A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in April 2014 at HMP Whatton

Our Vision

‘To be a leading, independent investigatory body, a model to others, that makes a significant contribution to safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who died in April 2014 after suffering a heart attack at HMP Whatton the day before. He was 45 years old. I offer my condolences to his family and friends.

A review of the man's clinical care at Whatton was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to an indeterminate sentence for public protection in 2007. He had a history of drug dependency and was a heavy smoker. He had very little contact with healthcare staff during his time in prison.

On the morning of Saturday 5 April, the man reported suffering from chest pain and was taken to the prison's healthcare centre. A nurse treated the pain as anxiety and gave him paracetamol and ibuprofen. She did not refer him for an ECG test, seek advice or send him to hospital. He went back to his wing, but collapsed later that afternoon. Prison officers began cardiopulmonary resuscitation and subsequently asked for an ambulance to be called. There was a delay before this was done. Paramedics took him to hospital by ambulance. He later died in hospital.

Although the general standard of healthcare which the man received during his time at Whatton was satisfactory, I agree with the clinical reviewer that he did not receive appropriate care when he reported chest pain on the morning of 5 April. For that reason, I am not satisfied that his clinical care was equivalent to that he might have expected in the community. As well as identifying a need for a better understanding and management of chest pain, the investigation also found that there was a need for improvements in emergency procedures to ensure there are no unnecessary delays in calling an ambulance.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2014**

CONTENTS

Summary

The investigation process

HMP Whatton

Key events

Issues

Recommendations

Action plan

SUMMARY

1. In June 2007, the man was sentenced to an indeterminate sentence for public protection and was sent to HMP Hull. He transferred to HMP Whatton on 2 October 2009. During his induction medical assessment at Whatton, he said he had misused drugs, was a heavy smoker and had hepatitis C (liver disease). No other significant health issues were noted and he visited the prison's healthcare centre on only a few occasions for back pain, help to stop smoking and for blood tests to monitor his hepatitis C.

2. On the morning of 5 April 2014, the man went to the wing office and said he was suffering from pains in his shoulder and chest and had been sick. The officer noted that he was sweating and looked grey. The officer contacted a nurse who asked him to bring him to the prison's healthcare centre. The officer asked another prisoner to take him in a wheelchair as he was very concerned about his appearance and was worried he might collapse.

3. A nurse took the man's clinical observations which she recorded as being within the normal range. She did not refer him for an ECG, to hospital or seek advice from a GP. She believed his pain was a result of anxiety and gave him paracetamol and ibuprofen. She said that she asked him to wait in the healthcare centre until he felt less anxious, but he went back to his wing very shortly afterwards. A few hours later, he collapsed in his cell. Prison officers began cardiopulmonary resuscitation, but did not call an emergency code. Thirteen minutes after he collapsed, one of the officers asked the control room to call an ambulance, but it was a further three minutes before this was done. He was taken to hospital by ambulance, but later died.

4. We agree with the clinical reviewer that the care on the morning of 5 April fell below the standard of care the man could have expected to receive in the community. The nurse did not respond appropriately to his chest pain and did not keep appropriate records. There was also a delay in calling an ambulance. We make four recommendations.

THE INVESTIGATION PROCESS

5. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

6. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. On 29 May 2014, she interviewed three members of staff and a prisoner at Whatton and gave the prison initial feedback on the findings of the investigation.

7. NHS East Midlands commissioned a clinical reviewer to review the man's clinical care at the prison.

8. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation, who provided the cause of death. We have sent the Coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted the man's family to let them know about the investigation. They had no specific issues they wanted the investigation to consider.

10. The man's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP WHATTON

11. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offenders.

12. Healthcare services are commissioned by NHS Nottinghamshire and provided by Nottinghamshire Community Health Trust. The healthcare centre is open during the week from 8.00am to 7.30pm. On Saturdays and Sundays there is nurse cover from 8.00am until 12.30pm, with a local out of hours service providing cover at night and at weekends. Specialist clinics are provided for older prisoners and those with life long conditions. There are no inpatient beds at Whatton.

