Investigation into the circumstances surrounding the death of a man at HMP & YOI Moorland Closed in August 2008

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the death of a man who died of natural causes in HMP Moorland in August 2008. The man had experienced chest pains the previous week and had undergone tests. During the early hours of 26 August he suffered further chest pains. In the morning he was found to have died in his cell. He was 32 years old.

One of my Family Liaison Officers contacted both the man's mother and his partner to explain our role. I would like to offer my personal condolences to the man's family.

This investigation was undertaken by my colleague. Both he and I would like to thank the Governor and staff of HMP Moorland for their participation. The clinical reviewer was identified by the local Primary Care Trust (PCT) to undertake a review of the man's clinical care. I very much appreciate his assistance and report. Unfortunately, due to its complex nature, a delay in receiving the clinical review has held up the publication of my report. I apologise for any additional distress this has caused.

When someone has died from natural causes, the clinical review plays a large part in helping me compile my report and reach my conclusions. In the man's case, the clinical review finds that he received care which was broadly equal to the standard he could have expected outside prison. There are, though, areas where the healthcare provided could be improved upon.

This is the third death I have investigated in HMP Moorland since I took over responsibility in April 2004. The previous deaths do not bear comparison to the circumstances of the man's. Since the man's death and, and until the time of writing, there have been two further deaths. In one of my reports I make recommendations about sharing of healthcare information and about record-keeping. Similar issues are highlighted in this report, and the clinical review carries recommendations on both. The clinical reviewer makes a number of additional recommendations, and I suggest that the Head of Healthcare and the Chief Executive of the PCT consider these. I make eight recommendations of my own, and I am pleased to see that the Prison Service has accepted them.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The man was 32 years old when he died. He had suffered some health problems, which may have included a stroke, as well as asthma and hypertension. He had been in custody previously.

Prison records consistently describe the man as quiet, well-mannered, and considerate. He seems to have worked hard in prison, completing a number of courses. They included Enhanced Thinking Skills, food hygiene, creative writing, budgeting and money management, and drug awareness. Although he had used drugs in the past, he said that he longer did so, and 20 consecutive prison drug tests proved negative.

During the night of 19 August 2008, the man suffered chest pains. He was referred for tests, which took place the following day. The results were normal.

A week later, on 26 August, the man again rang his cell bell to summon assistance during the night as he was suffering further chest pains. It was a single cell. A nurse came to his cell and assessed him, and decided that he did not require hospitalisation. He said he would put the man's name on the list to see the doctor in the morning, and gave him some indigestion medicine. He also offered painkillers, but the man declined to take them because he said that they would affect his asthma. When staff left him at 4.00am he was sitting on his bed.

When a member of staff carried out the morning roll check at approximately 4.50am, the man was lying in his bed under his covers. However, when staff changed shifts later that morning, the officer who checked on the man at approximately 7.25am saw him sitting up on his bed and was unable to get a response from him. He went back to the office and telephoned healthcare to summon assistance. When the nurse arrived, he too could gain no response from the man. He summoned assistance and an ambulance was called as staff attempted to revive the man. When paramedics arrived they too tried to revive him. Sadly, all attempts proved unsuccessful.

I make recommendations in relation to the monitoring of prisoners who require medical attention during the night, particularly those complaining of chest pain if they have a recent history of similar complaints. I also recommend that the Governor reminds staff of the correct procedures to be followed when discovering a possible death in custody, and for summoning emergency ambulances. I also make recommendations about the skill mix and emergency training in the nursing team.

THE INVESTIGATION PROCESS

1. My investigator visited Moorland and spoke to staff who worked with the man during his imprisonment. Notices were posted to staff and prisoners about the investigation, inviting any contributions. None were received.

2. My investigator studied all relevant prison records relating to the man. They included his main prison records and his medical records. He also visited the healthcare centre, and the houseblock and wing where the man lived, including his cell. He interviewed 13 members of staff, and transcripts of the interviews are attached to this report.

