

**Investigation into the circumstances surrounding the
death of a man,
a prisoner at HMP The Verne,
in hospital in June 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

February 2009

This is the report of an investigation into the circumstances surrounding the death of a man on 16 June 2008. At about 7.45am that day, the man collapsed at HM Prison The Verne. He was taken to hospital where death was pronounced at 9.30am. At the subsequent post mortem examination it was found that the man had died of a heart attack. A Spaniard, he was 52 years old when he died.

I offer my sincere sympathy and condolences to the man's family and friends for their sad and untimely loss.

The investigation was conducted by my colleague.

I also commissioned a clinical review of the management of the man's health needs while he was in prison custody. This was conducted on behalf of the Dorset Primary Care Trust. I am most grateful to the clinical reviewer for his contribution.

My thanks also go to the Governor and her staff at The Verne for their assistance during the investigation. I am especially grateful to the prison's liaison officer.

I have concluded that the man's health needs were satisfactorily met and that his fatal heart attack could not reasonably have been predicted.

One of the principal aims of my investigations is to help the Prison Service to learn relevant lessons from each death. Although I am satisfied that the man's death could not have been predicted, I nevertheless urge the Governor to implement recommendations I have made about the timing of health screens and about aspects of the management of life-threatening events.

In addition to my recommendations, I am pleased to draw attention to three examples of good practice.

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Prisons and Probation Ombudsman

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SUMMARY

The man was arrested at Gatwick Airport on 21 June 2007. He was charged with the illegal importation of drugs and later sentenced to six years imprisonment. He spent brief periods at HMP Elmley and HMP High Down before transferring to HMP The Verne in Dorset on 29 September. Although he was a heavy smoker and was troubled by persistent back pain, the man neither showed nor complained of any heart problems.

At about 7.45am on 16 June 2008, the man collapsed in his wing at The Verne. Initially it was thought he was experiencing convulsions. However, he quickly lost consciousness and was taken to hospital by ambulance. The man was pronounced dead at the hospital at 9.20am that day. A post mortem examination found that he had died of a heart attack.

My investigation found that the man's fatal heart attack could not reasonably have been predicted. A number of staff and one prisoner made determined attempts to save his life.

I make five recommendations, one of which concerns the timeliness of reception health screens. The other four concern aspects of the management of life-threatening emergencies. I also draw attention to three examples of good practice.

INVESTIGATION PROCESS

1. The investigation was conducted by my colleague. On 19 June, my investigator met with the Governor, a representative of the local branch of the Prison Officers' Association, a representative of the prison's Independent Monitoring Board, the Prison Intelligence Officer from Dorset Police, and the prison's Family Liaison Officer. My investigator explained the terms of reference for the investigation. The following day, notices were issued to staff and prisoners at The Verne to announce the investigation and to invite anyone with concerns about the man's death to make themselves known to my investigator. Two prisoners responded. Those two prisoners and three members of staff were interviewed informally. An informal discussion was also held with a fourth member of staff.
2. I commissioned a clinical review of the management of the man's health needs while he was in custody. This was conducted on behalf of the Dorset Primary Care Trust.
3. In July 2008, one of my Family Liaison Officers contacted the man's brother by letter, translated into Spanish, to an address in the Canary Islands provided by staff at The Verne. A Spanish version of the Prisons and Probation Ombudsman's Information Leaflet for Families about the investigation was sent at the same time. The letter invited the family to make contact about any concerns or questions they wished the investigation to address. No response has been received to date. Further attempts will be made to inform the man's family of the completion of the draft report and to ascertain whether they wish to receive a copy.

