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 at HMP Whitemoor in May 2014

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 the man who died of a cardiac arrest on 26 May 2014, while in the custody of HMP Whitemoor. I offer my condolences to the man's family and friends.

One of my investigators carried out the investigation. A clinical reviewer was appointed to review the man's clinical care at Whitemoor. The prison cooperated fully with the investigation.

The man had been in prison since August 2009 and was transferred to HMP Whitemoor in September 2012. He had Marfan syndrome (a genetic disorder which can affect the heart) and had annual specialist checks. In August 2013, a consultant considered the man needed heart surgery. In February 2014, a surgeon agreed with the man that he should have an operation in early June 2014.

On 5 May, the man complained of sudden chest pains. The prison called an ambulance quickly, but it took over an hour to arrange prison officer escorts to accompany the man to hospital. He transferred to Papworth Hospital later that day and doctors went ahead with the surgery that had been planned for June. The man remained in the critical care unit at the hospital for three weeks, but did not recover and died from a cardiac arrest.

I agree with the clinical reviewer that the man's clinical care at Whitemoor was equivalent to that he could have expected to receive in the community. I am pleased to note that the man was not restrained at any time after his surgery and his family were able to visit whenever they wished. However, I am concerned that the prison cancelled two hospital appointments without considering alternative arrangements. I also consider that it took too long arrange an escort for the emergency ambulance. While there is no evidence that either of these matters affected the outcome for the man, in other circumstances, they could be crucial and recommendations are made accordingly.

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

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

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SUMMARY

1. The man was remanded to prison in 2009. In May 2010, a judge sentenced him to life imprisonment. The man had Marfan syndrome, a genetic disorder that affects the body's connective tissue and means that the aorta (the main heart muscle) can become enlarged. A cardiologist regularly monitored the man.

2. In September 2012, the man transferred to HMP Whitemoor. He told healthcare staff about his Marfan syndrome. In May 2013, the John Radcliffe Hospital, Oxford, sent a reminder for the man's annual review. Because he was now at Whitemoor, the GP transferred his care to Addenbrooke's Hospital in Cambridge and made an appointment for 14 August. At this appointment, the consultant found the man's aorta had dilated further and wrote to a cardiac surgeon at Papworth Hospital for advice about the best time for aortic surgery.

3. The prison rearranged an aortic MRI scan planned for October to November, after the man became aware of the date. After the scan, a consultant discussed possible surgery with him and the man agreed to go ahead. The prison cancelled a hospital outpatient appointment in March, because the man had had a minor procedure on his foot the day before. Surgery was planned for June 2014.

4. On the morning of 5 May, the man had sudden chest pains. A nurse assessed him and found his blood pressure and ECG readings were abnormal. She called an ambulance, which arrived quickly. It took over an hour before the man left for a hospital in Peterborough, partly because paramedics were concerned he might have taken drugs but mainly because the prison took some time to arrange officers to accompany him.

5. The hospital diagnosed acute aortic dissection (a tear in the inner wall of the aorta, which results in decreased blood supply to other organs). The man transferred to Papworth hospital and the cardiothoracic team went ahead with surgery later that day. The critical care unit shared information with healthcare staff at Whitemoor about his condition.

6. The man remained sedated and on a ventilator. Attempts to reduce sedation were unsuccessful and he never recovered from the operation. The man's heart deteriorated and, at 11.34pm on 26 May, he had a cardiac arrest and died.

7. The clinical reviewer concluded that the man's care was equivalent to that he could have expected to receive in the community and made no recommendations. The prison appropriately decided that the man did not need to be restrained after his surgery and officers kept a discreet distance to allow the man's family some privacy during visits. However, we are concerned that the prison cancelled two hospital appointments without considering other arrangements and that there was an unnecessary delay in arranging an emergency escort. We make two recommendations.

THE INVESTIGATION PROCESS

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

9. NHS England commissioned a review of the man's clinical care in prison.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed two members of staff and two prisoners at Whitemoor and informed the Governor about the preliminary findings of the investigation.

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

12. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. The investigator and family liaison officer met the man's family. They had the following questions about the man's care:

- The man wrote about back pain in his diary, and had told his family that he had suffered from back pain. His family asked if he had complained to staff or prisoners about it.

- His family wanted to know why the man was taken to Peterborough hospital initially on 5 May and not to Papworth.

- His family believed that the man had a hospital appointment cancelled for security reasons, because he had accidentally seen a letter detailing the route. They wanted to know when the appointment was re-booked.