3. The local Primary Care Trust (PCT) identified the clinical reviewer to carry out a review of the man's clinical care. My investigator discussed aspects of the man's treatment with the clinical reviewer and conducted joint interviews of medical staff in the prison with him. I am grateful to the clinical reviewer for undertaking this review.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. On completion I will send him a copy of my report to help his investigations.

5. One of my family liaison officers spoke to the man's partner, whom he had listed as his next of kin, as well as to his mother. Each had some questions for my investigation to address and I hope I have done so to their satisfaction. In essence, they wanted to know:

    - whether the tests the man had the previous week should have identified the problems which caused his death?
    - If he had had an increase in medication which may have affected his heart.
    - What medication he was receiving.
    - Whether he had asked to see a doctor the day before he died.
    - Whether the prison were aware of the stroke the man may have suffered in 2006 when he was in HMP Rye Hill

HMP & YOI MOORLAND CLOSED

6. HMP & YOI Moorland has two sites, open and closed. The man was held in the closed site, which has separate sites for adults and young offenders. The adult site is a category C prison for convicted prisoners with an operational capacity of 791. Offending Behaviour groups include Enhanced Thinking Skills courses, Welfare to Work and Job Clubs.

7. There is 24-hour nursing cover in Moorland. Although healthcare arrangements have since changed, while the man was there, the healthcare centre had in-patient facilities.

Prison Service policy on resuscitation of prisoners

8. Prison Service policy on resuscitation of prisoners is contained in the Prison Service Order (PSO) 2700. This PSO, which relates primarily to suicide prevention and self-harm management, states:

> "**Resuscitation**: Policy remains that staff should continue to attempt resuscitation – as appropriate to the injury – until told to stop by a healthcare professional, e.g. a member of the Ambulance Service or a doctor, or rigor mortis has clearly set in …"

Release on licence

9. Parole is the system that allows a prisoner to be released before they have served their full sentence and is granted on the basis of reports by prison and probation staff. Prisoners are released on a licence, and if they break the terms of their licence and/or commit further offences before the end of their sentence, they can be recalled to prison.

Previous deaths at Moorland

10. The man's death was the third I have investigated in Moorland Closed since I took over responsibility for such investigations. The circumstances of the previous two deaths are quite different from this one.

11. Sadly, there have since been a further two deaths at Moorland. In one report I make a recommendation about the need for accurate record-keeping, and also a recommendation about test results being made available to staff and maintained within medical records.

Her Majesty's Chief Inspector of Prisons (HMCIP)

12. The last report on HMP Moorland published by Her Majesty's Chief Inspector of Prisons was of a full, announced inspection in December 2005. The report recommends that:

"A primary care mental health needs assessment should be conducted to ensure that … registered mental nurses are employed exclusively to provide mental health care."

Independent Monitoring Board (IMB)

13. Every prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life and to ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB at Moorland is that covering the period 1 March 2007 – 29 February 2008. None of the issues raised in that report are relevant to the circumstances of the man's death.

KEY FINDINGS

14. The man was born in September 1975 and was 32 years old when he died. He had a number of convictions and had served previous custodial sentences in Young Offender Institutions. The man had been in prison serving his latest sentence since 13 August 2002. At that time he was living in Tenerife and was holidaying in Venezuela. He was arrested for attempting to transport drugs and held in Venezuela for trial. He was convicted in October 2005. Sentenced to ten years imprisonment, he was repatriated on 9 December to serve the rest of his sentence in the United Kingdom. Initially located in HMP Wandsworth, in January 2006 he was transferred to HMP Rye Hill.

15. He learned in June that his sentence had been reduced to eight years following a change in Venezuelan law, and the Parole Board considered his case on 24 October. The Board did not recommend his release, but said that he needed to do further work to address his offending behaviour. The man later said that the following weekend, 28-29 October, he suffered a mild stroke, although his prison medical records do not contain any relevant documentation. The man was recategorised to category C on 28 November.

