Investigation into the circumstances surrounding the death of a man in a local medical centre, while a prisoner at HMP Whatton, in September 2009

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

This is the report of an investigation into the circumstances of the death of a life sentenced prisoner at HMP Whatton, on 14 September 2009. The man had a longstanding heart condition and a heart replacement valve was fitted in 2001. A post mortem found that the main cause of his death was acute heart failure.

The man's parents had died some years ago while he was in prison. He was an only child and no other next of kin or family members could be found. I would like to offer my sincere condolences to all those who knew him and were affected by his death.

One of my investigators conducted the investigation. An independent review of the man's medical care was undertaken by a clinical reviewer, on behalf of Nottinghamshire County Teaching Primary Care Trust (PCT). Not for the first time, I am grateful to this clinical reviewer for his contribution.

I would also like to thank the Governor of Whatton and her staff for their cooperation. I am grateful to the Head of the Secretariat and, particularly to the member of staff from Safer Custody who provided a very high standard of prison liaison. I would like to express my appreciation and thanks to the prisoners and staff on the man's wing who provided valuable information.

I make one recommendation about the monitoring of International Normalised Ratio (INR) results as the investigation found that healthcare staff failed to act upon information received from the hospital. On this occasion, it did not impact on the man's death, although it may prove critical in future. Aside from this, I judge that the care given to him at Whatton was equal to that which he would have received in the community.

The National Offender Management Service has accepted my recommendation and their response is documented on page 20 of the report.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2010**

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SUMMARY

The man was a life sentenced prisoner, he had served nearly 21 years in prison when he died. He served his sentence in a number of prisons, primarily in the north of England, before going to Whatton in January 2008. The man's behaviour in prison fell short of what was expected on a number of occasions, however, he learned to read and write and made progress.

From the outset, he had a number of medical conditions, including epilepsy (although he did not have seizures in custody), stomach problems, high cholesterol and heart disease. The most serious of these was heart failure, the condition from which he subsequently died. The man collapsed a number of times and was sent to hospital in the community.

In 1995, the man was diagnosed with mild aortic valve disease and an aortic valve replacement was advised in 1996. However, this did not take place until his health deteriorated at HMP Albany in January 2001. He underwent surgery for a mechanical aortic valve replacement at a local hospital. (Hospital A) He was then prescribed warfarin[1], (an anti blood clotting drug requiring constant monitoring). He recovered and was reviewed every year by a cardiologist.

The man's clinical record is extensive because of his heart condition. He continued to smoke against medical advice and did not eat very well. However, the clinical reviewer noted that he complied with his medication.

A few days before the man's death, prisoners on his wing noticed that he was violently sick and sleeping most of the day. He refused to take advice from friends on the wing to report this to healthcare.

On the day he died, the man was found collapsed in his cell at around lunchtime. A wing officer went to healthcare and asked for a nurse, who put him on oxygen to help his breathing, but noticed that he was coughing bright red blood. She asked for an emergency ambulance to be called. A paramedic arrived within ten minutes and an ambulance followed 50 minutes later.

The man was placed in restraints and, accompanied by two officers. He was taken by ambulance to the local medical centre. Although urgent, his condition was not thought to be life threatening. When he arrived at the hospital, medical staff carried out tests and judged that he needed to stay in hospital overnight, although he appeared to be recovering. At around 5.30pm, while in the cardiac unit, his condition suddenly deteriorated and he had a heart attack.

The escort staff who accompanied him were caught by surprise at his rapid deterioration and the restraints needed to be removed as a matter of urgency. The restraint at one end was removed from the officer but the attachment at the other end

[1] Warfarin is an anti coagulant drug used to thin the blood to stop clotting

could not be removed from the man as his body had rolled onto the chain. He could not be moved because staff were carrying out cardio pulmonary resuscitation and using the defibrillator. In these circumstances, not removing the restraint is regrettable, but understandable. Hospital staff made every effort to save the man's life, but sadly he died at 7.10pm. No next of kin could be found.

The clinical reviewer commented that the man had severe cardiac disease and his life expectancy was reduced. His death was understandable in the circumstances. He also found no significant shortcomings in how the man's medical care was managed at Whatton. I have recommended that the head of healthcare should review the healthcare department's systems and protocols for management of hospital information relating to these.

