed by Nurse A, who completed the First Reception Healthscreen. (This is designed to highlight any immediate mental or physical health problems requiring referral to the doctor or other specialist service). Nurse A was interviewed as part of this investigation. She said that the man was "pacing" outside the treatment room before the assessment and seemed "eager" to see the nurse. Her first impressions of him were that he was very weak and fragile looking. On beginning the assessment, Nurse A found that he was anxious to be prescribed methadone (a heroin substitute often prescribed to heroin users, although it can be obtained illicitly).

27. Nurse A recorded details of her assessment in the medical records. She noted that the man had a history of heroin use, and that he had used it within the last month. He told her that he had previously suffered with mental health problems, but had no thoughts of harming himself.

28. The man told the nurse that he had an appointment at the hospital in the next few weeks. In interview she said that he did not give her many details about the appointment, but she thought that it was in relation to a chest problem. Having

completed the assessment, she recorded that the man should see the prison doctor because he suffered with asthma, was a drug user, had a chest problem and was prescribed two inhalers: tiotropium (used to treat chronic pulmonary obstructive disease – a lung disease where the airways become narrowed) and salbutamol (for asthma). The nurse wrote that the man looked "very frail … weak and tired". She noted that he "appears stable" but was withdrawing from heroin. In interview, the nurse said that he was not breathless and did not appear to be in any distress, although he was beginning to get "agitated and … loud" because he wanted to be given methadone. She said that, in her view, he needed to be admitted to healthcare as an inpatient because of his physical condition.

29. A locum doctor and the detoxification nurse (part of the team responsible for the healthcare of substance misusing prisoners) examined the man at 7.20pm. The man repeated that he had a history of drug misuse and sometimes bought methadone from drug dealers. His urine was tested for the presence of drugs and showed that he had benzodiazepines (a sedative), methadone and cannabis present in his body. The man said that he had been losing weight and the doctor noted that he looked "grossly underweight and fragile". His blood pressure and pulse rate were "not recordable" (no further information about this was recorded). The doctor instructed that the man should be admitted to the healthcare centre and prescribed loperamide (to prevent diarrhoea), five milligrams (mg) of diazepam (a sedative drug which can help to reduce anxiety), a salbutamol inhaler and a tiotropium inhaler. Healthcare staff were directed to monitor the man's fluid intake and output and take his blood pressure and pulse readings. He was to be assessed by a substance misuse doctor the following day in relation to his drug detoxification and nutritional needs. (Unfortunately, the locum doctor no longer works at Belmarsh and could not be traced during the investigation.)

30. The man was admitted to inpatients and given a bed on the ward (which holds up to six prisoners). At 10.55pm, Nurse B made an entry on the man's medical record. She noted that the detoxification nurse had not been able to obtain a blood pressure or pulse reading from the man and so she did so at 10.45pm. His blood pressure reading was 90/45, which was low (the normal range is 120/80). The nurse noted that the man sounded "very chesty" and would need to be examined by a doctor the following day. She also recorded that his outside hospital appointment needed to be confirmed. She directed that nursing staff should monitor him every day and liaise with the doctor and detoxification team as necessary.

31. Nurse B was interviewed by the clinical reviewers. She explained that the man had already been admitted to the ward and was asleep in bed when she began her shift at 8.30pm. She was told that he had been admitted to undergo a detoxification programme. At about 10.00pm, Nurse A and the detoxification nurse in reception came to the healthcare centre. "In passing", they mentioned that the nurse and doctor had not been able to read the man's blood pressure. Nurse B said that she thought it "strange" that staff on the inpatients unit had not been told of this earlier.

32. During the night, access to prisoners in cells or on the inpatients ward is restricted for security reasons. Discipline staff on duty in the healthcare centre carry a key, contained in a sealed pouch, which unlocks the cells and wards in the inpatients unit. In an emergency, staff can break the seal and use the key. (If the seal is broken, staff must complete paperwork to account for this. This measure is in place at night in all prisons in England and Wales.) If staff are unsure, they can ask the night manager to attend.