16. Records show that the man went to outside hospital on several occasions in May 2007 to address problems with his right eye, and on 30 May he told a member of staff that he needed an operation. He said that this was a consequence of the stroke he had suffered the previous autumn.

17. The man's case was referred back to the Parole Board in April, and on this occasion they did recommend his release. He was released on licence from Rye Hill on 4 July. However, the man was arrested on 27 August, and two days later convicted of assault occasioning actual bodily harm and sentenced to four months imprisonment. He was taken to HMP Doncaster, and his licence was revoked. He was transferred to HMP Everthorpe on 5 October, and the Parole Board considered the circumstances of his licence revocation on 8 October. They confirmed the decision to recall him to prison.

18. The case was referred back to the Parole Board in February 2008, and they once more recommended the man's release. He was released on 4 March 2008. A note on the wing record on 2 March points out that the man was suffering with asthma at that time.

19. The man remained out of prison until 16 June, when he was arrested for various offences. He appeared before North Lincolnshire Magistrates' Court the following day. Once more his licence was revoked and he was taken to HMP Hull. On 1 July, he was sentenced to two months imprisonment. Designated as a category C prisoner, plans were put in place to transfer him to HMP Ranby.

20. However, on 8 July, the man told staff that he had swallowed two razor blades, and that if he was transferred to Ranby he would take his own life. The man was placed on suicide and self-harm monitoring procedures known as

Assessment, Care in Custody and Teamwork (ACCT). The proposed transfer to Ranby was subsequently cancelled, but the files do not indicate if the man's threats played a part in this decision. Instead, he transferred to Moorland on 10 July, his ACCT document remaining open.

21. On arrival at Moorland, the man underwent a reception medical screening. He said that he was having problems sleeping, and was noted to have a history of asthma, hypertension and dizzy spells. He had previously been a drug user but reported that he had not used drugs for a number of years. He also told staff that he had a history of depression and anxiety and said he had been prescribed antidepressants. He was still on an open ACCT document, and was referred to the mental health in-reach team. He had an introductory meeting with a member of the team the following day, and was more fully assessed the following Monday, 14 July, before seeing the doctor the next day. The doctor noted that the man was stressed and depressed, and was prescribed an antidepressant.

22. The ACCT document was closed on 15 July. The man was now being treated by the mental health team. On arrival at Moorland he had initially asked if he could be transferred to HMP Lindholme for family reasons, but he had now changed his mind. He no longer felt that ACCT observations were required.

23. The man saw the doctor again on 17 July, this time in relation to his asthma. The doctor gave repeat prescriptions for his inhalers. The man saw a nurse from the mental health team on 21 July and reported having problems sleeping. He said he was waking between 3.00am and 4.00am. He still complained of anxiety.

24. A nurse from the mental health team saw the man on 28 July. He said that he was still not sleeping, and the nurse noted that he looked tired. The man saw the doctor again on 30 July, and the doctor noted that he was distressed and anxious. The doctor prescribed further medication, in addition to his antidepressants, and set a review of the medication for the following week. He was seen by a member of the mental health team on 6 August, and his anxiety was slightly reduced.

25. The man again saw a doctor on 12 August, and once more complained of problems sleeping. The doctor suggested changing the time that the man took his antidepressants, and that he should discontinue taking the new medication. The man agreed to try this.

26. During the night of 19 August, the man complained of chest pains. Assistance was requested from healthcare, and at 11.00pm his cell was unlocked to allow a nurse to assess him. He told the nurse that the pain was intermittent, and was worse if he lay down. Lying down also made it difficult to breathe. The nurse checked the man's breathing, which appeared normal. He told the nurse that the pain was not radiating (shooting from the chest to other areas), and there was no evidence of nausea or clamminess to the man's skin (possible indications of an impending heart attack), although he did feel some numbness in his left hand. The nurse noted that the man suffered from anxiety. He was

not judged to be in imminent danger, but arrangements were made for him to see the doctor the following day. The man was content with this, and the nurse left the cell.