THE INVESTIGATION PROCESS

1. The man died on 14 September 2009. However, due to a misunderstanding between the prison and the National Offender Management Service (NOMS) regional office, this office was not notified of the man's death until 30 September 2009. Terms of reference and notices were issued to staff and prisoners at Whatton telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator , requested copies of the man's core record, clinical record, and other records relevant to his time in custody and his death.

2. The investigator also contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. A copy of the report was received by the office. The post mortem found that he died of:

   1a. Acute cardiac failure
   b. Left ventricular hypertrophy
   c. Aortic valve disease (prosthetic valve)

3. The Investigator and an Assistant Ombudsman visited Whatton on 2 December 2009. They met the prison's Safer Custody Officer, and visited the wing where the man lived before his death. The investigator spoke with prisoners and staff who knew him. She then wrote to the Governor, on 22 December 2009, updating her on the progress of the investigation.

4. A clinical review of the man's medical care was commissioned from Nottinghamshire County Teaching Primary Care Trust . The clinical reviewer focussed on the clinical care the man received at Whatton.

5. The prison made every effort to locate and contact the man's next of kin. His parents died while he was in prison and he was an only child. Despite their efforts, no next of kin were identified.

HMP WHATTON

10. HMP Whatton is a category C training prison for prisoners convicted of sexual offences, or who have a sexual element in their offending history. It holds a higher than average older population.

11. In response to overcrowding in prisons across England and Wales, Whatton underwent rapid expansion in 2006, increasing the operational capacity from around 400 prisoners to 861 by 2008.

12. Healthcare at Whatton is provided by Nottinghamshire County Teaching Primary Care Trust (PCT). The Independent Monitoring Board report for the period June 2008 to May 2009 said they were impressed by the "overall proactive management of all aspects relating to healthcare". The IMB judges that healthcare is responsive to the frequently changing needs of the population. This is a challenge as 60 to 70 per cent of the prisoners at Whatton are aged 40 and over, compared with 20 per cent of the adult population in the community. The IMB comments that it is therefore inevitable that more prisoners will die of natural causes. The IMB concludes that healthcare at Whatton continues to be excellent, with particular emphasis on palliative care.

13. Despite a high ratio of older prisoners, Whatton does not have an inpatient healthcare unit. The prison does not have 24 hour healthcare facilities and medical staff are not on site during the night or at weekends. (I have commented on this in previous death in custody reports). Out of hours medical care is provided by Nottingham Emergency Medical Services (NEMS).

14. Healthcare professionals visit the prison on a regular basis and deliver care through a series of clinics including a doctor, dentistry, chiropody, optician and psychiatry.

15. The IMB continues to voice concern about sex offenders sharing cells and the vulnerability of some prisoners. The Board also noted that at the time of writing their report, 11 percent of the prison population were life sentenced prisoners who were over their tariff, such as this man. There was concern that the prison was not adequately resourced to meet the needs of this population.

16. In her inspection report dated March 2007 the HM Chief Inspector of Prisons, said that many aspects of the regime at Whatton that had been applauded in a previous inspection were still in place. She acknowledged that the prison had to fully adapt to the changes it had been asked to take on so rapidly.

16. There have been 20 deaths at Whatton since the Ombudsman's office began investigating all deaths in prison custody in 2004.

KEY FINDINGS

17. The man was remanded into custody at HMP Hull in September 1987, charged with a murder. He was convicted and sentenced at a local Crown Court on 12 October 1988. A life sentence with a tariff [2] of 14 years imprisonment was imposed. His tariff was later raised to 18 years following a review by the Home Secretary. The man's tariff expired on 25 September 2005, but he was not considered suitable for immediate release into the community.

18. During his sentence, the man spent time in a number of prisons throughout England before going to HMP Whatton in January 2008. Prison and clinical records kept during the early years of the man's sentence are extensive and in paper form. Authors of the entries in those records did not always record their name, role or the prison where the entries were made. As a consequence, it is sometimes difficult to establish where the man was located in the earlier part of his sentence. The issue is made more complex as he occasionally spent time at other prisons for a short period in order to receive visits from family or friends.

