

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alvin Black, a prisoner at HMP Whitemoor, on 16 November 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Alvin Black died on 16 November 2019 of a pulmonary thromboembolus (a blood clot in the lungs) at HMP Whitemoor, following back surgery on 12 November. He was 59 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that the standard of healthcare that Mr Black received at Whitemoor was equivalent to that which he could have expected to receive in the community.

When Mr Black came back from hospital, he refused to go to the healthcare inpatient unit, where he would have been more closely monitored, and insisted on returning to his normal cell. We do not know why Mr Black took this decision.

Whether or not it is relevant, I am concerned that prison and healthcare managers accepted that the inpatient unit was not cleaned to an acceptable standard.

I am also concerned that staff did not initially give the control room information about Mr Black's condition. This meant that there was a delay of 19 minutes before the ambulance service despatched an emergency ambulance. We cannot say if this affected the outcome for Mr Black.

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

Sue McAllister CB
Prisons and Probation Ombudsman

June 2020

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Summary

Events

1. In 1997 and again in 2001, Mr Alvin Black received life sentences for murder. On 23 July 2001, he was sent to HMP Whitemoor.
2. On 1 August 2017, a prison GP saw Mr Black because he had back pain. He referred him for a pelvic x-ray and an MRI scan. The GP reviewed the results which showed that Mr Black had mild degenerative changes to his hips and that he had spinal cord compression.
3. On 29 March 2018, a prison GP reviewed the results of an MRI scan and noted that Mr Black had been born with a narrow spinal cord canal. He referred Mr Black to the hospital neurology department.
4. During 2019, Mr Black's spinal condition continued to deteriorate, and he was seen by hospital specialists in August, September and October. He was diagnosed with thoracic spinal canal stenosis (a degenerative condition in which the spinal canal narrows, putting pressure on the spinal cord and causing back and leg pain and weakness in the legs and, sometimes, pain and weakness in the shoulders and arms).
5. On 12 November, Mr Black had decompression surgery in hospital (to take the pressure off the spinal cord). On 14 November, he returned to Whitemoor. He refused to go to the prison's inpatient unit and went back to his cell.
6. Sometime between 11.00am and 11.20am on 16 November, Mr Black pressed his cell bell. He told an officer that he was short of breath and felt as though he had an infection. The officer asked for a nurse who saw Mr Black. He told the nurse that he also had chest pain. She asked the officer to radio a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing) and he did so at 11.32am.
7. At 11.33am, the prison's control room officer telephoned the ambulance service but, because they had no information about Mr Black's condition, the ambulance service did not give the ambulance the highest priority. At 11.52am, the control room officer telephoned the ambulance service a second time with more information about Mr Black's condition. The ambulance service upgraded the response to the highest level.
8. Mr Black became unresponsive and nurses and officers carried out cardiopulmonary resuscitation (CPR).
9. At 12.05pm, an ambulance arrived at Whitemoor and at 12.16pm, paramedics were at Mr Black's side. At 12.16pm, an air ambulance landed outside of Whitemoor and at 12.28pm, the crew were with Mr Black. At 12.33pm, the air ambulance doctor established that Mr Black had died.

Findings

Clinical care

10. The clinical reviewer was satisfied that the healthcare that Mr Black received at Whitemoor was of a reasonable standard and equivalent to that which he could have expected to receive in the community. When Mr Black told healthcare staff that he had back pain, they supported him appropriately and referred him promptly for MRI scans, physiotherapy and hospital treatment.
11. Mr Black refused to go to the prison's inpatient unit when he returned from hospital on 14 November. If he had done, he would have been monitored more closely by healthcare staff.
12. There is no evidence to support a prisoner's account that a nurse was told Mr Black was feeling unwell on 15 November and refused to see him.

Healthcare inpatient unit

13. The Head of Healthcare accepted that the cleanliness of the inpatient unit was a concern and the Head of Discrete Units accepted that there was a problem cleaning the unit.

Emergency response

14. Staff appropriately called a medical emergency code when Mr Black's condition deteriorated on 16 November and the control room called an ambulance immediately.
15. However, staff responding to the emergency did not give the control room information about Mr Black's condition or the nature of the emergency and they were therefore unable to pass any details about his condition to the ambulance service. This meant that the ambulance service did not initially prioritise sending an ambulance and there was a delay of 19 minutes before they did so. We cannot say if this affected the outcome for Mr Black.

