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 December 2014, a prisoner at HMP Isle of Wight

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 from a heart attack of a man in December 2014, a prisoner at HMP Isle of Wight. He was 52 years old. I offer my condolences to his family and friends.

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

The man was sentenced to 16 years in prison in March 2013 and had been at HMP Isle of Wight since April 2013. He had a history of chest pains and a family history of heart disease.

On 21 Dec 2014, the man told wing staff he had chest pain. Two nurses attended and were about to take him to the prison's healthcare centre for tests, when he collapsed. The nurses began cardiopulmonary resuscitation and continued to assist paramedics in the ambulance on the way to hospital. Shortly after he arrived at the hospital, a doctor declared him dead.

The clinical reviewer noted that the emergency care nurses gave the man at the time of his cardiac arrest was of a very good standard. When he reported symptoms of chest pain, healthcare staff provided appropriate treatment. However, the clinical reviewer was concerned that, although healthcare staff had identified that he had a number of significant risk factors for cardiovascular disease, there was little evidence of active intervention or encouragement towards primary prevention.

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

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

CONTENTS

SUMMARY

1. The man was remanded to HMP Winchester in December 2012. During December, he was admitted to hospital twice with chest pain and high blood pressure. On his first admission, the hospital considered the pain was due to a mild stroke. The second time, a doctor diagnosed anxiety and he discharged himself. In January 2013, he complained of chest pain and a prison doctor treated him for a possible chest infection.

2. In March 2013, the man was sentenced to 16 years in prison and transferred to the Isle of Wight in April. When he arrived, a nurse noted that he had a family history of heart problems. He also suffered from depression and anxiety, for which he received treatment at the prison.

3. In July 2014, the man developed mild chest pain after pulling a trolley up the hill, as part of his work in the prison's recycling plant. A doctor examined him and noted that all his clinical observations were normal. The doctor diagnosed muscle strain and prescribed pain relief medication.

4. On 5 December 2014, a doctor examined the man after he reported suffering chest pain and shortness of breath. He gave him a GTN spray to relieve his chest pain and aspirin. An ECG and other tests showed no abnormalities but the doctor referred him to a rapid access chest pain as he considered his pain was cardiac related and suspected angina. An appointment was expected within two weeks, but he was still waiting for one when he died.

5. A few weeks later, the man said he was suffering from chest pain, which his GTN spay had not relieved. Two nurses attended and noted his blood pressure was normal but his pulse was irregular. They decided to take him to the healthcare centre for an ECG, but before they could do so, he collapsed and became unresponsive. The nurses started resuscitation and an officer radioed a code blue emergency. The communications room called an ambulance immediately and paramedics arrived quickly and, after emergency treatment, took him to hospital. Shortly after he arrived at the hospital, a doctor confirmed that he had died.

6. The clinical reviewer noted that healthcare staff at the Isle of Wight had responded appropriately to the man's symptoms of chest pain when he reported them. However, although healthcare staff had identified and recorded his risk factors for cardiovascular disease they were insufficiently proactive in treating and managing those risks in a systematic way. Nurses provided a good standard of emergency care at the time of his cardiac arrest. We make one recommendation.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He interviewed seven members of staff at HMP Isle of Wight on 26 and 27 February 2015. He informed the Governor of the preliminary findings of the investigation.

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

10. We informed HM Coroner for Isle of Wight of the investigation who provided a copy of the post-mortem report. We have sent the coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers wrote to the man's daughter to inform her of the investigation. She did not have any issues about her father's care in prison for the investigation to consider.

12. The man's daughter was informed the draft report was available, but did not make any comment. The prison also received a copy of the draft and their response to our recommendations and action plan is added at the end of this report.

HMP ISLE OF WIGHT

13. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison holds mostly sex offenders.

14. Care UK provides healthcare at the prison. There is an inpatient unit with 18 beds on the Albany site, catering for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Isle of Wight was in May 2012. The Inspectorate noted that waiting times for routine GP appointments were sometimes too long. However, management of long-term conditions was good, with good care arrangements for men with palliative care needs.

Independent Monitoring Board

16. Each prison in England and Wales 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 recently published annual report for the year to December 2013, the IMB commented very favourably on the healthcare provision at the prison and care for prisoners with terminal illnesses.