19. The healthcare department at Hull wrote to the man's community doctor on 22 September 1987. The doctor confirmed on 25 September 1987 that the man was taking medication for epilepsy, did not abuse alcohol or drugs but was noted to be of "below average intelligence".

20. The man had a lengthy interview with healthcare staff at HMP Leeds on 9 March 1988. During that interview, he told the healthcare officer that he had suffered epileptic fits since the age of two and had taken Epilem [3]and Phenobarbitone [4] regularly until 1976. He said that his last epileptic fit was at the end of 1987. While on remand at Leeds in March 1988, he complained of pain in the left side of his chest which was treated with co-proxamol, a painkiller.

21. The man's clinical record shows that on 19 February 1991, he was assessed as fit for transfer to HMP Wakefield. Until July 1992, healthcare staff at Wakefield reviewed him on a regular basis for various conditions including stomach pain, for which he took Gaviscon[5] to relieve the symptoms.

22. In mid-July 1992, he experienced shooting pains in his upper abdomen. The clinical record shows that an electrocardiogram (ECG) was carried out. (An ECG is a measurement of the electrical activity of the heart.) The record is difficult to read but it is likely that the ECG was performed at a hospital as the word "discharged" is written across the date of 10 July 1992. However, the clinical record makes it clear

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[2] A Tariff is the minimum time a prisoner has to spend in prison before the Parole Board for England and Wales will consider release. At the time the man was imprisoned, the Home Secretary set the tariff. It is now set by the Trial Judge.
[3] Epilem (sodium valproate) is a medication to control epilepsy.
[4] Phenobarbitone is one of the oldest drugs used for the treatment of epilepsy.
[5] Gaviscon is medication for the relief of heartburn and indigestion.

that a referral was sent to a cardiologist. Again, it is not evident who made the referral but the healthcare department were advised to check on the man in two weeks.

23. In October 1992, the man was sent to hospital urgently after complaining of feeling breathless. He was discharged 9 October without a discharge letter. Under those circumstances, the prison spoke with hospital staff who thought that he had a viral infection affecting the muscles around his heart area. No treatment was necessary but a follow up appointment was made for 17 October. The man's clinical record says that he refused admission to the prison hospital for observation and signed a refusal of treatment form.

24. The man was subsequently diagnosed with mild aortic valve disease with no specific treatment advised. The hospital said they would see him every two years for review.

25. In May 1993, healthcare staff assessed him as fit to go to Hull to receive accumulated visits from his family. (When prisoners live a long distance from their home and are unable to receive visits, they can apply for a temporary move to a prison nearer to their family.)

26. Throughout his time at Wakefield, the man visited healthcare regularly until his transfer to HMP Frankland in December 1994. In February 1995, he complained of chest pain again and healthcare staff noted that a hospital (Hospital B) had diagnosed mild aortic valve disease. The man was working in the upholstery workshop at Frankland at the time and he was worried that lifting heavy furniture would worsen the condition. Healthcare staff advised that he should be excused from work the following day; they prescribed painkillers and reassured him.

27. After an appointment at his follow-up clinic for aortic stenosis (a narrowing of the aortic valve, which restricts the flow of blood), a Consultant Cardiologist, (Consultant A) wrote to a medical officer, at Frankland on 31 July 1996. He said the man felt breathless when climbing stairs and noted that his heart condition had deteriorated. In the circumstances, he felt that the man would need an aortic valve replacement. He agreed to see him in a year but wanted to be kept informed of developments in the meantime.

28. The man was noted to have recently given up smoking, but described himself as "feeling edgy". A nurse said at interview that the man continued to smoke throughout against medical advice and his clinical record shows that he regularly complained of chest pain.

29. Consultant A reviewed him again on 30 July 1997. The doctor judged that it was appropriate for the man to be referred to a Hospital (Hospital C) for aortic valve replacement surgery as his condition had deteriorated. He had complained of dizzy spells as well as feeling breathless when walking upstairs. The man was aware of his impending appointment for a valve replacement in July 1997, as he told

healthcare staff of his concern that he had to keep cancelling his accumulated visits while waiting for the operation.