27. As arranged, the man saw the prison doctor the following day, 20 August. The man told the doctor that he had a family history of heart disease, and said that he had previously had minor strokes. The doctor arranged blood tests and an electrocardiogram test (ECG: a check on the electrical activity of the heart which can detect irregularities in the rhythm, and possible weaknesses). The man had the blood tests done the same day, and the results came back from the hospital the following day. They did not show any abnormalities. The ECG was carried out in the prison healthcare centre, and the results were also normal. The prison doctor said in interview that he concluded that the pains the man suffered were probably not cardiac in nature. However, he said that if he was on duty when the man exhibited further chest pains, he would have referred him to hospital. He did not, however, pass this opinion on to nursing staff.

28. There were no more incidents of note until during the early hours of the morning on 26 August, a week later. At approximately 3.15am, the man pressed his cell bell to summon assistance. An Officer Support Grade (OSG) responded. The man was sitting on his bed holding his chest. He said that he was experiencing chest pains, and difficulty breathing when lying down. The OSG told him that she would call for medical staff.

29. There was a night duty officer on Houseblock Two. The OSG briefed the night duty officer and contacted the healthcare centre. This was at approximately 3.30am. The nursing cover that night was being provided by a Registered Mental Health Nurse (RMN). The OSG went back to the cell and the man was sitting in the same position. She then returned to the office to collect the RMN.

30. Cells may only be unlocked during the night with three members of staff present. While the OSG was collecting the RMN, the night duty officer contacted the Senior Officer (SO), the Night Orderly Officer (the most senior member of staff on duty through the night), to ensure that he was abreast of what was happening. The Officer, who was the Assistant Night Orderly Officer, heard the call over the radio and also attended.

31. A Prison Officer was on duty on Houseblock One. He said that before he was aware of the situation on Houseblock Two, the RMN arrived on Houseblock One and asked where the patient was. He said he was unaware of any patient requiring attention, but would check. The RMN left Houseblock One, and the Prison Officer made a telephone call to clarify what was needed and where. It was at this point that he was asked to come over to Houseblock Two. He did so, and when he arrived the RMN was already there.

32. The Night Orderly Officer unlocked the man's cell and went inside with the RMN and the night duty officer. The other members of staff remained outside. The man was sitting on the edge of his bed, holding his chest. The RMN noted in his written statement that he knew that the man had experienced similar

symptoms a few days earlier. He spoke to and examined the man. This was at approximately 3.45am. The RMN's statement shows that the man's pulse was firm and regular, and his breathing was regular. He told the RMN that his pain was not radiating. The man was not sweating nor suffering any discolouration of his skin (a potential indicator of heart problems). His temperature appeared to be normal, and he was rational and coherent. He told staff that he was concerned that the incident might be interpreted as a panic attack, as he was adamant that it was not. The RMN noticed that the man had a ventolin inhaler (for his asthma) in his cell. (Overuse of ventolin can cause chest pains and irregularity in the heart's rhythm.) He advised the man not to use the inhaler unless it was really necessary.

33. Having examined the man, the RMN had no immediate concerns about his welfare. He needed to return to the healthcare centre to get some medication, and to check the man's medical records. All the staff came out of the cell, and the man was locked inside whilst the RMN went to the healthcare centre. Whilst there he checked the man's medical notes. He noted that after the man had complained of chest pain the previous week he had undergone blood tests and an ECG, both with normal results.

