PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in July 2014, a prisoner at HMP Gartree

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 from a heart attack in July 2014, while in the custody of HMP Gartree. He was 56 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at Gartree was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in May 1995 and he arrived at Gartree in January 2011. A nurse noted that he had type two diabetes and heart disease, with a family history of heart disease. Healthcare staff saw him frequently and managed his diabetes well, but there is no evidence that they reviewed his heart condition. On 7 July, he complained of chest pain. Nurses reviewed him and carried out an ECG, which was abnormal. The next day a prison GP diagnosed an inflammation of the chest wall.

Several days later an officer found the man collapsed in his cell with a cut to his forehead. His condition quickly deteriorated and he stopped breathing. Staff attempted to resuscitate him. Paramedics took him to hospital where he was declared dead shortly after.

The clinical reviewer found that, until the time the man reported chest pain, he received a good standard of care at Gartree, equivalent to that he could have expected to receive in the community. However, there was no ongoing review of his heart condition and his chest pain was not managed appropriately in the days leading up to his death. While I am satisfied that he received appropriate emergency treatment, there is a need for Gartree to ensure, in line with national instructions, that staff call an ambulance immediately in an emergency.

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 involve din my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2015**

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SUMMARY

1. The man received a life sentence for murder in May 1995. He moved between several prisons and transferred to HMP Gartree on 11 January 2011.

2. At an initial health screen at Gartree, a nurse noted that the man had type two diabetes and a history of ischaemic heart disease and heart valve problems. He had a family history of heart disease. The nurse recorded that he had previously smoked but had given up. (He started smoking again at Gartree.)

3. Healthcare staff saw the man frequently to monitor his diabetes and related complications. However, there is no record of any monitoring of his heart conditions. In September 2012, he reported chest pains. He had an ECG (electrocardiogram) test and a prison GP diagnosed muscular chest pain.

4. On 7 July 2014, the man told healthcare staff that he had been suffering from central chest and arm pains, on and off for two days. ECG test results were abnormal and nurses gave him a GTN spray (to relieve chest pain) and paracetamol. On 8 July, a prison GP examined him and diagnosed costochondritis, an inflammation of the joints in the ribs and breastbone, which is a painful but not serious condition.

5. At around 11.45am a few days later, the man collapsed in his cell and cut his head. Another prisoner alerted officers, who called nurses to help. An officer radioed an emergency code red (indicating a blood injury). When nurses arrived and assessed him, they could find no signs of life and radioed a code blue (used when a prisoner is unconscious or has breathing problems). The communications room did not call an ambulance until six minutes after the first emergency code, when nurses directly asked for one. Officers and nurses attempted to resuscitate him until paramedics arrived and took him to hospital. At the hospital, staff pronounced him dead at 1.35pm. After he died, a manager informed his sister by phone, as another prisoner had already contacted her.

6. The clinical reviewer says that until July 2014, when the man reported chest pain, the overall care he received at Gartree was equivalent to that he could have expected to receive in the community. However, he was concerned that healthcare staff did not review and monitor his ongoing heart disease. He did not consider that the healthcare team managed his chest pain adequately, when he first reported problems in July 2014 and did not fully consider whether his pain had a cardiac cause. This aspect of his care was not equivalent to community standards. We do not know whether different management of his symptoms would have changed the outcome.

7. We make three recommendations about management of chest pain, monitoring heart conditions and emergency response procedures.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at Gartree informing them of the investigation and inviting anyone who had relevant information to contact him. No one responded.

9. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator and clinical reviewer interviewed seven members of staff at Gartree in September 2014. The investigator also interviewed two members of staff by telephone in October. He gave the Governor initial feedback about the preliminary findings of the investigation.

11. We informed HM Coroner for Leicester City and South District of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers wrote to the man's sister to explain the investigation. The family did not have any specific issues for this investigation to consider.

13. The man's sister received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft and their response to our recommendations and an action plan is added at the end of this report.

