Investigation into the circumstances surrounding the death of a man at HMP Kingston in June 2011

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

The man was 67 years old when he died at HMP Kingston in June 2011. He had spent the previous decade in custody. He had a history of heart disease and had undergone major surgery in 2008 for a number of aneurysms in his arteries. (An aneurysm is a balloon-like bulge in the wall of a blood vessel. These can rupture and cause complications.) The operation did not prevent further aneurysms from developing. He was a smoker and had high blood pressure and high cholesterol.

On the morning of 15 June, another prisoner found the man having a heart attack in his cell after their cells were unlocked. The Modern Matron, who is responsible for healthcare at Kingston, attended immediately and performed cardiopulmonary resuscitation. Despite a prolonged resuscitation effort and the assistance of paramedics, he was declared dead when he arrived at hospital. The post mortem showed that he died after the previously repaired aneurysm expanded, obstructed the supply of blood to his heart and caused a heart attack.

The investigation was completed by an investigator. Our Senior Family Liaison Officer was unable to speak with any of the man's relatives because he chose not to nominate a next of kin.

A clinical review of the treatment which the man received in prison was undertaken by a clinical reviewer, who was appointed by the local PCT. He assessed whether the care that the man received in custody was comparable to that he could have expected in the community.

I am satisfied that healthcare staff responded immediately when the man was found in his cell. The effort to resuscitate him was extensive and lasted nearly two hours. I do not think that the Modern Matron and her colleagues could have done more. However, the investigation has found that the officer who unlocked him that morning did not check him as he was required to do and therefore did not see that he was in distress. Instead, it was a fellow prisoner who discovered him a couple of minutes later. This issue was apparent when another man was found dead in his cell by the same prisoner in 2009. I make a recommendation in this regard.

I make five other recommendations as a result of the investigation and the clinical reviewer's review. These relate to clinical record keeping, the need for some discipline staff to have basic life support training and the importance of discipline staff calling an ambulance without waiting for a nurse's authorisation.

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
Prisons and Probation Ombudsman **December 2011**

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SUMMARY

1. The man was remanded into custody in 1999 for sexual offences. He received a life sentence in 2000. He moved from HMP Elmley to HMP Frankland and HMP Albany before transferring to HMP Kingston in Portsmouth in October 2004.

2. He had a history of high blood pressure and raised cholesterol. He developed symptoms of arterial disease and in 2008 underwent major surgery in hospital for three aneurysms in different arteries. The operation did not prevent other aneurysms from developing.

3. After his surgery, he continued to attend annual outpatient appointments. The consultant monitored his remaining aneurysms. He was prescribed aspirin (for heart disease), amlodipine (to treat high blood pressure), atorvastatin (to lower cholesterol), candesartan (to treat high blood pressure), enalapril (to treat high blood pressure and chronic heart failure) and glyceryl trinitrate (GTN) spray (for angina).

4. In early 2011, the man complained about pain in his groin and a hernia which had developed as a result of his surgery. He attended outpatient appointments to plan further treatment.

5. On 15 June, the prisoners' cells were unlocked at 8.10am. A couple of minutes later, a fellow prisoner went to see him and found him having a heart attack. He raised the alarm and the Modern Matron, who is responsible for healthcare at Kingston, attended immediately because she was only yards away in the healthcare centre. She requested an ambulance and began cardiopulmonary resuscitation. Despite her best efforts and the efforts of staff and paramedics, he did not recover and died after he arrived at hospital.

THE INVESTIGATION PROCESS

6. The investigator was informed of the man's death on 15 June 2011. Notices were issued to staff and prisoners at HMP Kingston telling them about the investigation process and inviting them to contact my investigator.

7. He liaised with one of the governors at Kingston during the investigation. He visited the prison on 21 June to speak to staff and collect paperwork relating to the man's time in custody.

8. The investigator contacted NHS Portsmouth to commission a clinical review into the medical treatment which the man received in custody. The purpose of the review is to establish whether the care which he was offered in prison was comparable with that he could have expected in the community. The clinical reviewer completed the review.

9. On 27 June, we received an anonymous telephone call from a woman claiming to be a partner of one of the prisoners at Kingston. She made a number of allegations about the healthcare at Kingston. My staff received another anonymous telephone call, presumably from the same woman, on 4 July.