Previous deaths at HMP Isle of Wight

17. The man was the seventh prisoner to die of natural causes at Isle of Wight since January 2014.

KEY EVENTS

18. The man was remanded to HMP Winchester in December 2012 after being convicted of sexual offences. Just after he arrived at Winchester, he suffered chest pain twice and his blood pressure was high. He was admitted to hospital both times. The first time, doctors considered he had suffered a minor stroke. The second time, doctors considered his pain was caused by anxiety and he discharged himself. In January 2013, he complained of chest pain again and a doctor treated him for a possible chest infection.

19. The man was sentenced to 16 years in prison on 18 March 2013 and moved to HMP Isle of Wight on 23 April 2013. A nurse carried out an initial health screen and noted that he had a history of chest pains and suffered from depression and anxiety. At the time, he was being managed under Prison Service suicide and self-harm prevention procedures. Doctors prescribed antidepressant medication and while he was at the Isle of Wight, healthcare staff reviewed and managed his depression.

20. The next day, a nurse carried out a further health assessment and noted that, in the past, doctors had concluded that the man's chest pains were due to panic attacks and ECGs (electrocardiograms, which can identify some heart disorders) had shown no abnormalities. The nurse noted that he smoked 15 cigarettes a day and declined any help to stop. She assessed him as fit for normal location, work and any cell occupancy. A prison GP noted that he had a cardiovascular disease 10-year risk score of 17.78% (a high risk of cardiovascular disease), and that his father had had a coronary bypass. A blood test showed that he had high cholesterol.

21. Over the next year, healthcare staff saw the man several times for minor matters such as a rash and knee pain. The mental health team supported him when his wife died.

22. On 23 July 2014, a prison GP was called to see the man in the prison's recycling area where he worked, after he reported chest pain. He recorded that the man had developed mild pain in his chest, after pulling a trolley up the hill. The doctor examined him and noted that all his clinical observations were normal, including pulse and blood pressure. He had no other associated symptoms and the GP diagnosed him muscle strain. He gave him pain relief and advised him to rest. There is no record of him reporting any further health problems for the next four months.

23. On 5 December, a prison GP examined the man, who reported having chest pains since the previous day and was short of breath. His blood pressure was high and the GP gave him a GTN spray and aspirin. The pain eased and the doctor admitted him to the prison's inpatient unit to monitor his him. An ECG and Troponin test (to confirm damage in the heart) showed no abnormality or damage, but blood tests showed high cholesterol levels. The GP referred him to a hospital rapid access chest pain clinic for an appointment within the next two weeks, because he suspected the pain was cardiac related and wondered if he had developed angina. He died before he received an appointment.

Events leading up to the incident

24. A prisoner told an officer that the man was sitting on his chair in his cell, complaining of chest pain. She went to his cell and noted he had a good colour and was talking clearly. He said he had had the pain for about five minutes and had used his GTN spray twice, but the pain continued.

25. The officer went to telephone healthcare staff and asked a colleague to stay and observe the man. At approximately 3.40pm, two nurses arrived to see him.

26. Nurse A recorded that the man was sitting on a hard chair in his cell leaning forward rubbing the centre of his chest up and down. She did not note any other cardiac symptoms or signs. He was able to speak in full sentences. The nurse recorded that his blood pressure was normal but his pulse was irregular. The nurse asked officers to take him to the healthcare unit by wheelchair, for an ECG. Nurse B gave him aspirin. Before they left, at 3.48pm, he suddenly collapsed.

27. Nurse A shouted for someone to radio a code blue (a medical emergency code indicating a prisoner is unresponsive, has breathing difficulties or chest pain) and started cardiopulmonary resuscitation. An officer heard her and radioed the communication room and staff requested an ambulance immediately. The ambulance arrived at 3.53pm and paramedics took the man to hospital at 4.20pm. The nurses continued to help paramedics with the resuscitation attempt on the way to hospital. He did not respond to emergency treatment and, at 4.54pm, a hospital doctor pronounced his death.

Family liaison

28. At 5.20pm, the prison asked an officer to act as the family liaison officer. The man had named his daughter as his next of kin. His daughter's address was in London, so the prison contacted HMP Pentonville and HMP Wandsworth to see whether one of their family liaison officers could break the news in person. They were unable to help. An operational manager therefore asked two officers to go to see his daughter in person. The officers left the Isle of Wight at about 9.00 pm.

29. Just after midnight, both officers arrived at the address they had for the man's daughter, but found she no longer lived there. One officer therefore decided to telephone the man's mother-in-law (who was on his telephone contact list) to see if she had an up to date contact details for his daughter. When he spoke to her, he told her that the man had died.