33. Nurse B asked for the night manager to attend so that the ward could be unlocked and she could check the man's blood pressure. She told the clinical reviewers that, although the reading was low, he was not in any distress or complaining of pain and had been asleep. Therefore the nurse thought that he should be allowed to rest for the remainder of that night. However, she thought that he needed to be checked by a doctor the next morning. She explained that she would have told the day staff relieving her in the morning that the man needed to be seen by a doctor, and it was their responsibility to ensure that this happened. Nurse B did not make any additional record that the man needed to be seen by a doctor in his medical record.

34. The following morning, 6 August, the man was assessed by the detoxification team doctor, Dr A. Dr A noted the man's "chronic history of heroin abuse". The man told the doctor that he had last used the community drugs services about four years ago, when he was prescribed 70 millilitres (ml) of methadone a day. He said he had been buying between 50 and 100 ml of methadone from drug dealers as well as using heroin. He said he had last taken 70 ml of methadone the previous day (5 August).

35. The doctor recorded that the man "looks unwell with difficulty breathing due to his uncontrolled asthma". The doctor placed the man on a methadone detoxification which means that a reducing dose of methadone is prescribed until the individual no longer requires it, starting with 30 ml to be given that day. He also prescribed a nutritional milkshake to help increase his weight and build his strength.

36. Dr A was interviewed as part of this investigation. He said that the man was unhappy that he was only being prescribed 30 ml of methadone and wanted a higher dose. The doctor explained that the man could not be prescribed a higher dose because he had not been given a methadone prescription in the community and so it was not possible to confirm the correct dose. In addition, the doctor explained that a higher dose would not have been appropriate given the man's breathing difficulties. (In large doses, methadone can cause low blood pressure, suppress breathing and lead to an irregular heartbeat.) The doctor said that the man was given his first dose of methadone at 2.00pm that day.

37. In interview, Dr A was asked whether he had physically assessed the man during his appointment. He said that he took the man's pulse rate and did some "observations" but did not carry out a full physical examination. The doctor explained that he thought the man had already been examined by a doctor, given that he was an inpatient. The doctor told the investigator that the substance misuse team were only responsible for managing the substance misuse related

needs of prisoners and that any other health needs should be managed by the general doctors or other specialist services.

38. During his appointment with the man, Dr A noted that he was breathless and his breathing was “laboured”. The doctor assumed that, because the man had been prescribed inhalers, he suffered with asthma. However, he said that he had not looked at the man’s medical record before the appointment.

39. Officer B, Nurse C and Nurse B were working in the healthcare centre overnight on 6 August. At about 2.30am, they heard banging and shouting from one of the wards. On checking, they found the man banging on the Perspex window separating the ward from the staff office. He said that he could not breathe and thought he was dying. Officer B telephoned the night manager, Developing Prison Service Manager (DPSM) A asking him to attend. DPSM A and three other members of staff arrived at the healthcare centre within about five minutes and unlocked the ward.

40. Nurse B and Nurse C examined the man, measuring his blood pressure (which was now 60/30), pulse, blood sugar level and oxygen saturation levels. Nurse C listened to the man’s chest which she described as sounding “rattley”. The nurses were concerned by his very low blood pressure. The man told the staff that his chest hurt and he thought he was dying. The nurses made him comfortable in his bed and gave him his inhaler, which he promptly used. Nurse B told the clinical reviewers that she could not remember whether they had given the man any treatment, such as oxygen, aspirin or carried out an electrocardiogram (ECG, which measures the heart beat and shows whether the heart is functioning normally). The two nurses told the DPSM that the man needed to be taken to hospital.

41. DPSM A said that he needed the on call doctor to confirm that the man needed to be taken to hospital. He contacted the control room who said that the on call doctor’s contact details were not available. The on call clinical lead, was contacted and spoke to Nurse B. The on call clinical lead confirmed that the man should be taken to hospital.