HMP GARTREE

14. HMP Gartree is a category B Prison, near Market Harborough in Leicestershire, which holds up to 708 men sentenced to life and other indeterminate sentences. Leicestershire Partnership Trust are responsible for delivering primary physical and mental health services in the prison and Northamptonshire Healthcare NHS Foundation Trust run secondary mental health in-reach services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Gartree was in March 2014. Inspectors were positive about the standard of health services and noted there was a stable healthcare workforce who were qualified to deliver a range of appropriate services. There were satisfactory facilities in reception for initial health screens. Prisoner's access to healthcare services was very good and waiting times for all clinics were short. Nurses held triage clinics daily and there was open access for patients with urgent needs. Patients were able to see a GP routinely within three days. There was sufficient emergency resuscitation equipment, including automated external defibrillators, which were appropriately positioned around the prison

Independent Monitoring Board

16. 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 most recent published annual report for the year to November 2013, the IMB reported that health services at the prison were good and waiting times had improved.

Previous deaths at HMP Gartree

17. The man was the fourth prisoner to die from natural causes at Gartree since 2011. We have raised the issue of the correct use of emergency codes and emergency response procedures before.

KEY EVENTS

17. The man received a mandatory life sentence for murder on 3 May 1995 and was sent to HMP Winchester. He had spent a significant amount of his adult life in prison. He spent time at several prisons before moving to HMP Gartree on 11 January 2011.

18. At the man's initial health screen at Gartree, a nurse noted that he had a history of ischaemic heart disease and heart valve problems, and a family history of heart disease. He also had type two diabetes. The nurse recorded that he used to smoke cigarettes but had stopped. (He started smoking again at Gartree and healthcare staff offered to help him stop, but he declined.)

19. Healthcare staff saw the man frequently for diabetic reviews, physical assessments and blood tests. Their input resulted in an improvement in his diabetes. However, there is no record of any review of his heart disease or follow up of his heart valve problems.

20. On 24 September 2012, the man had a diabetes review at which he complained of chest pain. A nurse carried out an ECG (electrocardiogram) test, which showed some abnormalities, and referred him to the GP. On 27 September, a prison GP examined him and concluded that he had a muscular chest pain. He continued to see healthcare frequently for his diabetes care. Healthcare staff recorded no further significant concerns about his health, including chest pain, until July 2014.

21. On 7 July 2014, the man reported to healthcare unit staff that he had central chest and arm pain which he had been experiencing on and off for the previous two days. A nurse performed an ECG. The results were abnormal and she discussed them with the nurse manager. The nurse manager gave him a GTN spray, a glyceryl trinitrate spray that relieves symptoms of cardiac chest pain, and paracetamol. He referred him to the GP.

22. On 8 July 2014, a doctor reviewed the man, who said that he had had a dull ache in the central chest area for the previous four days. The doctor noted that the pain was worse if he was on his side, but it reduced when he was on his back. Food did not make any difference to the pain.

23. The doctor analysed the ECG results from the day before and compared it with the ECG results from September 2012. The doctor found no differences between the two and diagnosed the man with costochondritis (a painful, but not serious, condition of the chest wall). He reassured him.

Events of the incident

24. One morning a few days later the man told Prisoner A that his chest pain was worse. The prisoner asked an officer if a nurse could come and see him, as he was not very well. She was unable to get any reply from the healthcare unit and asked the control room to radio healthcare staff.

25. At around 10.00am, a nurse went to see the man and took his medical observations, which were normal. The nurse did not see him again that day.

26. At around 11.45am, Prisoner A returned to the wing after work and after collecting some food, he went to see the man. He said that the man was sitting on the bed. He said he had chest pain and was struggling to breathe. He then collapsed and hit his head on a table. He went to get help from Prisoner B. They tried to lift him but noticed that he was bleeding. Prisoner B laid him back down in the recovery position.

27. Prisoner A told an officer that the man had fallen over and cut his head. She was busy serving meals so asked another officer to go to the cell. The officer first telephoned the communications room and asked healthcare staff to attend. When he got to the cell and saw him lying on the floor with a small amount of blood coming from his forehead, he radioed a code red emergency (which indicates a blood injury). The time of the call was 11.57am.