30. At 1.40pm the man's daughter called the officer, as her grandmother had contacted her. He offered condolences and support and agreed to visit after the Christmas period. He stayed in contact with her and assisted with arrangements for the funeral, which was held on 20 January. The prison paid funeral costs, in line with national guidance.

Support for staff and prisoners

31. The prison issued notices informing staff and prisoners of the man's death and the support available. A custodial manager debriefed the staff involved in the emergency response and offered appropriate support. 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

32. A post-mortem examination established that the cause of the man's death was severe coronary artery atherosclerosis (hardening of the arteries in the heart).

ISSUES

Clinical care

33. The clinical reviewer noted that the initial reception screening protocol included a number of investigations related to cardiovascular risk factors. He considered that the prison has effective nurse-led clinics for men's health, for monitoring raised blood pressure and cardiovascular risk factors, such as smoking and obesity. Healthcare staff also offer a wide range of information about health promotion. He noted that it is the responsibility of the GP to review and act upon any abnormal results and nurses would then be responsible for any planned follow up assessments or investigations.

34. Healthcare staff had identified and recorded clear evidence of the man's significant cardiac risk factors. These included a high 10-year risk score, smoking, high blood pressure as well as high cholesterol. He also had a family history of cardiac problems. However, after his reception, there appeared to be little recognition of his risk or any evidence of appropriate intervention or encouragement towards primary prevention of cardiovascular disease, in line with the National Institute of Health and Clinical Excellence (NICE) guidelines. The clinical reviewer recognised that he was sometimes a reluctant patient, but considered more could have been done to help him reduce his cardiovascular risks.

35. When the man presented to the healthcare team with chest pains (in particular, on 23 July and 5 December 2014) the clinical reviewer was satisfied that they carried out appropriate clinical assessments. However, he noted that doctors did not consider starting him on statins (a group of medicines that can help lower the level of cholesterol in the blood) in response to the abnormal cholesterol levels noted on 7 May 2013 and 5 December 2014.

36. We agree with the clinical reviewer that the emergency care nurses gave the man at the time of his cardiac arrest was good and that he received appropriate care in response to his reported symptoms. However, because there were missed opportunities in providing preventive care for cardiovascular disease, the clinical reviewer was not satisfied that his overall care was equivalent to that he could have expected to receive in the community. We make the following recommendation:

    The Head of Healthcare should introduce routine reviews of cardiovascular risk for prisoners with known risk factors, and ensure that such prisoners receive appropriate treatment and advice in line with NICE guidelines.

Emergency Response

37. We are pleased to note that, following a previous recommendation from this office, the prison drafted a comprehensive and clear emergency response code protocol, dated June 2014, in line with Prison Service Instruction (PSI) 03/2013. However, during the course of the investigation, not all the staff we spoke to fully understood the protocol – including that they could use a code blue in response to chest pain, without the need for healthcare staff to attend first. The investigator brought this to the Governor's attention and he has taken additional action to address this.

38. In this case, we are satisfied that the response when the man first reported chest pain on 21 December was appropriate. Although an officer did not immediately use a code blue, she asked for urgent help from the healthcare team who responded very quickly and brought emergency equipment. The nurses' initial assessment was that the man was stable. This situation changed when he collapsed and staff appropriately used a code blue at that stage, and called an ambulance. The nurses immediately began cardiopulmonary resuscitation and an ambulance arrived quickly. The clinical reviewer was satisfied that there was nothing else that staff at the prison could have done to improve his chance of survival.

RECOMMENDATION

The Head of Healthcare should introduce routine reviews of cardiovascular risk for prisoners with known risk factors, and ensure that such prisoners receive appropriate treatment and advice in line with NICE guidelines.

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 introduce routine reviews of cardiovascular risk for prisoners with known risk factors, and ensure that such prisoners receive appropriate treatment and advice in line with NICE guidelines.	Accepted	Routine reviews and 'well person' checks are already in place at HMP Isle of Wight for prisoners with cardio vascular and other chronic diseases. The Head of Healthcare recognises that those prisoners with known cardiovascular risk factors should be given appropriate treatment and advice and be routinely recalled and checked. The pathway at HMP Isle of Wight will be reviewed in light of this recommendation to ensure compliance with NICE guidelines.	Head of Healthcare 30 September 2015	