- His family asked if the infarcts (cerebral strokes – a blockage in the blood vessels supplying blood to the brain) that showed up on a head CT scan happened at the prison and whether the man had been in pain and able to communicate.

13. The man's family received a copy of the draft report. The solicitor representing the man's father wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP WHITEMOOR

14. HMP Whitemoor is a high security prison and holds over 450 category A and B prisoners serving long sentences. NHS East Anglia commissions healthcare services. Cambridgeshire and Peterborough NHS Foundation Trust manage the prison's mental health provision.

15. The prison healthcare centre includes a nine bed in-patient unit. The prison directly employs nurses, who provide a twenty-four hour service. Medacs provide the GP service and there is an on-call service for out of hours cover.

Her Majesty's Inspectorate of Prisons

16. The most recent inspection of Whitemoor was in January 2014. Overall, they judged Whitemoor to be a safe, respectful and purposeful prison which provided some constructive opportunities for prisoners serving long sentences to address their offending behaviour. The Inspectorate assessed health services as reasonable, but said there were staffing challenges because agency staff covered around half the posts.

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Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers who help ensure that prisoners are treated fairly and decently. In its most recent report, for the year ending May 2013 the Board commented that healthcare was continuing to improve and was now at least as good as services in the community.

Previous deaths at HMP Whitemoor

18. The man was the fourth prisoner to die at Whitemoor since 2008. There were no significant similarities with the issues in those deaths.

KEY EVENTS

19. The man was remanded to prison on 6 August 2009. On 4 May 2010, a judge sentenced him to life imprisonment, with a minimum time to serve of 21 years. He went to HMP Winchester.

20. The man had Marfan syndrome, a genetic disorder that affects the body's connective tissue and often affects the heart, blood vessels, bones, joints and eyes. People with Marfan syndrome are often tall, with long arms and legs. The aorta may become enlarged (aortic dilation) or the walls of the aorta may bulge (aortic aneurysm). These are very serious problems because a significantly enlarged aorta is at risk of tearing or rupture (aortic dissection). For most people with Marfan syndrome, the problem starts in the segment of the aorta closest to the heart known as the aortic root. People with Marfan syndrome are usually monitored carefully and sometimes heart surgery is necessary to repair or replace an enlarged aorta.

21. While he was at Winchester, the John Radcliffe Hospital in Oxford reviewed the man's condition annually. On 16 April 2012, the cardiology specialist registrar noted an enlargement of the aortic root (to 5cm). A hospital letter said the man was aware he would need planned aortic root surgery in the next few years to repair the aortic root and to replace the aortic valve. The hospital would review this in 12 months. The registrar said there was a possibility of referring him for aortic root surgery and advised the man to continue to take atenolol 50mg twice a day. This medication is a beta-blocker and helps to slow down the progression of aortic dilatation.

22. On 21 September 2012, the man transferred to HMP Whitemoor. He told Nurse A, at an initial health screen, that he had Marfan syndrome. At a secondary health screen on 2 October, Nurse B noted Marfan syndrome and that the man needed an annual check up. The nurse advised the man to give up smoking and ordered him a longer bed as he was very tall. A prison GP, Dr A, saw the man, on 5 October, and noted the need for annual reviews and that the last one had been at the John Radcliffe Hospital, in April 2012. The doctor continued the man's prescription of atenolol.

23. On 3 May 2013, the John Radcliffe Hospital sent a reminder that the man's annual review was on 20 May. As the man was now at Whitemoor, Dr A referred him to the clinical genetics department at Addenbrooke's Hospital, Cambridge, instead and arranged an appointment for 14 August 2013.

24. The man went to Addenbrooke's Hospital on 15 July for a cardiology appointment and had an ECG. On 14 August, he attended both the cardiovascular and genetics clinics at Addenbrooke's. After the appointment, the consultant cardiologist, wrote to Dr A and said that the man's aorta had severe aortic dilation (up to 5.2cm). The consultant cardiologist requested that the prison prescribe losartan (used for high blood pressure and heart disease) in addition to atenolol, to help slow the progression of aortic dilatation. The consultant cardiologist copied the letter to a consultant cardiac

surgeon (based at Papworth Hospital) to ask when the best time for aortic surgery would be.

25. Dr A discussed the appointment with the man on 19 August and recorded that he had declined genetic testing. The prison cancelled an aortic MRI scan at Papworth Hospital arranged for 23 October 2013, as a security precaution. The hospital had sent the letter directly to the man, who was therefore aware of the date in advance. The prison rescheduled the appointment for two weeks later on 6 November. The scan showed that his aortic root had increased in size.