30. On 14 May 1998, he transferred to HMP Albany on the Isle of Wight. His clinical record shows that he collapsed while working in the prison gardens on 28 January 1999 and was sent to a hospital. (Hospital D) The diagnosis of aortic stenosis was confirmed.

31. The man had chest pain again on 30 May 1999. In July, a locum medical officer, referred him to the consultant cardiologist at Hospital D to ask for a prognosis as the man had voiced concerns about his future prospects.

32. Throughout his sentence, the man's behaviour on the wing sometimes fell below the standard expected of an enhanced[6] prisoner at times and he was downgraded to standard privilege status. He was described as demanding of staff time and patience, and the standard of hygiene in his cell was poor. This was interspersed with other more positive entries made by wing staff which showed that there were periods when he made an effort to conform to prison standards and rules. On 21 December 1999, he returned to Hull to go to his father's funeral.

33. At Albany, an exercise stress test was cancelled twice due to a shortage of staff. On 8 December, an Honorary Consultant Cardiologist (Consultant B) at Hospital D wrote to Healthcare to advise they would not send another appointment but would wait for the prison to arrange for one. After he finally went for the test Consultant B wrote to give the results in a letter dated 19 July 2000. He advised that the man should be seen very soon at the cardiology clinic. The man attended the cardiac clinics and cardiac catheterisation[7] was advised.

34. Consultant B referred the man to a different Consultant Cardiologist (Consultant C) at Hospital A, for cardiac catheterisation. In August 2000 Consultant B's frustration at the man missing important appointments is made clear in his letter to the Governor of Albany. The Governor replied assuring Consultant B that every effort would be made to ensure that the man attended the hospital for the procedure.

35. The man eventually underwent the cardiac catheterisation procedure successfully on 21 November 2000. Consultant C advised that the man should be offered aortic valve replacement. He said that the man was agreeable to this and he intended to write to the appropriate cardiac surgeon to put his name on the waiting list.

36. The clinical record shows that on 16 January 2001, the man underwent surgery for a mechanical aortic valve replacement at Hospital A. He was prescribed warfarin [8]

[6] Enhanced status is part of the Incentive and Earned Privileges Scheme to encourage positive behaviour in prisons. There are three levels – basic, standard and enhanced, with the latter being the highest.
[7] Cardiac catheterisation is the insertion of a thin plastic tube into a chamber or vessel of the heart to measure information about the ability of the heart muscle, blood pressure and oxygen.
[8] Warfarin is a drug used to thin the blood

(which the cardiac surgeon said he would have to take for the rest of his life because of his mechanical heart valve) and pain relief. It was noted that he felt well after his operation. He was reviewed by a new Consultant Cardiologist, (Consultant D) six weeks later at the same hospital and was said to have made an excellent recovery. The hospital suggested an annual review.

37. The man's mother died in October 2001 and he went to the funeral in early November. He was then sent to a number of prisons for a variety of reasons, including accumulated visits with friends and family.

38. In December 2002, the Parole Board considered the man's case and refused a transfer to an open prison. The Board considered that, although he had made some progress, there was still a great deal of work to complete before he could be considered for a progressive move. In addition, the Board noted that he had been subject to ten adjudications (disciplinary charges).

39. In May 2003, he transferred to HMP Littlehey. He went to the healthcare centre on 5 February 2004 complaining of "heaviness in his chest". He was sent to hospital a few days later following a collapse at work. The man was referred to a different hospital (Hospital E) and the clinical record shows that the man refused to attend an appointment at the hospital and signed a disclaimer on 28 February 2004. No reason was given for his refusal on the disclaimer letter and the clinical record does not mention the reasons.

40. The man was still under the care of Hospital E when he was transferred to HMP Wymott in 2004 to undertake a specialist course designed to reduce his risk of re-offending. A letter dated 5 May 2004, from Littlehey to Wymott, suggests that Hospital E were unaware that he had transferred. The letter says that Hospital E telephoned Littlehey asking why he did not attend for an appointment on 19 April and did not realise that he had been transferred. In the circumstances, Hospital E suggested the man be referred to the local cardiac outpatient department for treatment and they would liaise with them regarding his care.