Recommendations

- The Governor and Head of Healthcare should ensure that the standard of cleanliness in the inpatient unit does not fall below that required by the NHS.
- The Governor should ensure that when a medical emergency code is called, staff responding to an emergency give the control room detailed information about a prisoner's condition and the nature of the emergency so that they can share it with the ambulance service when they call for an ambulance.
- The Governor should ensure that:
 - the prison's medical emergency response protocol is reviewed and agreed with the local ambulance trust in the light of the events of 16 November 2019; and

- the protocol covers what initial clinical information is required before despatching an ambulance and the need for urgency in emergency situations.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Whitemoor informing them of the investigation and asking anyone with relevant information to contact him. Four prisoners responded.
17. The investigator obtained copies of relevant extracts from Mr Black's prison and medical records.
18. NHS England commissioned a clinical reviewer to review Mr Black's clinical care at the prison. The investigator jointly interviewed seven members of staff and one prisoner with the clinical reviewer at Whitemoor on 10 December 2019.
19. The investigator interviewed two prisoners by telephone on 29 January 2020, and a further prisoner by telephone on 5 February.
20. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
21. The Ombudsman's family liaison officer wrote to Mr Black's next of kin to explain our investigation. Mr Black's next of kin asked:
 - if Mr Black had raised any concerns with staff or prisoners about his mental or physical health or concerns about his safety in the week before his death;
 - where Mr Black lived in the week before his death and if he had used his cell bell;
 - if Mr Black had complained to the prison in the month before his death and if he had been assaulted by another prisoner while at Whitemoor;
 - why Mr Black needed back surgery, what his hospital discharge plan said, and whether the hospital had prescribed him any medication;
 - whether he had any symptoms after he was discharged from hospital, whether Mr Black or other prisoners sought assistance from healthcare or prison staff for breathing difficulties;
 - whether an emergency code was called; and
 - whether prison and healthcare staff responded to the medical emergency and when the ambulances arrived at the prison?
22. We have addressed their concerns in our report and in the clinical review, and by separate correspondence.
23. We shared the initial report with the Prison Service. There were two factual inaccuracies and this report has been amended accordingly and their action plan has been appended to this report.
24. Mr Black's next of kin received a copy of the initial report. The solicitor representing Mr Black's next of kin wrote to us raising a number of questions that

did not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Whitemoor

25. HMP Whitemoor is a high security prison, which holds around 450 prisoners serving long sentences. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services. There is an inpatient healthcare unit with nine cells.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Whitemoor was in March 2017. Inspectors found that relationships between staff and prisoners were good and many staff knew about the personal circumstances of the prisoners in their care. They reported that GP services provided a good continuity of care but there were issues with the administering of prescription medications, including that the administration time was not long enough to allow for the administration of all medication. Inspectors noted that too few beds in the inpatient unit had been used for clinical purposes.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 May 2019, the IMB reported that Whitemoor was generally well managed and offered prisoners an environment which was calmer and safer than that of many other prisons. The IMB reported that prisoners in smaller units, including healthcare, continued to be the first to have regime restrictions due to staff shortages.

Previous deaths at HMP Whitemoor

28. Mr Black was the fifth prisoner to die at Whitemoor since November 2017. One of the previous deaths was from natural causes, two were drug-related and one was self-inflicted. There were no significant similarities with the previous deaths.