42. In interview with the clinical reviewers, DPSM A was asked about the procedure for calling an ambulance. He explained that if the nurses request that an ambulance should be called, he would seek confirmation from the on call clinical lead. (The on call clinical lead is not based in the prison at night but can be contacted by telephone at any time.) DPSM A said that he would then contact the duty governor (who is also contactable by telephone) and inform them. However, he explained that, in an emergency, the night manager uses their judgement as to whether an ambulance needs to be called.

43. At 2.55am, 25 minutes after the man alerted healthcare staff, DPSM A asked the staff in the control room to call 999 for an emergency ambulance.

44. DPSM A explained that when the nurses examined the man, they gave no indications that it was an emergency or that he was seriously unwell. He described them as being “calm” and making a “measured decision” having

carried out tests on him. He could not remember whether the nurses said that they thought the man might be having a heart attack. In the circumstances, he did not think there had been an undue delay in calling an ambulance.

45. Nurse B told the clinical reviewers that the man's blood pressure was "very low", he was clearly in pain and distress and that, as a result, she was "very concerned" and thought he needed to go to hospital "immediately". She told the reviewers that DPSM A asked if the man really needed to go to hospital or whether he could be treated at the prison. The nurse thought that she made the seriousness of the situation clear to the DPSM and said that she had not expected him to challenge her view. Nurse C was also interviewed by the clinical reviewers. She was surprised that the DPSM sought further authority before calling for an ambulance.

46. A London Ambulance Service single responder arrived at the prison at 3.05am. (Single responders are paramedics who work alone, usually in specially designed cars or on motorbikes. They are often sent to an incident as well as an ambulance as they may be able to reach the location more quickly and begin delivering medical treatment.) Another single responder arrived four minutes later and an ambulance arrived at 3.11am. The paramedics reached the man at about 3.20am.

47. The paramedics agreed that the man needed to go to hospital and transferred him to the ambulance. Due to concerns about his low blood pressure, the paramedics worked for some time to stabilise his condition before leaving for the hospital at 4.06am.

48. When a prisoner leaves prison for an appointment or in an emergency, a risk assessment is undertaken. The purpose of the risk assessment is to assess the risk to the public if the prisoner escaped. The level of risk decides how many staff must accompany the prisoner and whether the prisoner needs to be restrained. Because the man had not been at the prison for very long and little was known about him, the risk assessment meant that two officers (Officer C and Officer D) accompanied him in the ambulance. The man was handcuffed to Officer C for the duration of the journey.

49. The ambulance arrived at the Queen Elizabeth Hospital at 4.35am and staff carried out an electro cardiograph (ECG) and took blood for testing. Shortly after, a hospital doctor asked for a second ECG to be carried out.

50. At about 7.20am, the man became unresponsive and stopped breathing. The officers conducting the bedwatch alerted the hospital staff and the man was moved to the resuscitation room. Officer C removed the handcuffs from the man and hospital staff began cardio pulmonary resuscitation (CPR). At 7.45am, they established that the man had a weak pulse. He regained consciousness but had difficulty breathing. Hospital staff continued to treat him. Officer C and Officer D decided not to reapply the handcuffs but stayed with the man all the time. DPSM B authorised the decision not to reapply handcuffs.

51. At about 9.00am, hospital staff told the officers that the man had suffered a heart attack earlier that morning and needed to be transferred to St Thomas' Hospital as soon as possible for further treatment. At about 10.10am, the man was taken by emergency ambulance to St Thomas', arriving at about 10.50am. He was taken straight to the operating theatre where surgeons immediately began to operate. At about 12.25pm, the man's condition deteriorated. Despite efforts to save him, he died at 12.50pm.

Contact with the man's family

52. On his arrival at Belmarsh, the man had been asked to give the contact details for his next of kin, but he refused to do so. At 9.30am on 7 August, when the seriousness of his condition was clear, DPSM B contacted Thames Valley Police for help tracing members of the man's family. In the meantime, the prison Imam was asked to go to St Thomas' Hospital to be with the man.