HM Inspectorate of Prisons

13. The most recent inspection of Whatton was in February 2012. The Inspectorate found the prison was safe and decent. Health services were judged to be generally good and staff were polite and responsive to prisoners' needs. Primary care was well organised and access to nurse-led, GP and dental services was good. There was a wide range of chronic disease clinics and enablement therapies to meet the needs of the population.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest published report for the year to May 2013, the IMB reported favourably on healthcare services. The Board noted that over 40% of the prisoners at Whatton were aged over 50 and 15% over 65, which impacted on the healthcare department. However, the Board was satisfied that the clinical needs of all prisoners were met.

Previous deaths at Whatton

15. The man's death was the fourth from natural causes at Whatton since January 2013. There have been four deaths since his which are still being investigated. There were no similarities with any of the previous deaths.

KEY EVENTS

16. In June 2007, the man was sentenced to an indeterminate sentence for public protection and was sent to HMP Hull. He transferred to HMP Whatton in October 2009. He had hepatitis C (a chronic liver condition) which was monitored by regular blood tests.

17. At a reception health screen at Whatton, a nurse noted that the man had previously misused drugs and was a heavy cigarette smoker. Otherwise, he was generally fit and well.

18. From 2009 onwards, the man had little contact with healthcare apart from for back pain, minor ailments and blood tests to monitor his hepatitis C. He received help to give up smoking more than once, but records do not show whether he succeeded.

19. At about 10.50am on Saturday 5 April, the man went to the wing office and said he was not well. He had vomited and had pains in his shoulder and chest. An officer said that he did not look well and was pale and sweating. He telephoned a nurse in the prison's healthcare centre who asked for someone to take him there. The officer arranged for another prisoner to take him in a wheelchair, as he was concerned that he might collapse.

20. At 11.09am, Nurse A assessed the man and noted his oxygen saturation level was 98%, his pulse was 85 his temperature was 34.3 and his blood pressure was 129/81. All these were within the normal range. She noted that he said he had vomited and still had pins and needles in his arm from two hours previously. She noted that he had left hand grip, but felt breathless and anxious. He had no difficulty with his speech or coordination. She advised him to try breathing techniques and said she had told him to wait in the healthcare centre to review how he was feeling and if the shoulder pain eased. She gave him paracetamol and ibuprofen.

21. An officer told us that by 11.35am the man was back on the wing from the healthcare centre and said that he felt okay. He told the officer that the nurse had said his symptoms were caused by anxiety and, if he had any further problems, he should ring his cell bell or otherwise alert staff.

22. Prisoner A said that at about 11.20am the man was back on the wing and said that he thought he was having a heart attack. He said he could not take the pain and went back to his cell. After the prisoner had eaten his lunch, he went to see him in his cell and saw him lying on the bed holding his chest. He said he had chest pain and asked the prisoner to keep a check on him. Prisoners were then locked in their cells until 1.45pm.

23. Prisoner A said he had fallen asleep and woke just after 2.45pm. He said he then went to see the man in his cell. He was making himself a cup of tea and offered to make him one. He then shouted out and collapsed to the floor. The prisoner lifted him onto the bed and rang the cell bell. Records show this was at 3.20pm. Two officers attended. A Physical Education Instructor (PEI)

took the defibrillator from the main office to the cell. In his written statement, he said that he used the machine as directed by the voice prompts, it showed no shockable rhythm so officers continued with CPR. As it was Saturday afternoon, there were now no healthcare staff on duty. He did not appear to be breathing. The officers did not call an emergency code, but at 3.30pm, an officer radioed for an ambulance to be called. Records show the control room did not request an ambulance until 3.33pm, as they first tried to obtain further information about his condition. The ambulance was on the way while communications staff tried to put the call through to the staff on the wing, which happened at 3.37pm. Officers continued CPR until paramedics arrived at 3.52pm and, after treatment, took him to hospital by ambulance. He was not restrained.

24. An operational manager acted as the prison's family liaison officer and, at 4.30pm, telephoned the man's father (his recorded next of kin) to tell him that it appeared that his son had suffered a heart attack and was on his way to hospital. At hospital, he remained unresponsive and was moved to the critical care unit. His parents, brother and sister-in-law went to the hospital and the operational manager met them there.

25. The man remained unconscious on a life support machine. His family agreed to organ donation and he remained on life support to allow this to be done. That afternoon, his family agreed that the life support should be withdrawn. At 5.45pm, a hospital doctor confirmed that he had died. His family were with him at the time.