26. On 19 February 2014, the consultant cardiac surgeon discussed the results of the scan and possible surgery with the man. The man agreed to go ahead with an operation in early June 2014 to have his dilated aortic root repaired and his aortic valve replaced. Dr A told the clinical reviewer the man was fully aware of the risks of surgery as his uncle had had the same procedure and had died a few days after the operation.

27. On 11 March, the man had a podiatry procedure to remove a corn, which involved a local anaesthetic and radio waves to remove the infected tissue. The next day, he was due to go for a hospital outpatient appointment. When an officer went to collect him, he found that the GP had marked the man as 'rest in cell' because of the foot procedure. As a result, the prison did not take him to the hospital appointment. (Despite enquiries, we have been unable to establish with Whitemoor what this outpatient appointment was for.)

28. At about 10.10am on Monday 5 May 2014, the man was working in the prison kitchens as usual, when he started to feel dizzy and had chest pains. The person who was supervising prisoners in the kitchen, asked a nurse to come straightaway. He said the man was very pale and in distress, but could communicate easily. Nurse C arrived within a few minutes. She noted that the man had non-radiating chest pain and a cough. He felt dizzy and was sweating. She decided to take him to the prison's healthcare centre to take clinical observations and for an ECG test.

29. The man went to the healthcare in a wheelchair, although he said he could walk. He arrived there at about 10.30am. He described his symptoms to Nurse B who took clinical observations and noted his blood pressure was abnormally low. An ECG test was also abnormal. The nurse described the man as agitated and a little breathless, but said his speech was not unusually slurred. The nurse thought the man needed to go to hospital.

30. Nurse B telephoned the on-call registrar at Papworth Hospital because, in the past, patients who were already booked for surgery would often go straight to Papworth rather than the local accident and emergency department. The registrar told the nurse that this was no longer the procedure. She then telephoned the cardiac unit at Peterborough City Hospital and a nursing sister said she could not give advice without the man's full history and that the usual protocol was to take the patient to the hospital's accident and emergency

department. The prison called an emergency ambulance at 10.52am, which arrived at Whitemoor at 10.58am.

31. Nurse B briefed the paramedics about the man's symptoms. She told them that he had Marfan syndrome and had been due to attend Papworth Hospital for major heart surgery. The nurse said the paramedics were not entirely convinced that the man's symptoms were cardiac related and questioned whether he had taken an illicit substance. The prison's population management unit said there was some intelligence to suggest the man might have been taking illicit substances. The nurse told us she had assumed this information related to recent intelligence (in the last month or two), but it dated back to November 2013.

32. Nurse B told us that, at about 11.15am, the paramedics eventually decided to take the man to hospital, because they could not stabilise his blood pressure. It then took about an hour to arrange an escort to accompany the man to hospital. Nurse B said the man's condition did not deteriorate significantly during this time and that he appeared stable, but she had stressed to the prison staff arranging the escort that he needed to go to hospital as soon as possible.

33. The man left Whitemoor by ambulance at 12.24pm. He was quiet, but able to talk to the paramedics. Staff restrained him with double cuffs for the journey to hospital. This is the standard level of restraint for moving security category A and B prisoners in good health. (The man was category B.) Double cuffing means that the prisoner has his hands cuffed in front of him and then one wrist is attached to a prison officer by an additional set of handcuffs.

34. The ambulance arrived at Peterborough City Hospital at 12.50pm. Doctors examined the man and he had an X-ray and CT scan. He remained double cuffed for the X-ray at 1.20pm but an escort chain was used for the CT scan at 2.20pm. (An escort chain is a long chain with a single handcuff at each end, one of which is attached to the prisoner and the other to an officer.) After the CT scan double cuffs were used again. Doctors diagnosed acute aortic dissection. This is where a tear in the inner wall of the aorta causes blood to flow between the layers of the wall of the aorta. It is a medical emergency because it results in decreased blood supply to other organs. Later that day, the man transferred to Papworth hospital.

35. The cardiothoracic (heart and lung) team at Papworth decided to go ahead with surgery and the consultant cardiac surgegon carried out an aortic repair and valve replacement the same day. After the operation, the man moved to the hospital's critical care unit. The escorting officers had removed the handcuffs before the operation and they were never re-applied.

36. On 6 May, Nurse B spoke to Nurse D at Papworth Hospital and they agreed a password system to share clinical information over the telephone. Hospital staff told Nurse B about the surgery and that they had sedated the man because his heart function was poor. At that time, they expected him to remain in the hospital for 10 to 14 days.