10. The investigator returned to Kingston on 2 August to interview the Modern Matron in charge of healthcare. He was accompanied by the clinical reviewer and another investigator, who has investigated another death at Kingston. The Modern Matron's line manager was also present during the interviews. Both investigators each conducted separate interviews about their individual investigations. They also conducted a joint interview with the Modern Matron about the anonymous allegations we had received.

11. Both investigators visited the healthcare department and A wing (where the man had lived), and also spoke to the prisoner who found him on the morning he died. They met the Governor and provided verbal feedback about the findings of both investigations. My investigator subsequently wrote to the Governor outlining the preliminary findings of the investigation.

12. The investigator wrote to the local Coroner's office at the start of the investigation to inform them of its nature and scope. HM Coroner will be provided with a copy of this report.

13. The man did not provide prison staff with any details of his next of kin. They were unable to contact any of his relatives after his death. He had not received any personal visitors at Kingston, or any letters, and he had not made any personal telephone calls. My family liaison officer was also therefore unable to get in touch with any family members to speak about the investigation. A copy of the draft report was not therefore sent to a family member and there were no comments from any relatives to include in this final report.

HMP KINGSTON

14. HMP Kingston is located in Portsmouth, Hampshire. The prison can hold a maximum of 200 men. All of the prisoners are serving indeterminate or life sentences. Accommodation consists largely of single occupancy cells.

Healthcare

15. Healthcare services at HMP Kingston are commissioned by Portsmouth City NHS Teaching Primary Care Trust (PCT) and provided by Solent PCT. The Modern Matron at Kingston is responsible for the delivery of healthcare. She also practices as a nurse prescriber. Her staff consists of two primary care nurses (both cardiac trained), a mental health nurse, an administrator and two nurses who deliver the Integrated Drug Treatment System (IDTS) to prisoners with drug and alcohol problems.

16. Visiting General Practitioners hold surgeries on Mondays, Wednesdays and Fridays. The nursing staff work from 8.00am until 6.00pm on weekdays and from 8.30am until 1.00pm on weekends. At all other times, there are no healthcare staff on site and prison officers have to contact an out of hours service for advice if a prisoner becomes unwell. Prisoners can collect their daily medication from the dispensary at 8.15am, midday and 4.30pm.

HM Inspectorate of Prisons

17. HM Chief Inspector of Prisons inspected Kingston in August 2010. He made the following comments:

> 'Kingston is a small specialist prison for life- and other indeterminate-sentenced prisoners. This very positive report, of a full announced inspection, is testament to the benefits that can flow from having a small-scale niche prison, with a settled population. The inspection reaffirmed previous findings that Kingston is a safe and decent place, and also applauded the purposeful regime and sound focus on addressing the risks posed by the very serious offenders in the prison's care.
>
> 'There was a reasonable range of clinics for primary care and lifelong conditions.
>
> 'In our survey, more respondents than the comparator said they found it easy to access a health professional.
>
> 'Prisoners had no problems accessing clinics and continuing treatment at local general hospitals.'

Independent Monitoring Board (IMB)

18. The most recent annual report published by the Independent Monitoring Board (IMB) at Kingston covers the year from January to December 2010. (The IMB at each prison is made up of members of the public who are both independent and

unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB wrote:

> 'The prison benefits from an excellent healthcare service. Although provided through the local NHS Trust, the service is extremely well integrated into the management of the prison and the inclusion of the Modern Matron as a member of the Senior Management team ensures very effective joint working.
>
> 'The Board continues to be reassured to know that prisoners in Kingston receive the same quality of primary health care services as they would from a GP practice in the community.'

Previous deaths at Kingston

19. I am currently investigating the death of another man at Kingston in June 2011. The draft report of that investigation was also recently published. The post mortem found that the man had died of cancer. I am also still investigating the death of another man in December 2009. (I have waited to complete that investigation whilst the police concluded their own enquiries.) As I discuss in the 'Issues' section of this report, the man's death bore some similarities to the man's. Both men were found after their cells were unlocked in the morning by the same prisoner. Both had suffered heart attacks. In neither case did the unlocking prison officer apparently observe that the men were unwell. The other man had died overnight, whilst the man was still alive when he was found and died in hospital after efforts to resuscitate him failed.

KEY EVENTS

20. The man was convicted of committing sexual offences against children in 1963, 1973, 1976, 1978, 1994 and 1996 and had previously served custodial sentences. He committed further sexual offences against a child between December 1998 and July 1999. He was remanded into custody in August 1999 and taken to HMP Elmley. On 16 February 2000, he was convicted of the new offences. He received a life sentence at Crown Court on 15 June. The judge declared that he should serve a minimum of nine years in prison.