53. Prison staff spoke to one of the man's co-defendants, who was able to give some information about the man's family. He did not know the addresses of any family members but knew the area in which the man's brother lived. The information was passed to Thames Valley Police. Eventually, on 8 August, the police traced the man's sister. Governor B, the establishment's family liaison officer contacted HMP Reading (the closest prison to the sister's address) and asked if they could send a family liaison officer to break the news of the man's death. Reading agreed and visited her that evening.

54. The following day, 9 August, Belmarsh's Imam and the family liaison officer visited the family.

Support for prisoners and staff

55. Governor B broke the news of the man's death to his co-defendants on 7 August. The prison Imam was also present and offered them support. Other prisoners were informed of his death by way of a Governor's Notice to Prisoners.

56. After the man had been taken to hospital, DPSM A said that he and the other staff on duty discussed what had happened. On their return from the hospital, the escorting officers were offered the support of the prison Care Team. Governor B spoke to affected staff on the afternoon of 7 August.

Post mortem

57. The post mortem gave the cause of the man's death to be heart failure, with contributing factors listed as a heart attack and a blockage in the arteries supplying blood to the heart.

ISSUES

Clinical care

58. NHS Greenwich commissioned three people to consider the clinical care provided to the man by Belmarsh. The review highlighted a number of shortcomings in the care which the man received and the reviewers make nine recommendations as a result. Some of the recommendations have been incorporated into this report. I urge the relevant organisations and individuals to read and act upon the review in its entirety.

59. The reviewers conclude that the first reception healthscreen carried out by Nurse A identified the man's main health concerns, namely his substance misuse, poor physical condition and past mental health problems. However, they found that the doctor's assessment that followed Nurse A's review was "deficient with inadequate examination, no management plan and no follow up arranged for a GP to visit [the man] on the [inpatients] ward".

60. In particular, although the man's cough and chest problems were identified, there is no evidence that any further investigation of them took place while he was at Belmarsh. The reviewers concluded that no "peak flow" tests were taken, despite the man seemingly suffering with asthma and chest problems. (This test provides a measure of how well the lungs are working and is commonly carried out with patients who suffer from conditions that affect their breathing.) The man told the locum doctor that he was prescribed a tiotropium inhaler. This medicine is generally prescribed to patients suffering with chronic obstructive pulmonary disease, not asthma, but the doctor did not explore this any further with the man. No disease management plan was implemented at this stage. In addition, although the reception doctor could not read the man's blood pressure, nothing was done to follow this up.

61. Following the doctor's assessment, the man was admitted to healthcare as an inpatient. His blood pressure and pulse readings were taken at 10.45pm on 5 August. The locum doctor recorded in the medical record that the man's fluid intake and output and his blood pressure and pulse should be monitored by nursing staff. However, the reviewers found that no other entries were made in his medical record until 2.45am on 7 August, when the man complained of feeling unwell. The clinical reviewers noted:

    > "We would have expected that his vital readings of pulse, blood pressure, temperature and peak flow would have been taken regularly and at least once a day, but in view of his physical state, good practice would suggest two or three times a day, with urgent action being taken regarding his poor breathing and low blood pressure."

62. The reviewers found no evidence to suggest that the man was physically examined by a doctor on 6 August, or that any nursing staff asked for a doctor to check him – despite his recognised poor physical condition. They conclude that he should have been properly assessed on 6 August and a care management

plan put in place and followed. The clinical reviewers make the following two recommendations:

The Head of Healthcare should confirm that written policies and procedures are in place to ensure that inpatients are examined by a doctor in a timely fashion.

The Head of Healthcare should ensure that care management plans are recorded in the patient's medical record and followed accordingly.

63. Later during the day of 6 August, the man was assessed by prison doctor A, from the substance misuse team. This assessment was in relation to his admission that he was dependent on heroin. In interview, the doctor confirmed that he had not carried out a physical examination of the man, nor had he read the medical record. I understand that the doctor has a specialist role to provide substance misuse treatment. Nevertheless, by all accounts the man already looked frail and unwell. While an appropriate management plan was set up to manage the man's withdrawal symptoms, this was another opportunity which was missed to properly explore his other medical conditions.