41. The man developed a complication following his aortic valve replacement surgery. He was due to see to a Consultant Cardiologist (Consultant E) at a local Hospital (Hospital F) on 30 September for a follow up appointment. The prison asked Consultant E if he could see him earlier as he had developed a pyogenic granuloma[9] He considered the problem to be ongoing although the man denied it.

42. On 2 September 2004, the man missed a hospital cardiac appointment at a hospital (Hospital G) due to a lack of escort staff. They arrived two hours after the appointment and staff said they had called to say they would be late but the hospital said the man would not be seen. The appointment was rearranged for 16 September.

[9] A pyogenic granuloma is a harmless overgrowth of large numbers of tiny blood vessels.

43. Following the appointment on 16 September, the hospital told the prison that the man had a sternal wire protruding through his skin and there was evidence of an infection/abscess. On 8 November, the man was admitted to hospital and had an operation to correct the problem.

44. The man regularly attended the International Normalised Ratio (INR) clinic to monitor the clotting levels in his blood while on warfarin.

45. On 8 September 2006, he was found unconscious on his cell floor. An ambulance was called and he regained consciousness on the way to the hospital. He complained of chest and head pain. After investigation, he returned to the prison the following day. A discharge letter said that no treatment or follow up appointment was needed and advice was given about using a GTN[10] spray.

46. In January 2008, the man transferred to Whatton. Healthcare staff continued to monitor and adjust his medication as necessary. His behaviour on the wing was variable and continued to give cause for concern at times. He received a number of verbal warnings. Despite telling his personal officer that he wished to become an enhanced status prisoner, he remained on standard as his behaviour did not improve sufficiently for him to be upgraded.

47. A review of the man's status under the Incentives and Earned Privileges scheme was held on 2 July 2009. The review board concluded that the man's behaviour had improved sufficiently for him to be given enhanced status. He was working in the prison workshop and his behaviour had improved over the previous few months. The board felt that he had reflected upon his behaviour, was complying with his sentence plan and he had become a mentor to other prisoners experiencing difficulties.

48. A sentence planning and review report completed by the B wing residential manager and countersigned by the Lifer Manager on 6 July confirms that he had made progress in all areas. The recommendation was that he should be transferred to an open prison where he would be able to build on the progress he had made and continue to work towards his eventual release.

Events a few days before the man's death

48. A fellow prisoner (prisoner A) spoke with the investigator. Prisoner A said that he saw the man in the dining hall at lunchtime on Sunday 13 September and noticed that he was breathless. Later that afternoon, the man "barged through" prisoner A's cell door unexpectedly as he needed to use the toilet urgently because he had diarrhoea. He told prisoner A that he felt "collapsed and faint". He spent around 15 minutes using the toilet in prisoner A's cell. During this time he asked prisoner A to switch on his fan as he could not breathe. The man returned to his own cell once he had got his breath back. Prisoner A recalled that the man refused his offer of help.

[10] A GTN spray is glyceryl trinitrate. It is used to ease angina pains.

He used the corridor wall to support himself as he returned to his own cell at the end of the corridor. He said the man did the same thing the following day. The investigator asked prisoner A why he did not tell wing officers that the man was unwell. He explained that he did not tell an officer until the day after the man's collapse because prisoners are not meant to use a toilet in any cell other than their own.

49. Another prisoner (prisoner B) said he knew the man well and was aware that hehad been ill for around two weeks before his death. Prisoner B made a number of observations about the man's health and lifestyle. These included the man's refusal to go to the healthcare centre, despite urging him to do so, vomiting after every meal, repeated visits to the toilet and developing a cough that prisoner B said he had not heard before. He described the man's diet as very poor. He said he smoked, "ate rubbish and lived off pot noodles".

50. Prisoner B was aware that the man had undergone a number of heart operations in the past because he had shown him the scars. He recalled that about four days before the man's death, he noticed he was sleeping all day and was "really very ill". Prisoner B was able to confirm prisoner A's version of events about the man using his cell three days before his death, as he had witnessed it.

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53. The man's wing record says that he was sick in his cell at lunchtime on the day he died. The clinical record shows that at 12.10pm a wing officer went to the healthcare centre to say that the man was vomiting and struggling to breathe. A Senior Nurse went to his cell. When she arrived, the man told her that he had coughed clots of blood the day before but did not tell healthcare staff. The Nurse found that the man was pale and slightly grey, with an audible wheeze. He was beginning to lose consciousness and she and the Officer lowered him to the floor where he coughed bright red blood. The man was given oxygen and an emergency ambulance was called. The paramedic arrived at 12.40pm.