21. In January 2001, the man transferred to HMP Frankland before moving to HMP Albany in October 2003. His heart disease, high blood pressure and raised cholesterol are recorded in the clinical record. He was a smoker.

22. The man moved to HMP Kingston on 28 October 2004. During the next few years, he developed aneurysms in his arteries. (An aneurysm is a balloon-like bulge in the wall of a blood vessel. The arteries are large blood vessels. Aneurysms can rupture and cause complications.) He attended outpatient appointments with a consultant transplant and vascular surgeon at hospital. He occasionally reported chest pains, and on one occasion he collapsed and was escorted to the local hospital's accident and emergency department. He was prescribed glyceryl trinitrate (GTN) spray to treat symptoms of angina.

2008

23. On the advice of the consultant, the man was admitted to hospital between 19 and 27 May 2008. He underwent major surgery for an abdominal aortic aneurysm (AAA), right-sided common iliac artery aneurysm and right-sided common femoral artery aneurysm. A left-sided femoral artery aneurysm was not operated on and was to be monitored.

24. The aorta is the largest artery in the body. It begins at the heart and extends down to the abdomen, where it branches off. An AAA is an expansion of the part of the aorta located in the abdomen. The iliac arteries are two large arteries which branch off the aorta and are located near the pelvis. The femoral arteries are found in the thigh.

25. In early June, the man's solicitors wrote to the Governor to complain about their client being double handcuffed throughout his stay at the hospital. (His arms had been cuffed together using one set of handcuffs, whilst he was handcuffed to an escort officer with the other pair.) They asked for him not to be handcuffed in hospital whilst he was sedated.

26. The Governor replied stating that the man had been restrained using an escort chain whilst he underwent treatment. (An escort chain is a length of chain with handcuffs on both ends. This allows the escort officer to remain at a distance and allows the hospital staff to more easily treat the patient.) He wrote that restraints could not be removed entirely because of the risk that he presented and the nature of his offending behaviour.

27. On 18 June, the man was diagnosed with a post-operative wound infection. He was readmitted to hospital for six days until 24 June. He attended a further outpatient appointment at the consultant's clinic on 25 July. The consultant planned a further review in 12 months.

2009

28. On 16 October 2009, the man was taken to hospital for an outpatient appointment. The consultant found that the aneurysm in his left femoral artery had expanded. The man behaved aggressively and complained to the consultant that his operation the previous year had resulted in erectile dysfunction. He threatened to sue the surgeon. The man declined further surgery for the time being and a further review was scheduled for 12 months time.

2010

29. Staff were called to the man's cell after he became unwell on 22 July 2010. He was taken to hospital later that day. He was prescribed candesartan to treat his high blood pressure.

30. The man was escorted to his annual appointment with the consultant on 15 October. He apologised for his behaviour the previous year. The extent of the aneurysms in his arteries had not significantly changed. The consultant planned an ultrasound scan of both groins to assess the size of the aneurysm in his left femoral artery. (This is a painless technique used to create images of the inside of the body.) The consultant recorded that he did not have an infection in his groin but did have a small hernia. He advised the healthcare staff that he would only repair the hernia if further surgery on his arteries went ahead because of the risk that further general surgery carried.

31. The consultant assessed the man at hospital again on 6 December. He wrote to the healthcare staff, advising that an ultrasound scan had shown that the aneurysms in the left and right arteries in his groin were enlarged. He planned further tests before deciding on the most appropriate treatment.

2011

32. On 14 January 2011, the man complained about his hernia. The area around his femoral artery was swollen. The Modern Matron in charge of healthcare arranged for him to be referred to a general surgeon.

33. Prison Doctor A assessed the man on 18 February. The doctor recorded that he had been experiencing pain in his right groin for about a year and had already been referred to a surgeon. He had a hernia on his groin near his surgical scar and his temperature had increased. The doctor advised him to ask for him again if his condition worsened.

34. A week later, on 25 February, the man was found in a state of 'near collapse'. The pain in his groin was severe. A nurse explained that there was nothing that

she or her colleagues could do to relieve the pain until he received an outpatient appointment for further treatment. She made an appointment for him to see the doctor to discuss pain relief options.

35. Prison Doctor B assessed the man on 28 February. He refused to take pain killers for his groin pain because he was worried that they might interact with his other medication. The doctor persuaded him that he could safely take paracetamol for the pain.