The Head of Healthcare should remind clinicians to review a patient's clinical records before assessing them.

The deterioration in the man's health on 7 August

64. At about 2.30am on 7 August, the man began banging on the window separating the locked ward he was on from the staff office. He was complaining that he could not breathe and said that he thought he was dying. The staff on duty (two nurses and a discipline officer) called for the night manager, DPSM A, to attend. Although they were allowed to unlock the cell without his permission or presence, they decided to wait until he arrived before going into the ward. Those interviewed as part of this investigation said that DPSM A arrived within about five minutes. I think, in the circumstances, it was reasonable for them to wait for more staff to arrive before unlocking the ward (which holds six prisoners).

65. Once the ward was unlocked, Nurse C and Nurse B examined the man and took his blood pressure reading, which was very low. Nurse B told the clinical reviewers that the symptoms the man described did not clearly indicate that he was having a heart attack. The nurses encouraged him to use his inhalers. They did not give him any aspirin or carry out an ECG and the two nurses could not recall whether they gave him any oxygen. In any case, they decided that the man needed to go to hospital and told DPSM A that an ambulance should be called. However, the DPSM wanted confirmation of the seriousness of the man's condition from the on call doctor. When the doctor could not be contacted, the on call clinical lead was telephoned instead. Having spoken to one of the nurses, the on call clinical lead agreed that the man needed to be transferred to hospital.

66. In interview, DPSM A explained that it was normal procedure for the night manager to seek further clarification from either the on call doctor or clinical lead

before agreeing that a prisoner should be taken to hospital. He added that this was not necessary if it was clearly an emergency situation. DPSM A said that the nurses assessing the man did not suggest that their request for an ambulance was urgent. In interview, the nurses both thought the challenge to their decision had been unusual, and that they had made it clear that the man's situation was serious.

67. The ambulance was eventually called at 2.55am and the first paramedic arrived at the prison at 3.05am, 35 minutes after the man called for help. The clinical reviewers conclude that, had the man been in the community rather than in prison, his transfer to hospital would, in all likelihood, have occurred much more quickly.

68. I acknowledge that staff working in a prison, and especially those in the high secure estate, must balance security considerations with the specific needs of the prisoners. However, I believe that a healthcare decision that an ambulance is required should be followed. The prison's policies must reflect that they, ultimately, are responsible for making decisions relating to the health needs of prisoners. It is my view that calling an ambulance was unduly delayed by the unnecessary requirement that either the on call doctor or clinical lead be contacted. After all, they could only act on the information provided over the telephone by the nurses, given that neither is based in the prison at night. On that basis, I make the following recommendation:

    The Governor and Head of Healthcare should review the policies for calling an ambulance at night and ensure that nursing staff are given the authority to decide when one is necessary.

69. The clinical reviewers were also concerned that there were no written policies or procedures for managing common medical emergencies (for example, heart attacks or asthma attacks). Nursing staff interviewed had received updated resuscitation training but no training for other medical emergencies had been provided. I have recently published a thematic investigation of deaths due to chest pain and found that a prompt and efficient emergency response is instrumental in determining whether prisoners survive. The following recommendation is made as a result of this finding:

    The Head of Healthcare should develop written procedures for dealing with acute medical emergencies and implement them through a rigorous training programme and regular practice exercises.

70. This investigation and the clinical review have highlighted shortcomings in the response to the man's deteriorating health. However, the clinical reviewers conclude that "it is unlikely that in this case improved management would have made any difference to the final outcome".

71. Having considered all aspects of the clinical care provided by Belmarsh to the man, the reviewers conclude that it was not equitable to what he might reasonably have expected to receive in the community. This is a disappointing

finding and I urge both the Governor and Head of Healthcare to seriously consider all aspects of the clinical review.