54. The Radio Daily Transmission Log records that the ambulance was called at 12.30pm and arrived over an hour later at 13.28pm. Two escort officers[11] went with the man to the hospital in the ambulance, Officer A and Officer B. When Officer B arrived at the prison to start his shift, he was told that he would have to leave the prison immediately on an emergency escort. Officer B went to the cell. The paramedics had put the man in a chair and wheeled him to the ambulance. He was placed in restraints known as an escort chain. One end of the cuff was attached to his wrist and the other to Officer B, linked with a long length of chain. The Gatekeeper's Daily Occurrence Book shows that the ambulance left the prison at 2.03pm. Officer A recalled that the ambulance did not travel under emergency "blue

[11] An escort officer is a prison officer who accompanies a prisoner into the community for an appointment or medical emergency.

light" conditions. The man was given oxygen and Officer B described him as quiet and apparently exhausted throughout the journey.

55. Officer B said that the man was allocated a bay in the Accident and Emergency Department at the local Medical Centre. Nursing staff carried out a number of tests and the man was offered aspirin for his heart. He refused this on the basis that he was not allowed to take it unless healthcare at Whatton agreed. Officer B gave the direct telephone number of the healthcare department to hospital staff and, when Whatton healthcare staff confirmed that the man should take aspirin, he did so.

56. Despite the man becoming more alert, doctors told the escort officers that he would remain in hospital overnight. Officer B saw the man tell a doctor that he did not have next of kin and that he was on his own.

57. At around 5.30pm, the man was moved to the cardiac care unit for observation. The officers did not think that medical staff had any apparent concerns. Unexpectedly, he suddenly struggled to breathe despite being given oxygen since he left the prison. Officer A had left the area to make a telephone call to update the prison, leaving Officer B on his own with him. Officer B alerted medical staff who came to assist. The man's condition deteriorated and medical staff judged that he was on the verge of a heart attack. Senior Officer A arrived on the ward at this point (6.40pm).

58. A few seconds before Senior Officer A arrived, Officer A had left the bay to telephone the prison to ask permission for the restraints to be removed. Officer B instantly assessed the situation and then told Senior Officer A that he wanted the restraints removed immediately as a defibrillator[12] was about to be used to shock the man and he (the officer) did not want to receive an electric shock when this happened.

59. A few seconds later, the man had a heart attack. Senior Officer A said he took the restraint keys from Officer B's pocket while he was using the telephone. He immediately removed the cuff from Officer B as the medical staff needed to begin chest compressions and apply the defibrillator. Senior Officer A said that he was unable to remove the restraints from the man as he had rolled over and was lying on top of the escort chain. Senior Officer A said that a few seconds later, Officer A returned saying that Principal Officer A had given permission to remove the restraints.

60. Officer A told the investigator that when it was clear that there was a medical emergency, he had some discretion regarding removing restraints. He was waiting for guidance from the medical staff because the man's situation was not clear to him and he was uncertain whether they were going to use a defibrillator or not. To pre-empt matters in case removal of the restraints became essential, he sought

[12] A defibrillator is a machine that delivers an electric shock to try and restart the heart in the event of cardiac arrest.

permission from the prison. Sadly, despite the efforts of hospital staff, the man died at 7.10pm.

61. At 8.10pm that evening, a hot debrief[13] was held. According to the notes of the meeting, Officers A and B attended along with other prison staff. The note records that both Officer A and Officer B were offered support from staff care or employee support services. They were also offered time off from work if they felt they needed it.

62. The man had not listed any next of kin and the prison and the police were unable to find or contact any family members. The investigator spoke with the Coroner's Officer. She confirmed that the man did not have any next of kin who had made themselves known to the Coroner.

[13] A hot debrief is a meeting held immediately after a death in prison custody. Staff are able to talk about their experiences and learning points (if any) are identified. Members of the staff welfare team (care team) are also usually present.