36. On 1 March, a member of healthcare staff (it is not clear from the record who this was) issued the man with a crutch. He scored the 'severe' pain in his right groin as '8 out of 10'. The staff member thought that his description of his pain did not correlate with his ability to move around when he did not think staff were watching him. The staff member thought that his description of 'an artery or vein coming to the surface of his groin' made no sense.

37. The man was escorted to an outpatient appointment with a consultant surgeon at hospital on 14 March. The surgeon assessed his hernia and explained that this was a 'minor consequence' of his 'very big vascular operation'. He told him that surgery was an option but that the general anaesthetic would be a risk because of his poor health and history as a smoker. The surgeon offered him the alternative of a truss (a device used to contain a hernia). The next day, he told staff that he had decided not to undergo surgery and to choose the option of a truss.

38. The man was given an injection of thrombin (a protein used to clot blood) directly into the aneurysm in his right groin at the hospital on 21 March. The procedure had a 'reasonable amount of success'. His condition was reviewed by the consultant on 6 April. He attended a further outpatient appointment for an ultrasound on 10 May to help plan his future treatment. His next outpatient appointment with the consultant at the hospital was scheduled for Friday 8 July.

39. On 24 May, the Public Protection Casework Section of the National Offender Management Service (NOMS) wrote to the man to confirm that, following his latest Parole Board Review, he would neither be released on life licence, nor moved to an open prison. He had not completed any offending behaviour programmes and continued to deny his offences. The risk that he presented to children continued to be assessed as 'very high'.

40. The following day, the man complained that the pain in his groin had been aggravated following a security rub down. The nurse recorded that his groin was swollen, but noted that it was difficult to tell if the swelling was new or associated with his pre-existing condition. On 26 May, an officer recorded that he appeared to be in increased pain and was 'walking even slower than before'.

41. Prison Doctor B assessed the man again on 1 June and ordered blood tests. She advised him to stop smoking but he said that he was not ready. She reviewed the results of these tests on 10 June. She told him that the results were normal and that she would order further tests in six months.

42. On 13 June, the Modern Matron examined a leg ulcer for which the man had been treated and had now healed over. The ulcer did not require any further treatment. He did not report any other significant pain or discomfort.

43. The man's prescriptions were renewed as normal on 10 June. He was given a week's supply of medication at a time using the 'Nomad' monitored dosage system. (This device provides the patient with seven pre-prepared batches of their daily drugs.) His regular medication consisted of:

- aspirin (for heart disease)
- amlodipine (to treat high blood pressure)
- atorvastatin (to lower cholesterol)
- candesartan (to treat high blood pressure)
- enalapril (to treat high blood pressure and chronic heart failure)
- glyceryl trinitrate (GTN) spray (for angina).

15 June

44. The man lived in cell A1-01. Staff unlocked the prisoners on A wing as usual at about 8.10am. When officers move along the landing unlocking cells, they are supposed to have sight of the prisoner through the observation flap before turning the key. However, it would appear that the officer who unlocked his cell did not observe him because they did not notice that he was unwell and raise the alarm. (My investigator requested a statement from the officer who unlocked the cell but managers at Kingston were unable to identify this member of staff.)

45. As soon as his own cell was unlocked another prisoner picked up his own laundry bag and went to collect those of another prisoner and the man. (He did so because the man was now too frail to carry his own laundry.) After he had collected the other prisoner's bag, he knocked on the door to the man's cell. Only a couple of minutes had passed since the prisoners were unlocked. He pushed the door open. As soon as he saw him lying on his bed, he was in no doubt that he was extremely unwell. He told the investigator that he was 'writhing and groaning'. The prisoner asked Officer A who was standing a few feet away to check him. The officer entered the cell.

46. The prisoner and Officer B both rushed around the corner to alert the Matron. The officer asked the matron to urgently assess the man in his cell. The Matron was just about to open the dispensary to distribute the morning medication. (The dispensary is located about 20 yards from the man's cell on A wing.) She immediately picked up the emergency bag and went straight to cell A1-01.

47. When the Matron arrived in the cell, Officer A was checking the man. He was lying fully clothed on his bed and looked pale, sweaty and clammy. The matron asked if he was having chest pains. He could hardly speak but indicated that he was. She told my investigator that he was clearly having a heart attack and so she immediately told the officer to request an emergency ambulance over the radio. Control room staff telephoned the ambulance service at 8.17am. (The Matron later recorded in an internal review of the emergency the need to develop

a code system to improve communication between the attending nurse and the gate lodge when asking for an ambulance.)