The prompt removal of restraints

72. Within hours of being admitted to hospital, the man suffered a serious heart attack and had to be resuscitated by hospital staff. The restraints were removed while medical staff worked on the man. The two escorting officers decided that the handcuffs should not be reapplied when the man regained consciousness. Their decision was supported by the duty governor. I consider this to have been an appropriate and sensitive decision.

Family liaison

73. When the man arrived in prison he refused to give details for his next of kin, or someone who he would want to be contacted in an emergency. Once he had been taken to hospital and was clearly very unwell, the prison went to great lengths to notify his family. I think it was a very sensitive and compassionate decision to ask the prison Imam to visit the man in hospital in the absence of his family. I am also pleased to see that the prison, Thames Valley Police and HMP Reading worked together to locate and inform the man's family. I consider the family liaison in this case to be an example of good practice.

CONCLUSION

74. The man arrived at Belmarsh on 5 August 2010. Healthcare staff who assessed him that day noted that he was frail, weak and had existing health problems. In addition, he said that he was dependent on heroin. He was examined by a doctor in reception but his physical health needs were not properly investigated. Although I am satisfied that his substance misuse needs were met, I do not think that his physical health was properly assessed.

75. In the early hours of 7 August, the man complained of chest pains. Having examined him, nursing staff decided that he needed to be admitted to hospital. Prison procedures meant that confirmation was sought from more senior healthcare staff before an ambulance was called which caused a delay.

76. The man was taken to hospital where he suffered a heart attack. He was transferred to another hospital for surgery, but sadly died there later on 7 August. The clinical reviewers concluded that the clinical care provided to the man at Belmarsh was not of an equitable standard to that he might have received in the community. I criticise the doctors who did not examine him fully, the response to the medical emergency and especially the delay calling an ambulance.

RECOMMENDATIONS

The National Offender Management Service (NOMS) response is included in italics below each recommendation.

1. The Head of Healthcare should confirm that written policies and procedures are in place to ensure that inpatients are examined by a doctor in a timely fashion.

   NOMS accepted this recommendation, responding: "All patients admitted to the unit are immediately assessed by a registered nurse should this holistic nursing assessment determine that a medical assessment is indicated, this will be arranged without delay. All prisoners and inpatients are supported by on site General Practitioners. In the event that a doctor is not on site an on call GP is available 24/7"

2. The Head of Healthcare should ensure that care management plans are recorded in the patient's medical record and followed accordingly.

   NOMS accepted this recommendation. "An electronic Clinical record system was implemented in May 2010. Every inpatient has an embedded personal care plan which is subject to regular review and regular clinical audit. The clinical care plan is revised by the multi disciplinary team on a weekly basis."

3. The Head of Healthcare should remind clinicians to review a patient's clinical records before assessing them.

   NOMS partially accepted this recommendation: "The Head of Healthcare has written to all doctors reminding them to comply with this recommendation In urgent circumstances, the attending doctor will tend to the patient before consulting the clinical records."

4. The Governor and Head of Healthcare should review the policies for calling an ambulance at night and ensure that nursing staff are given the authority to decide when one is necessary.

   NOMS accepted this recommendation: "The policy for calling an ambulance and effectively managing the egress and exit from the prison is regularly reviewed to ensure unnecessary delays are eradicated, delays are minimised and security is maintained at the highest level."

5. The Head of Healthcare should develop written procedures for dealing with acute medical emergencies and implement them through a rigorous training programme and regular practice exercises.

   NOMS accepted this recommendation: "Every registered nurse required to participate in the emergency response service is required to maintain regular and mandatory training, including the Immediate Life Support Qualification, issued by the Resuscitation Council for the UK. The qualification is examinable and requires annual completion.

The emergency response service has recently been re designed to further improve efficiency and effectiveness. The service provides a decentralised and multidisciplinary approach to supporting prisoners in clinical emergencies. Regular live contingency exercises are planned and scheduled for 2011 onwards."