Support for staff and prisoners

26. Shortly after the man was taken to hospital, all prison staff involved at the scene attended a hot debrief, for reassurance and support. Healthcare staff attended a debrief on the Monday when they were next on duty.

27. A Governor's notice informed staff and prisoners of the man's death and offered support to anyone affected. Prisoner A was told individually and offered support if he needed it.

Contact with the man's family

28. The operational manager supported the man's family during his short time in hospital and after his death and had helped them when they decided to donate his organs. The prison held a memorial service for him on14 April. A letter from his family was read out as they had not wanted to attend. The funeral was held on 29 April. The prison paid for the funeral in line with national guidance.

Cause of death

29. The Coroner's office confirmed that the cause of death was hypoxic brain injury (decreased oxygen to the brain), cardiac arrest and myocardial infarction (heart attack).

ISSUES

Clinical care

30. The clinical reviewer found that the general standard of the man's care at the prison was satisfactory. However, while the sudden events on 5 April could not have been anticipated, the standard of care he received after he reported chest pain fell below the care he could have expected to receive in the community.

Cardiac risk Screening

31. The clinical reviewer points out that the man had a number of cardiac risk factors including his age, smoking, substance misuse and weight, which do not appear to have been considered. A registered mental health nurse told us that Whatton does not offer cardiovascular risk assessments to any prisoners. NHS guidelines recommend that all people aged 40 and over should have a routine cardiovascular risk assessment. It is important that such screening is made available to those in a prison such as Whatton which has a significant proportion of older prisoners particularly vulnerable to cardiac risk factors. We make the following recommendation:

The Head of Healthcare should ensure that cardiovascular risk assessments are available to all prisoners aged over 40 or with relevant risk factors, in line with that offered in the community.

Responding to chest pain

32. Records show the man was sweating, had pains in his shoulder and chest and looked grey when he went to the wing office on 5 April. When the officer contacted the prison's healthcare centre, the nurse told him to send him to the healthcare centre. The officer arranged for a wheelchair to take him because he was so concerned that he might collapse. He said he did not call an emergency code blue at the time because the man had not actually collapsed. With the symptoms the officer described, we would have expected a nurse to attend the wing immediately to examine him.

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33. It appears that when Nurse A saw the man she placed a great deal of emphasis on his clinical observations being normal. We would expect nurses to recognise potentially serious conditions and when to refer to a doctor or the emergency services. The National Institute for Health and Care Excellence (NICE) Clinical Guideline 95 provides information on recent onset chest pain. It advises clinicians to assess patients for signs of and risk factors for cardiovascular disease and indicates that a person with chest pain of suspected cardiac origin should be referred to hospital for same day or urgent assessment and treatment. The clinical reviewer notes that the symptoms he presented on the morning of 5 April were consistent with cardiac pain and the nurse who saw him did not identify this. His age, previous drug use and

heavy smoking meant he was at high risk of heart attack, and this should have been considered.

34. The healthcare manager told us that Whatton does not have a chest pain protocol, and her view was the NICE guidance was more for acute coronary syndrome which was usually hospital based. However, it gives guidance on the circumstances in which a person reporting sudden onset chest pain should be referred to hospital. She said that a nurse could obtain support or guidance from a doctor in the prison or through the out of hours service. However, this was not done.

35. The clinical reviewer considered that healthcare staff should have a high index of suspicion when middle aged prisoners present with new chest pain, as they are a high risk group of premature heart disease. In his opinion, at the very least, a working diagnosis should have been made and an ECG carried out. The nurse was unable to give a satisfactory explanation why she did not arrange for an ECG, refer the man to a doctor or arrange for any follow up. She said that she was not trained to read an ECG which she would have arranged if it had been a weekday, as a doctor would have been available. However, she did not call the out of hours GP service for advice. If the prison had had a chest pain protocol the nurse would have been able to refer to this to help complete a working diagnosis or obtain appropriate advice. It is not possible to say whether this would have made a difference to the outcome for him, but he would have received earlier treatment. We make the following recommendation:

The Head of Healthcare should ensure that there is an effective chest pain protocol so that all healthcare staff are aware of current clinical guidance for managing chest pain and that prisoners presenting with such symptoms are assessed urgently, in line with NICE guidelines on the diagnosis of chest pain and, where indicated, referred to hospital for emergency treatment

Record keeping

36. The clinical reviewer noted that the nurses did not keep full and accurate records during the events of 5 April. Nurse A told the investigator that two other nurses had completed observations on the man, that he had taken the tablets she had issued him and that she had arranged for follow up treatment. However, there is nothing in his medical records to confirm any of this. Records were not written at the same time, or as close to the events as possible, as professional guidance requires. For example, records show she made a belated entry on his prison medical record at 7.57am on 6 April to say that on 5 April he had remained in healthcare and when his pain subsided he had wanted to return to his wing. We make the following recommendation:

The Head of Healthcare should ensure that nurses follow the Nursing and Midwifery Council's guidance for record keeping including making entries in medical records as close to the actual time as possible.