48. Officer A asked to his colleague Officer C to assist. The Matron tried to administer two doses of GTN angina spray under the man's tongue to try to ease his chest pain. A Senior Officer (SO) fetched oxygen from the healthcare centre. He returned with the wrong bottle, so had to go back and collect the correct one. The matron then gave him oxygen using a mask.

49. The man stopped breathing. The matron inserted an airway and asked the officers to help her perform cardiopulmonary resuscitation (CPR). Officer C gave chest compressions despite not having current basic life support training. The Matron used an inflatable bag and mask to give breaths to begin with, before swapping with the officer and giving chest compressions. They performed CPR whilst he remained on the bed.

50. The Matron asked Officer A to fetch the defibrillator from the healthcare centre. (A defibrillator is a machine which checks for a shockable heart rhythm. If one is found, the machine advises the user to shock the patient. The healthcare centre is located centrally between the different wings.) She attached the defibrillator to the man. The machine detected a heart rhythm and advised her to shock him, which she did at 8.20am. The staff continued to perform CPR. In the meanwhile, officers erected privacy screens around the entrance to the cell and moved the other prisoners off the landing.

51. An ambulance arrived at 8.28am. Staff had been sent to the gate to make sure that there were no problems admitting the vehicle. The crew of three reached the wing at 8.30am. They gave the man amiodarone (medication used to treat an irregular heartbeat) and andrenaline. The matron and the paramedics continued to administer CPR whilst he remained on the bed. They gave repeated shocks and adrenaline, but he did not respond.

52. The man was shocked 34 times before he was taken to the ambulance (a defibrillator will advise the staff to continue shocking the patient if it detects a heart rhythm in ventricular fibrillation). He was not moved off the wing and into the ambulance for some considerable time because his condition was unstable. The team treating him continued to detect a heart rhythm and had to repeatedly deliver shocks.

53. Eventually the paramedics decided to take the man to hospital. The Matron continued to perform CPR whilst he was placed on a stretcher. He was taken to the ambulance at 9.44am. A route was cleared in advance. The Matron continued to give chest compressions as the paramedics carried the stretcher. The paramedics formally took over his care at 9.50am.

54. The man was not restrained for the journey to hospital but the two escorting officers had to stay with him at all times. The ambulance departed at 9.54am, arriving at the hospital at 10.03am. Accident and emergency staff declared him dead at 10.15am.

55. The duty governor held a debrief meeting for the staff involved in the emergency as soon as the man had departed in the ambulance. (The purpose of this meeting is to check how staff are feeling and to learn any immediate lessons from the emergency.)

56. Prison staff subsequently reviewed any prisoners currently or recently subject to self harm monitoring. The deputy governor issued notices to staff and prisoners informing them of his death.

57. The man had no named next of kin so prison staff arranged his funeral.

58. The post mortem report determined the cause of the man's death to be acute heart disease. He died after the previously repaired aneurysm expanded, obstructed the supply of blood to his heart and caused a heart attack. The pathologist who wrote the report remarked that death is very likely in such circumstances.

ISSUES

Clinical care

59. The man was a smoker, had high blood pressure and raised cholesterol. The clinical reviewer writes in his report that these factors increased the risk of him having heart problems. Although staff offered him advice to stop smoking, he said that he did not want to.

60. The clinical reviewer notes that the man's cholesterol levels were checked regularly. However, he was given the lowest dose of atorvastatin (10mg), even though his cholesterol was raised above recommended guidelines. The clinical reviewer comments that it is 'common' to prescribe 20mg of cholesterol and 'not unusual' to prescribed 40mg. However, he also remarks that:

> '…the contribution to the man's cardiac risk from his slightly raised cholesterol levels was minor compared to the risk afforded by him continuing to smoke.'

61. The clinical reviewer writes that:

> '[The man] was not on maximum therapy [for his cholesterol]. This may have been because of his wishes or because of side-effects, but, if so, this was not documented.'

62. I make the following recommendation based on the clinical reviewer's findings:

The Head of Healthcare should ensure that staff record their decision making with regard to medication if a patient's presentation suggests a different course of action.

63. In his clinical review, the clinical reviewer finds that the man's blood pressure was initially 'monitored regularly and was consistently at an acceptable level'. He writes:

> '…the treatment prescribed for his hypertension [high blood pressure] was suitable and in sufficient dosage…
>
> 'It is not unusual for a patient with known serious arterial disease to need three different medications to control their blood pressure.'