Key Events

29. In 1997 and 2001, Mr Alvin Black received life sentences for murder. On 23 July 2001, he was sent to HMP Whitemoor.
30. On 1 August 2017, Dr A, a prison GP, saw Mr Black because he had been wearing a heel raise (a shoe insert) prescribed by podiatry services to relieve back pain. Mr Black told the doctor that the heel raise did not help as he still had back pain. The doctor referred Mr Black for a pelvic x-ray and an MRI scan. He also referred him for a physiotherapy assessment.
31. On 8 August, Dr A reviewed the x-ray results and saw that Mr Black had mild degenerative changes to both of his hips with normal sacroiliac joints (which link the pelvis to the lower spine).
32. On 14 August, a physiotherapist, saw Mr Black who said that his back pain was worse, that his toes were numb, and he had mild back spasms. The physiotherapist noted that Mr Black had back pain, possibly from a damaged vertebra. He gave Mr Black exercises to complete, noted that he was on the waiting list for an MRI scan and planned to review him after he had the results of the scan.
33. On 17 October, Dr A reviewed the results of the MRI scan and noted that Mr Black had spinal cord compression, disrupting normal nerve transmission. The doctor said that Mr Black should have another more targeted MRI scan of the lower thoracic (chest) spine.
34. On 29 March 2018, Dr A reviewed the results of the targeted MRI scan and noted that there was no cord compression but that the spinal canal was congenitally narrow (meaning Mr Black had been born with this condition). The doctor referred Mr Black to the hospital neurology department.
35. On 29 April, Nurse A saw Mr Black after he had a fight with another prisoner. Mr Black told her that he was fine, and she noted that he had a small lump on the right side of his forehead.
36. On 2 May, Dr A told Mr Black that the hospital neurology department had reviewed the MRI scans and said that neuro-surgery was not appropriate. He told Mr Black that he was waiting for a neurology outpatient appointment for him. That day, Mr Black told the doctor that he had had ear, neck and shoulder pain since the fight. The doctor prescribed him ibuprofen (anti-inflammatory pain relief).
37. On 6 July, Dr A saw Mr Black because he still had back pain. The doctor noted that Mr Black had a lipoma on his neck (a non-cancerous tumour made up of fat and tissue) and left ear pain. Dr A re-prescribed ibuprofen and referred him to physiotherapy.
38. On 5 September, Mr Black saw a physiotherapist and told him that something was wrong and that the exercises were not helping. The physiotherapist told him that he would review him after another MRI scan. He asked him to do the exercises in his cell and not in the gymnasium.

39. On 30 October, Mr Black saw the physiotherapist and told him that his back spasms were improving and that he had a better range of movement in his back. The physiotherapist planned to review Mr Black in eight weeks. On 19 December, Mr Black was discharged from physiotherapy services because he said that his back pain was much improved, and he had a full range of movement.
40. On 15 April 2019, Mr Black saw Dr B, a prison GP, because he had pain in his back and leg and numbness in his toes. The doctor saw that Mr Black had a good range of movement with no neurological abnormalities (such as paralysis, muscle weakness, loss of sensation, seizures, or poor cognitive ability).
41. On 25 May, Mr Black went back to Dr B because the pain was worse and spreading into both legs. He said that he also had a weakness in his left leg and numbness in his left foot. The doctor referred him for another MRI scan and to the back clinic.
42. On 6 August, Mr Black had an MRI scan of his lower back. Dr A noted that the MRI scan showed that Mr Black's cord dimensions appeared to have reduced slightly since 2018 and that it showed some thoracic stenosis (a degenerative condition in which the spinal canal in the upper/middle back is narrowed). The doctor prescribed him anti-inflammatory pain relief.
43. On 27 September, Mr Black went to the neurosurgery outpatient department, where a hospital consultant diagnosed him with thoracic myelopathy (back pain, numbness, weakness and a tingling sensation in one or both legs as a result of pressure on the spinal cord). On 21 October, Mr Black went back to the outpatient department for a pre-operation review and consented to spinal decompression surgery.
44. On 12 November, Mr Black went to hospital for surgery. Healthcare and prison staff completed an escort risk assessment before he left. Dr A completed the medical section of the assessment and did not object to the use of restraints because he considered that Mr Black's medical condition would not restrict his ability to escape. The Acting Deputy Governor, decided that Mr Black should be escorted to hospital in line with standard Category A requirements. He noted that Mr Black should wear a two-piece high visibility suit, that he should be double cuffed but remain single cuffed in the cell of the escort vehicle. He noted that officers should reduce the restraint to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) to allow medical staff to carry out pre-operative procedures. He noted that once the anaesthetist confirmed that Mr Black was fully anaesthetised, the restraints could be removed.
45. An operational manager in the Category A Team in the Long-Term and High Security (LTHS) Prisons Group, approved the level of restraint and noted that when Mr Black regained consciousness, he should be double cuffed with an escort chain before moving to a ward.