Emergency response

37. Records indicate that prison officers began cardiopulmonary resuscitation when they found the man collapsed on 5 April. They continued this for over thirty minutes, until the paramedics arrived. The PEI used the defibrillator which indicated no shockable rhythm. Officers worked hard and professionally and this should be commended. Although officers responded immediately to the cell bell on 5 April, they did not call an emergency code. An officer radioed for an ambulance three minutes later. The ambulance was on the way while communications staff tried to put the call through to the staff on the wing for more information. It therefore took 13 minutes from the time he collapsed to calling an ambulance. This is an unacceptable delay.

38. PSI 03/2013 was issued at the beginning of February 2013 and required governors to have a medical emergency response code protocol based on the instruction by 28 February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called.

39. A Governor's notice at Whatton was issued in March 2012 (before PSI 03/2013) briefly describing the emergency codes, code blue (a prisoner is unresponsive or not breathing) and code red (a prisoner is severe blood loss). However it does not reflect the requirements of PSI 03/2013 and does not state that the control room should call an ambulance immediately an emergency code blue or red is received.

40. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and that Whatton has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

RECOMMENDATIONS

1. The Head of Healthcare should ensure that cardiovascular risk assessments are available to all prisoners aged over 40 or with relevant risk factors, in line with that offered in the community.

2. The Head of Healthcare should ensure that there is an effective chest pain protocol so that all healthcare staff are aware of current clinical guidance for managing chest pain and that prisoners presenting with such symptoms are assessed urgently, in line with NICE guidelines on the diagnosis of chest pain and, where indicated, referred to hospital for emergency treatment.

3. The Head of Healthcare should ensure that nurses follow the Nursing and Midwifery Council's guidance for record keeping including making entries in medical records as close to the actual time as possible.

4. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and that Whatton has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency; and
    - Ensures there are no delays in calling, directing or discharging ambulances.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that cardiovascular risk assessments are available to all prisoners aged over 40 or with relevant risk factors, in line with that offered in the community	Accepted	Systems and processes are now in place. An automated system is available through SystmOne (cardiovascular risk calculator). Based on the results, all patients over 40 years of age will be reviewed at clinics.	Completed Head of Healthcare	
2	The Head of Healthcare should ensure that there is an effective chest pain protocol so that all healthcare staff are aware of current clinical guidance for managing chest pain and that prisoners presenting with such symptoms are assessed urgently, in line with NICE guidelines on the diagnosis of chest pain and, where indicated, referred to hospital for emergency treatment.	Accepted	The chest pain protocol will be implemented in line with National Early Warning Scores (NEWS) issued in July 2012 to standardise the assessments of prisoners presenting with chest pain. Referrals to hospital will be made in line with NEWS thresholds and triggers.	31 December 2014 (to allow for training) Head of Healthcare in conjunction with Notts Healthcare Trust / Resuscitation Lead	
3	The Head of Healthcare should ensure that nurses follow the Nursing and Midwifery Council's	Accepted	All healthcare staff have been informed of this requirement and medical records will be made as close to the actual time as possible.	Completed Head of Healthcare	

	guidance for record keeping including making entries in medical records as close to the actual time as possible.				
4	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and that Whatton has a Medical Emergency Response Code protocol which: • Provides guidance to staff on efficiently communicating the nature of a medical emergency; and • Ensures there are no delays in calling, directing or discharging ambulances.	Accepted	The prison has adopted the Code Red/Code Blue protocol outlined in PSI 03/2013. All operational staff will be reminded of the appropriate use of emergency codes. Staff will also be briefed on the procedure for ambulances so there are no delays in calling, directing or discharging ambulances.	30 September 2014 Head of Safer Custody	