64. However, he notes that the man's blood pressure was only recorded once (in February 2011) in the clinical record after he started taking a different medication (candesartan) to treat this condition in July 2010. I make the following recommendation based on his findings:

The Head of Healthcare should ensure that staff regularly record a patient's blood pressure if they have a history of hypertension, particularly if they are prescribed a new form of medication.

65. The man had already undergone major surgery in 2008 on three arterial aneurysms. The surgery was not able to prevent the development of further aneurysms. The Matron told the investigator that her team relied on the guidance of the consultant at the local hospital in relation to the treatment of the aneurysms in his arteries. He was reviewed by the consultant on an annual basis.

66. The post mortem showed that the man died after the previously repaired aortic aneurysm expanded, obstructed the supply of blood to his heart and caused a heart attack. Although he had undergone surgery before, the clinical reviewer comments that:

> 'Even if [the aneurysm] had been recognised earlier, aneurysms of this part of the aorta are not amenable to surgical repair.'

Unlocking prisoners' cells

67. Night staff perform a check on all prisoners at about 6.30am. The purpose of the check is to confirm the welfare and presence of the prisoner. Staff should open the observation flap and can use a night light to view the prisoner. The officer who performed this check on the man on 15 June and provided my investigator with the following statement:

> 'On the morning of the 15th June 2011 at approximately 0630hrs I checked the man, he was sat on his chair and turned his head and acknowledged me as I opened the observation flap.'

68. I am satisfied that the man was not in distress at 6.30am. Prisoners are given a breakfast pack the night before, so are not unlocked by day staff until after the 8.00am staff briefing. Officers then move along the wings unlocking each cell at about 8.10am. They are supposed to open the observation flap to view the prisoner and ensure that it is safe for them to unlock the door without fear of assault. They should then unlock the door and move onto the next cell. The prisoners are trusted to leave the cell of their own accord to start their usual daily activities.

69. The circumstances in which the man was found on the morning of 15 June were markedly similar to those of another prisoner who died in 2009 at Kingston and also lived on A wing. The cause of his death was also heart disease. He was also found after the cells were unlocked at about 8.10am. Coincidentally, the same prisoner found both men in their cells. The other prisoner had died during the night, whereas the man was critically ill and resuscitation was attempted.

70. I am concerned that both men were found by chance when the prisoner decided to visit them in their cells. I consider that, in the man's case, the officer unlocking the cell a couple of minutes earlier should have been able to observe that he was unwell had he looked through the observation flap. The prisoner and Matron both subsequently described how he was writhing with discomfort. However, it would appear that this officer did not check him because they did not notice that he was unwell and raise the alarm.

71. My investigator requested a statement from the officer who unlocked the man's cell at 8.10am but unfortunately managers at Kingston were unable to identify this member of staff. This is an unsatisfactory situation. It is important that officers are both personally accountable for their actions and able to learn lessons for future practice. The Governor will want to satisfy himself that every effort has been made to identify the officer concerned.

72. Had the prisoner not gone to the man's cell to collect his laundry bag, then I understand another 40 or 50 minutes might well have elapsed before staff realised that he was not out of his cell and pursuing his usual daily activities.

73. We accept that the routine of unlocking prisoners' cells (especially lifers at Kingston who may have been there for many years and have never previously presented a security risk) can lead to a degree of complacency. The investigator addressed the matter when he spoke to the Governor during the investigation. The Governor agreed that the officers on A wing should have sight of the prisoner in their cell before they unlock the door in the morning. They should ideally obtain some form of response, either physical or verbal. The similarities between the death of the other prisoner in 2009 and the man's death suggest that this is not always the case. I make the following recommendation:

    The Governor should remind staff to always have sight of a prisoner and obtain a response from him before unlocking his cell.

The response to the emergency

74. The clinical reviewer finds that:

> 'Attempted cardiac resuscitation was carried out in a professional and timely manner both by the healthcare staff at HMP Kingston and by the paramedics who arrived. Because of the underlying causative event there was very little chance that this would be successful.'

Requesting an ambulance

75. When the Matron arrived in the man's cell, she immediately told the attending officers to order an emergency ambulance. When she spoke to my investigator, she said that it was self evident from the moment she arrived that he was extremely unwell and was having a heart attack. Although she responded immediately to the emergency and was only yards away at the medication hatch, she thought that discipline staff could have called for an ambulance as soon as they saw him.