28. At approximately 11.59am, a nurse arrived and asked Prisoner B who had stayed with the man to leave. She noticed that the man's lips were blue and was unable to find a pulse. A minute later, another nurse arrived and she asked her to bring a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) and to call an ambulance immediately. The nurse radioed a code blue emergency call (which indicates when a prisoner is unconscious or has respiratory problems) and shouted to officers to call 999 immediately. The officer and nurse started cardiopulmonary resuscitation (CPR). The nurses applied the defibrillator but there was no detectable heart rhythm. The staff continued CPR and administered oxygen,

29. At 12.03pm, an officer in the communications room called an ambulance. A paramedic car arrived at the wing at 12.10pm and the ambulance arrived at 12.15pm. Paramedics took the man to the ambulance and continued CPR and emergency treatment. At 12.50pm, the ambulance left the prison and took him to hospital. He was pronounced dead in hospital at 1.25pm.

Family contact

30. The Head of Operations telephoned the man's sister, his next of kin, to inform her that her brother had died, soon after the hospital informed the prison. The prison's family liaison officer (FLO) contacted her two days later and offered support. Gartree organised the funeral and contributed to the costs, in line with national guidelines.

Support for staff and prisoners

31. The Head of Operations held a debrief for staff involved in the emergency response at 5.30pm on 10 July. She directed the staff to the available support services if they needed them.

32. The care team at Gartree offered support to the man's friends, in particular to both prisoners. A Governor's notice informed staff and prisoners of his death and the support available. The prison reviewed prisoners identified as at risk of suicide and self-harm in case the news of his death had adversely affected them.

Post-mortem report

33. A post-mortem examination gave the cause of death as an acute complication of the man's long-standing heart disease, acute myocardial infarction and coronary artery atheroma. The post-mortem report noted that his clinical history, chest pain and shortness of breath in the days before his death would correlate with the development of a myocardial infarction during this time and this was the underlying reason for the symptoms that prompted him to seek medical attention on 7 July.

ISSUES

Clinical Care

34. The clinical reviewer concluded that the general standard of care the man received at Gartree, until he reported chest pain on 7 July was of a good standard, and in line with the care he could have expected to receive in the community. When he arrived, he had an appropriate initial health screen and healthcare staff reviewed him appropriately afterwards for his known conditions. Throughout his stay, the primary health care team provided good care for his diabetes, including reviewing him regularly with regular physical assessments and blood tests, which led to some improvement in his condition. However, there is no record that healthcare staff reviewed or monitored his heart disease. The clinical reviewer noted that it is possible that some of this was done at diabetic appointments, but if so, it was not separately recorded as would be expected in a community setting.

35. Coronary heart disease cannot be cured, but treatment can help manage the symptoms and reduce the risk of further problems. We consider that healthcare staff should have reviewed the man's ongoing heart condition and should have kept a record of it in accordance with current NHS guidance.

36. We also share clinical reviewer's concerns about the management of the man's chest pain during the days leading up to his death. When he complained of chest pain on 7 July, a nurse performed an ECG, which was abnormal. A senior nurse issued a GTN spay which suggested he considered that there was a cardiac cause for the pain. The clinical reviewer considers that the abnormal ECG should have led to a further review by a doctor or in hospital that day.

37. On 8 July, a doctor saw the man. The doctor told us that he reviewed the ECG results, although he did not record this action in the medical records. He compared the ECG with a previous ECG from 2012 (the clinical reviewer noted that both show abnormalities). In his opinion, there was no material change in the ECG from the previous one and he diagnosed him with costochondritis.

38. Healthcare staff did not review the man after his appointment with the GP on 8 July. The clinical reviewer considers that the doctor's diagnosis, although possible, did not take into account, or give sufficient weight to, his medical history, including his heart disease and long-standing diabetes. The clinical reviewer concludes that he should have had a further assessment to determine the cause of his symptoms.

39. We share the clinical reviewer's concern that there was no follow up of the man's chest pain and the doctor did not consider his medical history. The National Institute for Health and Care Excellent (NICE) guidelines for chest pain say that healthcare staff should assess chest pain urgently and refer the patient to hospital if necessary. We are concerned that this was not done.