Events of 14 November 2019

46. On 14 November, Nurse A spoke to hospital staff who said that when Mr Black returned to the prison, he should stay in a cell on the ground floor.
47. At 5.00pm, Mr Black returned to Whitemoor and at 8.00pm, Nurse A saw Mr Black who had a post-surgical dressing on his back. The nurse told him that he should stay in the healthcare inpatient unit for monitoring, but he chose to go back to his cell on Level 3 of the wing. (The entry to the wing is on Level 2 so Mr Black had to climb one flight of stairs to Level 3.). Mr Black signed a medical disclaimer to say that he was not accepting the advice from the healthcare team.
48. Prisoner A said he had been a friend of Mr Black's for seven or eight years. He told the investigator that Mr Black refused to go to the healthcare unit because he thought it was unfit for purpose. He said Mr Black had spent the night before his operation there and that there was excrement on the walls of his cell and it was unclean. Three other prisoners also said that the healthcare department was dirty, and prisoners did not want to stay there.
49. Mr Black's hospital discharge letter said that there were no post-operative complications and that he would be reviewed in three months. He was discharged on codeine tablets for pain relief, and his medical notes record that he was told he would need to attend the medication hatch for this and would not be able to have it in possession.

Events of 15 November 2019

50. Prison A said that when he saw Mr Black in his cell on the morning of 15 November, he said that he was not feeling great, even though he was 'up and about'. He said that Mr Black was short of breath that afternoon and that another prisoner, told Officer A, who went to the medication hatch on the wing to find a nurse. Prison, A, said that the nurse said that Mr Black was not entitled to medical care because he had refused to stay in the healthcare unit. The investigator established that although the officer worked on Mr Black's wing, he had not been on duty that day. There is nothing in Mr Black's prison or medical records to say that he said he felt unwell or asked to see a nurse on 15 November.
51. Nurse B, the nurse on duty at the medication hatch that day, said that no one told her that Mr Black felt unwell that day, that she was not asked to see him in his cell and that as far as she knew no member of healthcare staff refused to see him in his cell. She said that an officer told her that Mr Black was asking for pain relief medication. She said that Mr Black was prescribed pain relief to be taken at the medication hatch, but he had not attended for it. She said that officers on the wing were told that Mr Black could return to healthcare for pain management if required
52. She said that the issue was raised at the afternoon handover meeting that day and healthcare managers clarified that nurses were not allowed to take medication to a prisoner's cell when prisoners were unlocked. Nurse B said that she was told that Mr Black had discharged himself from healthcare after he came back from hospital.

Events of 16 November 2019

53. Between 11.00am and 11.20am on 16 November, Officer B went to Mr Black's cell because he pressed his cell bell. (There is no record to indicate when he did so because the cell bell recording system failed.) The officer spoke to Mr Black through his locked door and saw that he was lying on his bed. Mr Black told him that he was short of breath, that he felt as though he had an infection and that he needed to see a nurse.
54. Officer B went to the centre office on the wing and telephoned the healthcare department three times, but no one replied. The officer went back to Mr Black's cell but was delayed by another prisoner. He told Mr Black that he was trying to speak to a member of healthcare staff and went to the senior officer's office on the wing, where he again telephoned the healthcare department. This time, he was told that the nurses were on D Wing (an adjacent wing) and that they would make their way to the cell.
55. Officer B went back to Mr Black's cell and saw that Officer C and Nurse C were there. The nurse said that Mr Black was lying on his bed and was talking in short sentences. He told her that he was short of breath and had central chest pain. The nurse saw that Mr Black was sweating. He showed her his hospital discharge summary. At 11.32am, Officer C radioed a medical emergency code blue at the nurse's request. The nurse also asked for oxygen to be brought to the cell.
56. At 11.33am, a control room officer telephoned for an ambulance but told the ambulance service that she had no details of the medical emergency. At 11.34am, ambulance records show that an ambulance was scheduled to attend Whitemoor for a patient with breathing difficulties, a lower priority than a medical emergency. The control room officer said that there was a code blue which meant that somebody was not breathing and that they were getting oxygen. When the operator asked to clarify that the prisoner was not breathing, the control room officer said that she did not know. The call continued, and the operator asked again for the reason for the ambulance because the clinical coordinator needed information about the prisoner's condition. The control room manager told the operator that they were remote from the situation and had no information. The telephone call lasted 11 minutes and 48 seconds.
57. At 11.52am, the control room officer telephoned the ambulance service again to tell them that they needed the ambulance to arrive quickly. The operator again asked for information about the patient. The control room officer said that Mr Black had very low blood pressure and that they could not find a pulse. The operator asked if Mr Black was conscious, but the control room officer had no further information. The control room officer said that Mr Black was barely conscious. The operator upgraded the priority of the call to the highest level (cardiac arrest and chest pains).
58. The telephone call remained open to the ambulance service. The control room officer then said that Mr Black was no longer conscious, and the operator advised them to start CPR and asked if they had a defibrillator. The control room officer said that they had started CPR and had a defibrillator. The telephone call remained open until the ambulance arrived at the prison.