76. We do not consider that the ambulance was delayed or the outcome was affected in this instance. Nonetheless, this is a theme common to many of my investigations. Discipline staff often seem reluctant to request an ambulance without the authorisation of a member of healthcare staff. The Matron commented during interview that she would prefer prison officers to order an

ambulance as a precaution. She stressed that she would rather have to contact the ambulance service and withdraw the request if she deemed it unnecessary.

77. Following publication of the Prisons and Probation Ombudsman's report entitled 'Deaths from circulatory diseases' in November 2010, the Chief Executive Officer of the National Offender Management Service and the Director of Offender Health wrote to all Prison Service Governors on 17 February 2011. They stressed:

> 'The most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner.'

78. Whilst it would not have made a difference in this instance, I am conscious that Kingston does not have 24 hour healthcare and officers may well need to make similar decisions without the advice of a nurse. I make the following recommendation:

The Governor should remind all of their staff that they do not require the authorisation of healthcare staff to request an ambulance in an emergency.

79. At the initial debrief meeting on 15 June, staff raised concerns about the call to the ambulance service. The emergency services worker asked for additional information which the matron had to provide over the radio to the control room whilst continuing to perform CPR.

80. The investigator was told that the Matron's line manager is presently liaising with South Central Ambulance Service to devise standard operating procedures for the three establishments in the area (Kingston, HMP Winchester and Haslar Immigration Removal Centre). This will simplify and clarify the information the gate staff need to provide when they request an ambulance. I gather that a resuscitation officer from the Ambulance Service has already met the Matron to discuss how best to proceed in the future.

81. A meeting between the line manager, Matron, the Modern Matrons from Winchester and Haslar, the resuscitation officer and the liaison manager from the South Central Ambulance Service was scheduled for 27 September 2011. The resuscitation officer has agreed to develop a training package for Kingston, Winchester and Haslar to be delivered to healthcare staff, prison officers and gate lodge staff.

Basic life support training

82. The Matron commented during interview that the officers who arrived in the man's cell before her (albeit only a matter of seconds before) did not start CPR. Fortunately, she was very close by and began CPR immediately. Indeed, her efforts to save him are noteable. Nonetheless, she expressed the view that officers with resuscitation training should start CPR as soon as possible. I am pleased that Officer C performed CPR, despite not having up-to-date first aid training, under the guidance of the Matron. Nonetheless, I think it is important

that officers like him receive training to give them the best chance possible to help during an emergency.

83. The Modern Matron completed her own internal review of the emergency and commented that the need for a duty first aider (a trained prison officer) to assist with CPR is particularly pressing if there is only one member of healthcare staff on duty or indeed none at all. The clinical reviewer echoes her comments in his review and thinks that the discipline staff should receive basic life support training as a matter of routine. This is particularly important because Kingston does not have 24 hour healthcare.

84. The Chief Executive of NOMS wrote to all Prison Service Governors on 29 October 2010. He highlighted the need for all Governors to review their first aid arrangements and to offer training if inadequacies were identified. I make the following recommendation:

    The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.

85. The Matron also highlights in her internal review the need for a code system to help healthcare staff communicate efficiently and quickly with staff in the gate lodge who are requesting an ambulance. I endorse her comments and make the following recommendation to ensure that staff can communicate as effectively as possible during an emergency:

    The Head of Healthcare should establish a code system to improve communication between the nursing staff and the gate lodge staff during an emergency.

86. Similarly, the Matron remarks on the error made when an officer brought her the wrong piece of equipment during the emergency. She suggests that the healthcare staff should train the officers to recognise the different items of emergency medical equipment. I endorse her comments and trust that this matter can also be taken forward by the Modern Matron and the Governor. I would also suggest that items such as oxygen are clearly labelled for ease of recognition.

Electronic clinical record

87. It is not always clear who wrote some of the entries in the man's electronic clinical record. Instead, the person making the entry is recorded as 'Unknown staff member'. My investigators drew this problem to the attention of the Modern Matron when they interviewed her. She agreed to pursue the matter and ensure that the error is corrected.

88. The clinical reviewer describes the man's clinical record as 'difficult to follow'. He comments:

‘In particular there is no overall summary listing major illnesses, both past and present, and regular medication. This would be a great help in emergency situations or where the patient is being seen by the Out of Hours service.’