34. The RMN returned to Houseblock Two at approximately 3.50am and the cell was unlocked once more. The same three members of staff re-entered, and again the Prison Officer and the Assistant Night Orderly Officer remained outside. The RMN noted that the man's breathing and pulse were still regular, he was not in distress, and was still behaving rationally. He gave the man's magnesium trisilicate (to treat indigestion and reduce acidity) and offered a brufen tablet (a painkiller). The man declined to take the tablet, as he believed that people with asthma should not take them. The Night Orderly Officer asked the RMN if he thought the man would need to go to hospital, because he would need to make staffing arrangements. The RMN said that he did not judge that immediate hospitalisation was necessary. He said he would ensure that the man was listed to see the doctor in the morning.

35. At approximately 4.00am, all the staff left the cell, which was locked. The man was still sitting on his bed with both feet on the floor and his arms across his chest. The night duty officer thought that the man appeared to still be in some discomfort. The RMN asked to be contacted again if there were any further problems. The OSG told my investigator that nobody asked her to make any specific checks on the man through the remainder of the night. The RMN returned to the healthcare centre and added the man's name to the list to see the doctor later that morning.

36. The Prison Officer returned to Houseblock One. He said in interview that, bearing in mind how unwell the man appeared to be, he was surprised that he had been left in his cell. He assumed that he would be called upon to escort the man to hospital at some point, and prepared himself to be able to leave quickly if a call came through.

37. The OSG conducted her morning roll check at approximately 4.50am. She noted that the man was lying on his back in his bed, facing the wall, with his

bed covers over him. A roll check is only to ensure that the prisoner is where they should be, not to gain a response from them.

38. At 7.05am a second Prison Officer came on duty in Houseblock Two and night staff briefed him on the night's events. He began the roll check of A1 landing ten minutes later. When he reached the man's cell he saw that he was slumped on his bed with his back against the wall. He tried a number of times to get a response from the man by first tapping, then banging, on the observation panel and then the door. Failing to elicit a response, he went into the cell. The man was cold to touch, had no pulse, and his legs were discoloured. The second Prison Officer had received some instruction in cardio-pulmonary resuscitation (CPR) as part of his initial training some years previously. He had also had first aid training in the past, but it had lapsed and he had had no refresher training for some time. He told my investigator that he believed that the man was dead and therefore did not attempt resuscitation.

39. The second Prison Officer went back to the wing office. He telephoned the healthcare centre and spoke to the healthcare nurse. He also contacted the communications centre to inform them of what was happening. An ambulance was not requested at this stage.

40. Moorland uses a code system for emergency calls. A Code Blue call means that a prisoner does not appear to be breathing or is unconscious. The second Prison Officer did not use the emergency code. In interview, my investigator asked the second Prison Officer why he did not use his radio to summon emergency assistance. The second Prison Officer said that he did not do so because he thought that the man was already dead.

41. The healthcare nurse had taken over from the RMN between 7.05am and 7.20am, having been briefed on what had happened during the night. At approximately 7.25am he received a telephone call from the second Prison Officer. In interview he told my investigator that the second Prison Officer told him that there was a prisoner he was "not happy with". He asked what the problem was, and was told that the prisoner was unresponsive but was sitting up. The healthcare nurse did not get a sense of urgency. If the situation had been identified as an emergency, he would have expected a radio emergency call with the appropriate code.

42. The healthcare nurse collected the grab bag (containing basic first aid equipment for a range of possible situations) and went to Houseblock Two. He was met at the gate, but was still not given any sense of urgency as he was guided to the man's cell. The man was sitting up in bed with his back against the wall. The healthcare nurse approached the man and checked for a pulse but did not find one. The man did not respond when spoken to, nor when shaken by the shoulders. He was not breathing, was cold to touch, and he was pale. The healthcare nurse told the second Prison Officer to call an ambulance. This was at 7.30am.