37. Two prison officers escorted the man at all times, but sat near the nursing station where they could keep the man in view without impinging on his family's privacy when they visited him.

38. Nurse B contacted the hospital regularly about his condition. The man remained sedated and on a ventilator. The hospital described his condition as stable, but critical.

39. The man's condition changed little over the next few days. On 14 May, the medical team tried to take the man off sedation and the ventilator, but he was unable to breathe without assistance. A CT scan showed evidence of an infarct (blockage to the blood supply to the brain) and possible damage to his brain. The next day, Nurse B visited and hospital staff updated her on his treatment and condition. They did not know if his heart would recover or whether he had brain damage. If his heart did start working again, they estimated that the man would be in hospital for a further three weeks at least. The doctor said it was difficult to judge what quality of life the man might have.

40. The prison and hospital remained in frequent contact. On 18 May, hospital staff said that the man was progressing slowly and that he had squeezed his father's hand.

41. On 23 May, the hospital reported that the man's health had been deteriorating over the past two days. An ECG, on 25 May, showed the man's heart was becoming less effective. The hospital team regularly updated the man's family about his condition and treatment. The next day the critical care nurse said there had been no change.

42. At 11.34pm on 26 May, the man had a cardiac arrest. Hospital staff were unable to resuscitate him and a doctor certified his death at 11.50pm. Hospital staff at Papworth informed the man's family.

Liaison with the man's Family

43. When the man was taken to hospital on 5 May, a prison family liaison officer contacted the man's mother to inform her and offer support and assistance. The chaplain also spoke to the man's parents. The man's family were able to visit him in hospital at any time.

44. The prison's family liaison officer remained in contact with the man's family during his stay in hospital. After the man died, the family liaison officer spoke to his mother on 27 May to offer condolences and help with making funeral arrangements. In line with national policy, the prison contributed towards the cost of the man's funeral.

45. The Governor sent a letter of condolence to the man's family on 2 June. The prison held a memorial service and a memorial fund was set up at the request of some prisoners.

Support for staff and prisoners

46. A Governor's notice of 27 May, informed staff and prisoners of the man's death and offered support to those affected. A Prison manager debriefed the escort staff at the hospital and ensured they knew where to get support if they needed it.

Post-mortem

47. A post-mortem examination found that the man's surgery was satisfactory. He died from adult respiratory distress syndrome (where the lungs cannot provide enough oxygen for the rest of the body); due to aortic dissection (operated on); brought on by Marfan syndrome. There were also some cerebral infarcts (blockages to the blood vessels supplying the brain).

ISSUES

Clinical care

48. We agree with the clinical reviewer that the man's clinical care in prison was equivalent to that which he could have expected to receive in the community. In particular, she noted that there was excellent communication, which allowed continuity of care between Whitemoor and Papworth Hospital. The clinical reviewer made no recommendations.

49. The prison cancelled an MRI scan at Papworth hospital arranged for 23 October 2013 because the hospital had sent the appointment letter directly to the man. This meant he knew the date, time and location of his appointment, which the prison considered a security risk. As a result, the prison reorganised the appointment for two weeks later on 6 November.

50. The Prison Service's National Security Framework does not require hospital appointments to be cancelled automatically when prisoners become aware of the time and date, although our experience is that prisons often do this without sufficient reason. The national security guidance expects that the prisoner's condition and the urgency of the treatment required should be taken into account when making such a decision. If necessary, additional security arrangements can be put in place rather than cancelling appointments.

51. In this case, it appears the two week wait did not lead to any delay in treatment decisions or clinic appointments for the man because his pre-arranged follow up appointment to discuss the results of the MRI was not until February 2014. However, the prison could not have known this at the time. The man had a serious heart condition and it is possible that the MRI scan could have identified a need for more urgent treatment. It is not necessary to cancel an appointment when a prisoner becomes aware of the date and time, unless there is clear intelligence that the prisoner is a high risk of escape or likely to have external assistance to aid an escape. There is no evidence that this was the case with the man. If the prison had security concerns they should have considered strengthening the escort arrangements.

52. The man missed another hospital outpatient appointment on 12 March 2014, because he had had a corn removed the day before. There was no liaison between healthcare and population management unit (who book and arrange hospital appointments) about the date or to decide which appointment should take priority. The prison should have done more to enable the man to attend the appointment. We consider that the man could have attended the outpatient appointment in a wheelchair if he was unable to weight bear on his foot. We have seen no evidence of consultation with healthcare staff or with the hospital about the cancellation of either appointment. We make the following recommendation:

The Governor should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.