59. Nurse C tried to get a blood oxygen level reading but could not do so because Mr Black had a very weak pulse. She said that his systolic blood pressure (pressure in the arteries) was very low and she could not find a diastolic reading (the pressure between beats) but that he was still talking. His respiratory rate was high (22 breaths per minute). Nurse D went to the cell and gave Mr Black oxygen. Nurse C dissolved aspirin in water and tried to give it to him, but he was unable to take it and he became unresponsive.
60. Nurse C started CPR. Nurse D and Nurse E inserted a tube into Mr Black's airway. Nurse D attached a defibrillator which advised not to shock Mr Black but to continue CPR. Supervising Officer (SO) A, Officer D, Officer E, Officer F and Officer G carried out chest compressions in rotation.
61. At 12.05pm, an ambulance arrived at Whitemoor and at 12.16pm, paramedics were at Mr Black's side. At 12.16pm, an air ambulance landed outside Whitemoor and at 12.28pm, the crew was at Mr Black's side. The air ambulance doctor established at 12.33pm that Mr Black had died.

Contact with Mr Black's family

62. On 16 November, Whitemoor appointed the Head of Rehabilitation, as the family liaison officer and Officer H as the deputy family liaison officer. At 3.35pm, they visited Mr Black's next of kin to break the news of his death and offer their condolences. On 21 November, Officer I, took over as the prison's family liaison officer. He remained in contact with Mr Black's family. Mr Black's funeral took place on 11 December. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

63. After Mr Black's death, the Head of the Offender Management Unit, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
64. The prison posted notices informing other prisoners of Mr Black's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Black's death.

Post-mortem report

65. A post-mortem examination established that Mr Black died of a pulmonary thromboembolus (a blood clot in the lung) caused by deep vein thrombosis. The pathologist noted that thoracic spinal myelopathy, reduced mobility and recent spinal surgery were well-recognised risk factors for thromboembolic disease.
66. Toxicology tests showed that Mr Black had levels of morphine, codeine and naproxen consistent with post-operative pain relief in his body.

Findings

Clinical care

Healthcare prior to Mr Black's surgery

67. Mr Black suffered from spinal cord compression due to a narrow spinal canal, a condition that he had had from birth and was getting progressively worse as he got older. Although Mr Black believed that his back problems were the result of being assaulted by another prisoner in April 2018, it is clear that his condition was first diagnosed in October 2017.
68. The clinical reviewer was satisfied that the healthcare that Mr Black received at Whitemoor was of a reasonable standard and equivalent to that which he could have expected to receive in the community. When Mr Black asked for support, the healthcare team provided it in a prompt and timely manner. When Mr Black told healthcare that he had back pain, he was appropriately supported and referred promptly for MRI scans, physiotherapy and hospital treatment.

Healthcare after Mr Black's surgery

69. When Mr Black returned from hospital on 14 November, he refused to go to the inpatient unit where he would have been monitored by healthcare staff. Mr Black signed a disclaimer accepting responsibility for this decision. There is no evidence to say why he refused, and we consider that it would have been good practice to have recorded the reason.
70. There may have been several reasons for Mr Black's decision. Prisoners in the long-term estate can become set in their ways and want to live in their own cell surrounded by their own possessions and by prisoners they know. Prisoners also tend to be locked up for longer in the healthcare unit because officers are deployed elsewhere to fill gaps on other wings. The unit may also be noisy if there are prisoners with mental health issues being held there and because it is used as overflow accommodation for the segregation unit.
71. A prisoner said that Mr Black refused because the inpatient unit was dirty. Three other prisoners also said that the inpatient unit was dirty.
72. The new Head of Healthcare acknowledged that the cleanliness of the inpatient unit was a concern and was a priority on the healthcare risk register. She said that the Prison Service was responsible for the cleaning of the inpatient unit, and healthcare staff considered that the standards fell below what was expected in an NHS service.
73. She said she had discussed the issue with, the Head of Discrete Units, and the regional NHS commissioner. The cleaning company contracted by the Prison Service had been dismissed and prisoners were now employed as cleaners, but their cleaning fell below the required standard. The Head of Discrete Units told us that he planned to have the unit deep-cleaned every six months.
74. If Mr Black had gone to the inpatient unit when he returned from hospital, he would have been monitored more closely by healthcare staff. We do not know

why Mr Black refused to go to the inpatient unit and we cannot say whether it was because he thought the unit was dirty.