43. The healthcare nurse called for immediate assistance over the radio, and also asked for some oxygen. He laid the man on his back on the bed, and began to

perform CPR. A second healthcare nurse had just come on duty in the healthcare centre when she was told by telephone that assistance was needed on Houseblock Two. She took a grab bag and oxygen and made her way there, telling a third healthcare nurse to come with her. On arrival the second healthcare nurse also checked the man for signs of life, and was unable to find any. The nurses made a joint decision to leave him on his bed rather than moving him to a hard surface such as the floor and continued to attempt to resuscitate the man.

44. The paramedics arrived at approximately 7.45am. The healthcare nurse briefed them, and they moved the man onto the floor to continue attempts to resuscitate. The three prison nurses continued to assist. The third healthcare nurse went to collect the man's medical records. The second healthcare nurse left the cell at 7.55am and spoke to the Governor, who had come to the wing and taken control of co-ordinating outside the cell. The second healthcare nurse left the area to carry out duties elsewhere in the prison. The healthcare nurse left the cell at 8.05am and waited outside. At 8.09am the man was still not responding to treatment, and the paramedics declared that he had died.

45. A hot debrief was held that afternoon, chaired by the Deputy Governor. (Hot debriefs are held as soon as possible on the same day after a death in custody. They are held to ensure that staff involved have an opportunity to discuss any issues arising.) The Care Team were available for any staff who felt they may need support. The Prison Officer, the RMN and Night Orderly Officer were spoken to as they arrived for work on their next shifts, and support was offered to them.

46. Prison staff went to visit the man's partner and informed her of his death. She was subsequently given the opportunity to visit the prison, and the prison assisted with the costs of the man's funeral. When the man's mother received the sad news that her son had died, she contacted the prison and staff also visited her. They provided her with her son's belongings and contact details in the prison should she require anything further.

Cause of death

47. A post mortem was carried out. The cause of death was concluded to be from a natural disease process leading to Coronary Artery Occlusion, due to Coronary Artery Atheroma (a heart attack due to a blockage of an artery).

ISSUES

The man's health

48. The clinical reviewer finds that broadly speaking the man's received care which would accord with that he could have hoped to receive in the community. But there were some areas which could be improved. The clinical reviewer makes a number of recommendations, some of which relate to housekeeping and not all of which I will detail here. I bring the Head of Healthcare's attention to the points he makes regarding the communication of information and record-keeping. I also ask the Chief Executive of the PCT to consider the recommendations to the commissioning body about the healthcare provisions in Moorland.

49. The results from the tests the man underwent after 19 August were not documented and it is not clear if they were communicated to nursing staff. The prison doctor said in interview that he thought any further chest pain should have resulted in the man being referred to hospital, but there is no reference to his view in the medical record. Staff were not aware of this. The man was given blood and heart tests, and the results did not show any abnormalities. It seems that the man's death the following week could not have been foreseen in these tests. The clinical reviewer recommends that communication within healthcare is reviewed to ensure that all the relevant information is available to staff who are assessing the options for treatment.

Response to the emergency

50. I am concerned at the care the man received when he complained of chest pains during the night of 26 August. He had complained of chest pains a week previously, which should have given rise to more concern than appears to have been the case. I take into consideration the fact that tests on the man's heart had shown no abnormalities, but the clinical reviewer notes that when the man was assessed in his cell a full set of observations was not carried out. I note that the Registered Mental Health Nurse has no background in general nursing outside the prison. There were no notes on the man's medical record to suggest that any further chest pain should result in immediate referral to hospital, and this may have had a bearing on the RMN's decision. The man was given an indigestion treatment and then left in his cell, even though uniformed staff noted that he still appeared to be in distress and at least one officer was surprised that the man was not referred to hospital. No subsequent checks were made as to whether the treatment had been effective, and there does not appear to be a policy. No further specific checks were made on the man during the night beyond the standard visual roll check (ensuring that the cell was occupied) made on all prisoners. Any episodes of chest pain must be treated more seriously.

    The Head of Healthcare should consider whether there should be a system in place to monitor prisoners who have required treatment during the night.