Emergency response

53. A nurse took the man quickly to the prison's healthcare centre when he complained of chest pain on 5 May. This enabled the nurses to consult his medical record, take observations and an ECG. They then requested an emergency ambulance at 10.52am, which arrived six minutes later. However, it was some time before the man left for hospital at 12.24pm.

54. We are satisfied that the prison called an ambulance quickly after nurses had taken observations and it was clear that the man needed to go to hospital. However, we are concerned about the subsequent delay in the man leaving for hospital. Part of the delay appears to be because the paramedics questioned whether the man had taken illicit drugs. It is not clear how long it took to get information about this, but the intelligence dated back to November 2013, and was the only entry in the man's record suggesting any suspicion of drug taking. The prison staff should have made this clear to the nurse and paramedics to enable a more balanced view about whether drugs were a factor in his symptoms.

55. However, it is apparent that paramedics had decided at 11.15am, that the man needed to go to hospital yet it was over an hour after that before he left. We are concerned about this delay. Records show that staff had completed a person escort form (PER) and risk assessments by 11.30am. A manager did not brief the staff who would be escorting the man until 11.50am. Staff then searched and handcuffed the man at 12.00pm before putting him on the ambulance, ten minutes later. Prison staff then searched the ambulance before it left for the hospital at 12.24pm. Although the man appeared stable at the time, this was an emergency situation for a man with a serious heart condition and the prison should have made every effort to get him to hospital as quickly as possible.

56. We understand that paramedics wanted first to determine whether the man might have taken drugs which meant that the ambulance could not leave immediately. However, the delay after that was unacceptable. Prison staff should have started planning the arrangements for the escort as soon as they called an emergency ambulance at 10.52am and should have been in a position to leave as soon as the paramedics were ready. Prison Service Instruction 03/2013, which deals with medical emergencies, has a mandatory requirement that prisons should have protocols to ensure there are no unnecessary delays in ambulances leaving prisons to take prisoners to hospital. We do not consider that Whitemoor met this standard. Although it is unlikely to have changed the outcome for the man, in another situation such a delay could be crucial. We make the following recommendation:

The Governor should ensure that staff arrange escorts immediately they call an emergency ambulance, so that there is no unnecessary delay in taking a prisoner to hospital.

Use of Restraints

57. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape and the risk to the public, and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that prison staff must consider medical opinion about the prisoner's ability to escape as part of the assessment process. The judgement required that prisons should assess risks during stays in hospital separately and review them regularly during a hospital stay or when circumstances change.

58. We are satisfied that there was an appropriate risk assessment when the man went to hospital on 5 May. Nurse B completed the healthcare section of the risk assessment and indicated no medical objections to restraints and that the man's condition did not affect his risk of escape. We are also satisfied that Whitemoor consistently reviewed the man's risk and considered his medical condition before and after surgery, and took an appropriate decision not to use restraints again.

Family concerns

59. The man's family had a number of questions about his treatment, most of which have been covered elsewhere in the report. We cover the other points below.

60. The man wrote about back pain in his diary and also told his family when they spoke on the telephone. His family asked if he had complained to staff or other prisoners about it. The investigator spoke to a friend of the man, another prisoner at Whitemoor, about this. The man's friend said that the man had told him about his back, but said he did not like to make a fuss, and he had not told healthcare staff. There is no record that the man ever reported back pain to either prison or healthcare staff at Whitemoor.

61. The man's family asked if the infarcts (cerebral strokes – a blockage in the blood vessels supplying blood to the brain) that showed up on a head CT scan happened at the prison and whether the man had been in pain and able to communicate. The clinical reviewer said that it is not possible to say where the man was when the infarcts occurred. However, while the man was clearly unwell on 5 May, he was able to communicate and was mobile at the time.

RECOMMENDATIONS

1. The Governor should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.

2. The Governor should ensure that staff arrange escorts immediately an emergency ambulance is called so that there is no unnecessary delay in taking a prisoner to hospital.

ACTION PLAN: The man - HMP Whitemoor

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and **function responsible**	Progress (to be updated after 6 months)
1	The Governor should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.	Accepted	Any decisions to alter hospital appointments will only be made after full discussion between Security and Healthcare. Where the clinical indication and Security recommendations do not align, a decision will be made by the Governor in charge of the prison.	Completed Governor	
2	The Governor should ensure that staff arrange escorts immediately an emergency ambulance is called so that there is no unnecessary delay in taking a prisoner to hospital.	Accepted	Arrangements will be put in place to begin escort arrangements as soon as an emergency ambulance is called, and will be finalised once it is confirmed that an external escort is required.	Completed Governor	