75. However, we are very concerned about the condition of the inpatient unit. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the standard of cleanliness in the inpatient unit does not fall below that required by the NHS.

76. The clinical reviewer noted that Mr Black's discharge summary letter from the hospital did not include a course of anti-coagulant (blood thinning) drugs, often given to patients before and after surgery to reduce the risk of blood clots. The former Head of Healthcare said that Mr Black was discharged to Whitemoor with compression socks (designed to prevent blood clots) and confirmed that he was not prescribed anti-coagulants. He said that he had spoken to hospital staff who confirmed that if a patient was mobile and had been assessed by a physiotherapist (as Mr Black had been), they would not routinely prescribe an anti-coagulant after an operation.
77. A prisoner said that he had been told that another prisoner told an officer that Mr Black was feeling short of breath on the afternoon of 15 November, and that the officer told the nurse in the medication hatch, but the nurse refused to see him.
78. There is nothing in Mr Black's health or prison records to suggest that anyone was told that Mr Black was feeling unwell on 15 November. The nurse in the medication hatch that day says that she was not told this, although she says that an officer did tell her that Mr Black was asking for pain relief and that she said he would need to attend the medication hatch as prison policy would not allow her to take the medication to Mr Black in his cell. The investigator established that the officer the prisoner named was not working that day.

Emergency response

79. When Mr Black pressed his cell bell on 16 November, an officer responded. We do not know how promptly he responded because the prison had no cell bell records for C Wing. (A data system failure the week before Mr Black's death meant no cell bell records could be retrieved.) Whitemoor told the investigator that this fault has since been rectified.
80. The officer appropriately telephoned the healthcare department because at that time, Mr Black's condition did not amount to a medical emergency. As soon as it became clear that Mr Black's medical condition required urgent attention, an officer promptly radioed a medical emergency code blue.
81. We are concerned, however, that although the control room requested an ambulance at 11.33am, as soon as the code blue had been called, the ambulance service did not despatch an emergency ambulance until 11.52am, a delay of 19 minutes, because control room staff were unable to give details of Mr Black's condition. We cannot say whether the outcome might have been different for Mr Black if the ambulance had been despatched sooner.

82. Although the control room officer remained calm and tried to get the information to the ambulance service, staff who responded to the emergency in Mr Black's cell failed to pass information about his condition promptly to the control room despite a number of them having radios. It is critical that the control room receives accurate information about a prisoner's condition so that they can update the ambulance service appropriately.

83. It is also important that the local ambulance trust understands that the special circumstances in prisons mean that staff in the control room may not always have information about the prisoner or his condition. Prison Service Instruction (PSI) 3/2013, *Medical Emergency Medical Codes*, says:

“As the logistical and operational arrangements of each prison will differ, the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust ... Regular reviews of the protocol should be built into the process and agreed with the local healthcare commissioner and ambulance trust.”

84. We make the following recommendations:

The Governor should ensure that when a medical emergency code is called, staff responding to an emergency give the control room detailed information about a prisoner's condition and the nature of the emergency so that they can share it with the ambulance service when they call for an ambulance.

The Governor should ensure that:

- **the prison's medical emergency response protocol is reviewed and agreed with the local ambulance trust in the light of the events of 16 November 2019; and**
- **the protocol covers what initial clinical information is required before despatching an ambulance and the need for urgency in emergency situations.**

85. PSI 3/2013 also says that the local medical emergency response protocol must “prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison”.

86. Paramedics from the land and air ambulance noted that they were delayed getting into the prison and reaching Mr Black. It took the first ambulance crew 11 minutes and the air ambulance crew 12 minutes after landing outside the prison to get to Mr Black.

87. A prison manager said that the security measures were essential and necessary in a Category A prison and there would therefore always be a delay in getting an ambulance into the prison. Officer D said that C Wing, where Mr Black lived, was one of the furthest wings from the main gate and because it was a high-security prison, there were many gates to get through. SO A said that he had worked at Whitemoor for 15 years and had worked on the prison gate. He said that when

an ambulance arrived at the prison, an operational support grade had to unlock and lock each gate in turn to let the ambulance through and there were four gates to get to C Wing.

88. We are satisfied that the delay was not unreasonable due to the location of C Wing and the security measures needed at Whitemoor.

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