ISSUES

Clinical care

63. The clinical review was undertaken by the clinical reviewer for Nottinghamshire Teaching Primary Care Trust (PCT). His review is based on prison medical records and liaison with my investigator. He found that a comprehensive reception screening took place at Whatton. It identified the major issues concerning the man's physical health and initial management plans were put in place.

64. The clinical reviewer judged that overall, the medical care given to the man at Whatton was satisfactory. He noted that the man frequently required warfarin dose changes, which was consistent with his condition. In his opinion, the man's warfarin control was difficult to stabilize. He acknowledged that, while other medication and lifestyle factors influenced warfarin control, healthcare staff were responsive and they made clinical management changes and performed sufficient checks to try and optimize control. The clinical reviewer noted that it was also difficult to take blood from the man and the healthcare department did well to manage to get a sample.

65. The clinical reviewer concludes that the man had severe heart disease and his life expectancy was therefore reduced. The doctor questions whether the stress of diarrhoea in the few days immediately before the man's death may have placed undue stress on his heart which subsequently failed.

66. The clinical reviewer highlights one area of concern where healthcare did not act on information received from the hospital:

> "In my opinion, there were many occasions when the man's INR was not in the therapeutic window[14] and this is completely understandable considering the problems with medication interactions, and that his INR varied even when no other medication changes were made and when he otherwise appeared to be in stable health. On two occasions the procedures in the Healthcare department did not flag up important protocol changes; failing to act immediately from a fax from the hospital of a low INR and failing to initiate enoxapirin treatment when INR dropped below 1.8. These two episodes should be discussed at the next clinical audit meeting in the healthcare department."

67. The clinical reviewer recommends that healthcare staff failing to act immediately on important information received from the hospital and not reacting appropriately when the man's INR fell below acceptable levels be discussed at the next clinical audit meeting. I endorse his view that the matter needs to be reviewed and acted upon by the healthcare department.

[14] Therapeutic window (or pharmaceutical window) is an index for estimation of drug dosage which can treat disease effectively while staying within the safety range.

The Head of Healthcare should review the systems and protocols regarding receiving, analysing and acting upon information received from a hospital relating to the monitoring of INR results. The Head of Healthcare should ensure that all INR results are closely monitored and are acted upon in a timely and appropriate manner.

Ambulance delay

68. I must comment on the fact that the ambulance took just over an hour to reach the prison from the time it was called at 12.30pm to 13.28pm. A paramedic was sent ahead and arrived within ten minutes but without the ability to take the man to hospital immediately. The length of time the ambulance took to arrive at the prison is a concern as the prison is in a rural location and does not have an inpatient healthcare facility. It is around 16 miles to the local Medical Centre and I am concerned about the distance from the prison to the hospital given there is no internal out of hours medical support. Although there is little that can be done about the location of the prison in relation to the nearest hospital, the Governor might wish to keep under review the best way of minimising delays in accessing medical attention for emergencies.

CONCLUSION

31. The man was a life sentenced prisoner who spent many years in prison. Although not in good health, his death was sudden and unexpected. He had long term heart problems and had undergone an aortic valve replacement to help his condition. Amongst other medication, he was required to take warfarin to help stop blood clotting. Officers were unable to completely remove the restraints when the man took a turn for the worse, but this was understandable as he had rolled onto the chain while staff were attempting to resuscitate him.

32. The clinical reviewer is satisfied that, overall, the man received good care at Whatton. He has suggested one recommendation regarding the raising of a protocol for dealing with INR results and I endorse this recommendation. My recommendation aside, I judge that the care the man received was comparable to that which he would have received in the community.

RECOMMENDATION

The Head of Healthcare should review the systems and protocols regarding receiving, analysing and acting upon information received from a hospital relating to the monitoring of INR results. The Head of Healthcare should ensure that all INR results are closely monitored and are acted upon in a timely and appropriate manner.

Accepted. Head of Healthcare has reviewed systems and protocols relating to receiving and analysing and acting upon information received relating to INR results.

Lead INR nurse in place.

Standard Operating Procedure to be written reflecting the review.

Monitoring and audit processes relating to INR monitoring and action are in place.

Discussions regarding issues raised in the report to be discussed within nursing and multi disciplinary team meetings.