The Head of Healthcare should ensure that any episodes of chest pain in prisoners who have made recent similar complaints are addressed as a matter of urgency.

51. When the second Prison Officer was unable to obtain a response from the man later in the morning, he returned to the office to use the telephone to summon medical assistance. He did not use his radio, nor did he give the emergency Code Blue call. The nurse who took the call says he did not get a sense of urgency. The second Prison Officer told my investigator that he thought at this stage that the man was dead, but the healthcare nurse only remembers the second Prison Officer saying that he had a prisoner he was not happy with, who was unresponsive. Because the Code Blue call was not used, he only brought the emergency grab bag with him and did not bring the correct equipment.

52. Moorland's Local Notice to Staff No. 209/04 details emergency response protocols. The notice says:

> "In response to a medical emergency it is essential that Health Care staff are aware of the nature of the emergency to enable the right equipment to be taken to the scene:
>
> Code Blue – Indicates Compromised Airway (Choking/ligature)
> Breathing Difficulties (unconscious)"

53. Moorland's staff instructions on death in custody say "Death should never be assumed and First Aid should be administered whenever appropriate". The instructions set out procedures for the first person on the scene:

> "1. On discovery of a suspected death of an inmate raise the alarm by:
>
> UHF radio if available (Communications Room)
>
> Telephone xxx (Communications Room)
>
> Shout for assistance
>
> 2. Never assume the inmate is dead – administer First Aid and treatment whenever appropriate…"

54. The second Prison Officer's actions also led to a short delay of a few minutes in an ambulance being summoned. The clinical reviewer says it is not clear whether the delay in getting treatment to the man would have made a difference. I note that the healthcare nurse found no pulse or breathing, and that the man was cold. I also note that the second healthcare nurse said that when she checked him for signs of life, she thought the man had been dead for "a while".

55. Nevertheless, the nurses attempted to resuscitate the man, and when paramedics arrived, they did too. Prison Service Order 2700 says that Prison Service policy is that "staff should continue to attempt resuscitation … until told

to stop by a healthcare professional … or rigor mortis has clearly set in". I recommend that the Governor reminds all staff that in the case of a medical emergency, the correct emergency codes should be used, medical staff should be summoned urgently and given a good understanding of the problem. Resuscitation should be attempted as set out in PSO 2700.

The Governor should remind all staff of the importance of using the correct emergency code when summoning emergency assistance.

The Governor should remind all staff of the procedure to be followed on discovery of a suspected death.

The Governor should remind all staff of Prison Service policy on resuscitation as stated in PSO 2700.

56. The clinical reviewer recommends in his review that the prison considers its policy for summoning emergency ambulances. I agree. There should be a clear policy with which staff are fully conversant. It is by no means certain that the delay in this instance had any effect on the final outcome, but it could do in other instances.

The Governor should consider the policy for summoning emergency ambulances and ensure that staff are aware of the correct procedures for doing so.

57. The clinical reviewer also notes that the nursing staff have different levels of experience in general nursing. The RMN was left to make decisions on the man's wellbeing during the night, despite only having a background in mental health nursing. Later that morning, when trying to resuscitate the man, nursing staff had some difficulty in using the equipment. They also performed CPR whilst the man remained lying on his bed, whereas a hard surface is more suitable. The clinical reviewer recommends that the Head of Healthcare addresses the skill mix of the nursing team, and their training in using emergency equipment. I concur and repeat these recommendations.

The Head of Healthcare should consider the skill mix of the nursing team to ensure that the necessary skills to cover the prison are available at all times.

The Head of Healthcare should ensure that healthcare staff have received training in and are familiar with the use of emergency equipment.