89. I make the following recommendation:

The Head of Healthcare should ensure that staff maintain an up-to-date summary in the clinical records of all patients with chronic diseases recording their medical history and ongoing medication.

Anonymous complaint

90. On 27 June, the Prisons and Probation Ombudsman’s office received an anonymous telephone call from a woman claiming to be the partner of a prisoner at Kingston. She made a further telephone call to the office on 4 July. The woman made a number of allegations about the delivery of healthcare to different prisoners at Kingston. The investigator and his colleague (who investigated the recent death of another prisoner at Kingston) interviewed the Matron about the allegations. She was able to address each allegation, identify the prisoner concerned and point out factual inaccuracies in what the caller had said. For instance, the caller said that the Matron had replaced a colleague who had been sacked. In fact, the Matron has been in post since October 2008 and her predecessor left to take up another job.

91. We do not repeat the allegations pertaining to other prisoners. There is no record of the ma making any complaints to the Prisons and Probation Ombudsman. My investigator examined the log of internal complaints made by prisoners about healthcare. The Matron demonstrated that the complaints are personally answered. They are audited on a monthly basis and sent to the local Primary Care Trust for further analysis, to ensure that there is no identifiable pattern of complaints about a particular member of staff or healthcare service.

92. As regards the man, the caller alleged that he ‘continually went to healthcare complaining of chest pains and was sent away with paracetamol – apparently his numerous visits were not recorded by healthcare’. The Matron said that she did not recognise this description of his care. Her comments are supported by the clinical reviewer’s findings. Although he has identified some learning points in his clinical review, he is satisfied that the man received a good level of care comparable with that he could have expected in the community.

CONCLUSION

93. The man developed aneurysms in his arteries over a number of years. I am satisfied that he was given regular access to outpatient appointments. He underwent major surgery whilst he was a serving prisoner. When he was found in his cell, I am satisfied that the response was swift and extremely thorough. I do not think that staff could have done any more to save him.

94. The investigation has highlighted some learning points for the prison to address. In particular, the failure of prison officers to properly observe prisoners when unlocking them in the morning. This is a theme common to two of my recent investigations at Kingston. Although I do not think that this made any difference to the outcome on this occasion, it is concerning that the prisoner had to raise the alarm in both instances.

RECOMMENDATIONS

For the Head of Healthcare:

1. **The Head of Healthcare should ensure that staff record their decision making with regard to medication if a patient's presentation suggests a different course of action.**

   The Head of Healthcare accepted the recommendation and provided the following response:

   'Most change of medication is identified following assessment from blood results or out patient appointments. However, all visiting GPs and future will be informed of the need to clearly document rationale for treatment change.'

2. **The Head of Healthcare should ensure that staff regularly record a patient's blood pressure if they have a history of hypertension, particularly if they are prescribed a new form of medication.**

   The Head of Healthcare accepted the recommendation and provided the following response:

   'Recordings of blood pressures are maintained, but are to be documented as a read code to ensure easy accessibility for reviews rather than having to look through the general medical journal.'

3. **The Head of Healthcare should establish a code system to improve communication between the nursing staff and the gate lodge staff during an emergency.**

   The Head of Healthcare accepted the recommendation and provided the following response:

   'Awaiting sign off for the SOP with regards the ambulance service and emergency calls. Matron to advise Governor of the SEND protocol and potential use of Code 35.'

4. **The Head of Healthcare should ensure that staff maintain an up-to-date summary in the clinical records of all patients with chronic diseases recording their medical history and ongoing medication.**

   The Head of Healthcare accepted the recommendation and provided the following response:

   'A summary of clinical records is already available and was available at the time of the investigation. This is part of SystmOne.'

For the Governor:

5. **The Governor should remind staff to always have sight of a prisoner and obtain a response from him before unlocking his cell.**

   The Governor accepted the recommendation and provided the following response:

   'All staff have been reminded of the need to look through the observation hatch and check the welfare of a prisoner prior to unlocking the door.'

6. **The Governor should remind all of their staff that they do not require the authorisation of healthcare staff to request an ambulance in an emergency.**

   The Governor accepted the recommendation and provided the following response:

   'A notice to staff issued reminding staff that they do not require the authorisation of healthcare staff to request an ambulance in an emergency.'

7. **The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.**

   The Governor accepted the recommendation and provided the following response:

   'All Senior Officers are trained in first aid or basic life support; this provides 24 hour cover on the residential units.'