40. We agree with the clinical reviewer's recommendation that the healthcare unit at Gartree should review their processes in relation to the assessment, management and documentation of patients with symptoms which may suggest acute heart conditions. This should include clear policies on the initial assessment, including the review and interpretation of ECGs and review by appropriate senior clinicians if necessary. The investigation found that there is no chest pain protocol at Gartree. The clinical reviewer said it is not possible to say whether different management of the man's symptoms would have changed the outcome. We make the following recommendations:

The Head of Healthcare should ensure that prisoners with ongoing heart conditions are appropriately reviewed and monitored in line with current NHS guidelines.

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.

Emergency response

41. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires governors to have a medical emergency response code protocol that instructs staff how to communicate the nature of a medical emergency using agreed emergency codes and ensures that the control room calls an ambulance automatically, as soon as a member of staff calls an emergency code.

42. Gartree has an ambulance call protocol directed to the communications room staff when healthcare staff or the duty governor requires an ambulance. The protocol does not comply with the PSI. There is no medical emergency response protocol, as the PSI requires. The Head of Operations told us that staff are fully aware of their responsiblities under PSI 03/2013. We found this was not the case.

43. On 10 July, an officer radioed a code red emergency as the man was bleeding from a small head wound. This created some initial confusion, as two nurses did not bring the appropriate equipment for resuscitation. After assessing him, the nurses called a code blue and one nurse had to leave the cell to bring the code blue emergency bag.

44. The communications room did not call an ambulance in response to either emergency code, as the PSI 03/2013 requires. They did not request an ambulance until a nurse specifically requested one, six minutes after the first emergency code call. The practice at Gartree is not to request an ambulance until healthcare staff or the orderly officer attend the scene and confirm that one is required. The PSI explicitly states that "local procedures must ensure that staff understand they should not delay summoning emergency

assistance. For example, it must not be a requirement for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are called".

45. We have made recommendations about the correct use of emergency codes and calling an ambulance to Gartree before. In response, the prison said that they had briefed staff about the requirements to call an ambulance, but it is evident that this was inadequate. We make a further 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 Gartree has a medical emergency response protocol which

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

Informing the man's next of kin

46. The man's sister, his next of kin, lived in Edinburgh. The senior manager on the day of the incident decided not to contact a local prison or use the police to break the news of his death but instead telephoned her at 2.15pm, shortly after the hospital had informed the prison of his death.

47. The senior manager explained that she had telephoned the man's sister because she knew that Prisoner B had already phoned his sister and told her that he had collapsed and been taken to hospital. The prisoner had agreed with the man that they would contact each other's next of kin if something happened to them in prison. The manager did not want the man's sister to wait any longer to have the full information about what had happened. We are satisfied that, in these circumstances, this was an appropriate decision.

48. The senior manager arranged the prison's family liaison officer would contact the man's sister on 12 July. We are satisfied that she received appropriate support from the prison after his death.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with ongoing heart conditions are appropriately reviewed and monitored in line with current NHS guidelines.

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 Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Gartree has a Medical Emergency Response Protocol which

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene bring the relevant equipment; 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 prisoners with ongoing heart conditions are appropriately reviewed and monitored in line with current NHS guidelines.	Accepted	Long-term condition registers are now completed and care planned on an individual basis. Leads within the GP team have been identified for specific monitoring of these conditions. Nursing staff are being encouraged to spend time in the local GP practice to gain experience of nursing these conditions.	31/03/2015 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	Chest pain protocol has been developed and is now in place for all healthcare staff.	Completed Head of Healthcare	
3	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 Gartree has a Medical Emergency Response Protocol which • Provides guidance to staff on	Accepted	A policy compliant with PSI 03/2013 and covering all points raised in the action has been published and implemented for all staff.	Completed Head of Residence, Safety & Equalities	

	efficiently communicating the nature of a medical emergency; • Ensures staff called to the scene bring the relevant equipment; and; • Ensures there are no delays in calling, directing or discharging ambulances.				