58. The clinical review comments that the man's medical records were poorly maintained, with illegible and undated entries. The man told staff that he had suffered a minor stroke whilst at Rye Hill in October 2006. However, the clinical reviewer notes that the man's medical records appear to be complete, and do not contain any reference to or diagnosis of a stroke. When the man told the prison doctor that he had previously suffered a stroke, the prison doctor took him at his word. Any treatment the man received therefore took account of the fact that he might have had a stroke in the past. However, whilst there are

some references in the man's prison records, there are no medical records showing any details of a stroke. If the man did indeed suffer a stroke, this is a serious omission from his medical record.

Issues raised by the man's family

59. The man's family asked if an increase in the dosage of pills the man was taking could have had an effect on his heart. According to his medical notes, the man was advised to change the time he took his medication, but the dosage was not altered. The medication the man was taking is listed in the clinical review.

60. Although his records are not clear about the stroke the man said he had suffered in Rye Hill, his treatment was provided on the understanding that he had indeed had a stroke. This was based on his own information.

61. The family also asked if he had asked to see a doctor the day before he died. There is no evidence to suggest that this was the case.

CONCLUSION

62. It is impossible to say whether the man's death could have been prevented. The nurse who assessed him during the night knew the man's medical history and having examined and questioned him, judged that he was not in imminent danger. Whether he was right and the man developed a further problem afterwards is something we cannot know. However, I believe that given the man's previous chest pains and medical history, it would have been safer to take the precaution of referring him to hospital.

63. It is similarly impossible to say whether the delay in the man receiving emergency treatment had any effect. No signs of life were detected by two nurses and, despite the efforts of nurses and paramedics, resuscitation was unsuccessful. Nonetheless, emergency treatment should have been provided immediately and urgently. Prison Service Order 2700 clearly states that resuscitation should be attempted until told to stop by a healthcare professional, or if rigor mortis has clearly set in. This was apparently not the case, and the delay in the man receiving urgent medical attention should not have happened.

RECOMMENDATIONS

1. The Head of Healthcare should consider whether there should be a system in place to monitor prisoners who have required treatment during the night.

   The Prison Service have accepted this recommendation. They comment that care plans will be introduced to follow any further attention/observations a prisoner may require after receiving a visit from a nurse during night patrol state.

2. The Head of Healthcare should ensure that any episodes of chest pain in prisoners who have made recent similar complaints are addressed as a matter of urgency.

   The Prison Service have accepted this recommendation. They say that an Instruction is being issued to all nursing staff to respond immediately to prisoners with chest pains as a priority, particularly if there has been a previous complaint.

3. The Governor should remind all staff of the importance of using the correct emergency code when summoning emergency assistance.

   The Prison Service have accepted this recommendation. A notice was issued to staff on 2 July 2009, and repeat notices will be issued as a reminder every six months.

4. The Governor should remind all staff of the procedure to be followed on discovery of a suspected death.

   The Prison Service have accepted this recommendation. They say that information is now available on the intranet, within the death in custody local policy section 4.2 (action to take on discovering the apparent death of a prisoner). A notice to staff will be issued every six months containing the policy section 4.2 and reminding staff where to obtain this information.

5. The Governor should remind all staff of Prison Service policy on resuscitation as stated in PSO 2700.

   The Prison Service have accepted this recommendation. They say that a notice to staff was issued on 2 July 2009, and repeat notices will be issued every six months.

6. The Governor should consider the policy for summoning emergency ambulances and ensure that staff are aware of the correct procedures for doing so.

   The Prison Service have accepted this recommendation. They say that the contingency plans have been revisited and updated.

7. The Head of Healthcare should consider the skill mix of the nursing team to ensure that the necessary skills to cover the prison are available at all times.

   The Prison Service have accepted this recommendation in principle. They comment that they are not directly responsible for employing the nursing staff and, as the services commissioned by the PCT were new, a full skill mix was not in place. Recruitment is currently ongoing in line with service specification.

8. The Head of Healthcare should ensure that healthcare staff have received training in and are familiar with the use of emergency equipment.

   The Prison Service have accepted this recommendation. They comment that this is included in their training plan.