HMP THE VERNE

4. The Verne is a category C training prison for up to 595 male adult prisoners situated on the isle of Portland near Weymouth in Dorset. Most of the prisoners at The Verne are foreign nationals.
5. There are six identical wings, five of which hold a maximum of 86 prisoners and one of which (C2) holds 92. In addition, D wing provides dormitory accommodation with curtained bed spaces. A1 and C1 wings hold prisoners who have attained the highest level in the incentives and earned privileges scheme. A2 wing is the induction unit.
6. Health services are commissioned and provided by the Dorset Primary Care Trust. The healthcare centre is a single storey building located at one end of the prison. There are no inpatient facilities. Prisoners who need inpatient care are normally taken to a hospital some 14 miles away.
7. The Verne was last inspected by Her Majesty's Chief Inspector of Prisons in August 2007. In the report of that inspection, published the following October, the Chief Inspector made a number of recommendations about healthcare, none of which is relevant to this investigation.
8. In their report on The Verne for the period November 2006 - May 2008, the Independent Monitoring Board (IMB) drew attention to some aspects of the provision of healthcare by the Dorset Primary Care Trust. However, these issues too are unrelated to the findings of this investigation.
9. I have investigated two previous deaths at The Verne. These occurred in November 2004 and March 2008 respectively. In my report of the investigation into the first of those deaths, I drew attention to the absence of defibrillators at The Verne and recommended that the Primary Care Care Trust should provide a defibrillator to the establishment. I am pleased to be able to record that this recommendation was implemented. I also note that, since the man's death, a second defibrillator has been acquired. However, I have recommended that thought should be given to the location of one of them in a more central location in the prison. None of the issues that arose from the investigation of the other death I have investigated at The Verne is relevant here.

KEY EVENTS

Arrest and appearance in court

10. On 21 June 2007, the man, a Spanish national, formerly resident in Alicante, flew in to Gatwick Airport from Port of Spain in Trinidad. He passed through the “nothing to declare” channel where his luggage was searched. In it was found a large quantity of illegal drugs.
11. The man was arrested at 8.40am and taken into custody for interview in the presence of an interpreter and a solicitor. That evening, he was taken to a police station in Brighton. He remained in police custody until 25 June. His medical record shows that he was regularly given paracetamol and ibuprofen for back pain.
12. The man appeared before magistrates on 25 June, accused of the illegal importation of drugs. He was remanded in custody at HMP Elmley.

HMP Elmley

13. The man spoke very little English. His ability to communicate was therefore largely dependent on the use of interpreters.
14. The man’s medical records show that upon his reception he complained of a history of back pain but was otherwise considered to be fit and well. During his first reception health screen, with the aid of an interpreter, the man told a nurse he had not seen a doctor in the previous few months and was not in receipt of any medication. He said he consumed neither drugs nor alcohol. However, he was heavy smoker.
15. His pulse rate was recorded as 73 beats per minute (i.e. within normal range). His weight was 70kg. His height was recorded as 184cm and his body mass index was 20.68. His blood pressure was measured as 102/65, which is below normal limits. The man was given two paracetamol tablets for his back pain.
16. Just over a fortnight later, the man failed to keep an appointment for a triage assessment. However, the appointment did take place a week later. Once again, the man complained of back pain. His medical record shows that an appointment was to be made for him to be assessed by a doctor that afternoon. At this appointment, a prison doctor prescribed Diclofenac 75mg for his back pain.
17. The man remained at Elmley until 13 September when he appeared at Crown Court and was given a six year prison sentence. He was transferred to HMP High Down the next day.

HMP High Down

18. Upon his arrival at High Down, the man attended a “well man“ clinic. He admitted to smoking 20 cigarettes a day and said he would not give up the habit. He said there was no family history of serious illnesses.
19. The man’s blood pressure was recorded as 157/96, above the normal range. (My investigator was advised that this is borderline high.) The man’s pulse was 83. This is considered to be normal for a person who is a regular smoker. The man also confirmed he did not have a pacemaker (a device fitted surgically to a patient to regulate the heartbeat).
20. After two weeks at HMP High Down, the man was assessed as being fit for transfer to HMP The Verne. The following table shows the questions asked and his answers:

Does this prisoner have any outstanding hospital appointments?	No
Is this prisoner on medical hold/any other medical reason?	No
Does this prisoner require regular medication?	Not ticked
Does this prisoner need 24 hour healthcare input?	Not ticked
Do you need the doctor’s opinion about this transfer?	Not ticked
Is there any risk of self-harm?	No
Is there any clinical reason why this prisoner should not be transferred? Awaiting transfer to hospital Awaiting psychiatric referral Care programme approach Awaiting psychiatric referral	Not ticked
Is this prisoner fit for transfer? (In other words, are there any medical reasons why he should not be moved to another prison?)	Yes (he is fit for transfer)

21. The man was transferred the next day.

HMP The Verne

22. Upon arrival at The Verne, the man was allocated to a unit where there were other Spanish speaking prisoners. By all accounts, he soon settled and got on well with a small group of prisoners who spoke his language. Although by this time his use of English had begun to improve, the man remained somewhat dependent on the ability of other prisoners to interpret for him when speaking to staff and to help him fill in forms.
23. He was assessed by a prison doctor five days after his arrival. The doctor recorded that the man complained of low back pain and prescribed Diclofenac tablets that are designed to help relieve pain and inflammation as well as to minimise the risk of side effects. The doctor also suggested that the man should consider taking paracetamol - a mild painkiller - as an alternative.

24. On 26 October, a month after his arrival at The Verne, the man underwent a further routine health assessment. The nurse who carried out the assessment considered that there were no grounds for referring him to a doctor, although she advised the man to try to reduce his level of smoking. The man told the nurse he had no concerns about his health and did not think there was any health information he considered to be important. He was assessed as being fit for normal location (i.e. in a wing rather than in a healthcare centre), work and any cell occupancy.
25. Healthcare staff continued to emphasise to the man the importance of reducing his smoking throughout his time at The Verne. The only other medical issue of note was the management of his back pain, for which the man continued to receive Diclofenac, paracetamol and ibuprofen.
26. Although the man came to the attention of the healthcare department on numerous occasions thereafter, the consultations were unrelated to any complaints or issues of a significant nature, and no consultations raised the issue of possible heart disease.

Events on 16 June

27. Shortly before 7.00am on 16 June 2008, the man unexpectedly collapsed in his wing. Another prisoner located in the same wing as the man, made a written statement to the Governor in which he described what happened.
28. My investigator interviewed two other prisoners and three members of staff who, amongst others, were involved in the discovery of, and response to, the collapse. Those staff were the first person to respond to the emergency, the officer who asked for an ambulance to be called and the first member of the healthcare team to respond.
29. The other prisoner said he first saw the man shortly before 6.50am. He was walking along his landing in search of someone who might give him a cigarette. The prisoner described the man as being "his normal self". He said he saw the man again in the recess about 45 minutes later and noticed that he was carrying a blue plastic bowl and his glasses. After the morning roll check was complete, the prisoner said he went to the wing office to collect the keys to the cupboard where cleaning equipment was kept, and prepared to empty the office rubbish. He then stood in the corridor, not far from the office, to await breakfast.
30. The prisoner said that, at about 7.45am, he, the man, and another prisoner waited at the entrance to the servery. He had earlier seen the man reading the notices on the wall at the end of the corridor. During his conversation with another prisoner, the prisoner noticed that the man had put one of his feet on a cereal bowl that had been left on the floor. The prisoner said he continued talking but heard a "scrape" and so turned and then saw the man "fall back very hard". The prisoner said the man was "straight" as he fell and made no attempt to save himself with his hands. He explained that the man fell

31. The prisoner said he was then joined by an officer. The officer confirmed to my investigator that, at about 7.40am, a prisoner ran to the office and told him that someone had fallen. The officer went to investigate and found the man unconscious on the floor near the servery entrance. The officer stressed that there were no obvious signs of any injury to the man. Although he appeared to be having a fit, the man was not breathing. The officer said that he asked a second officer to seek assistance and then, with help from the prisoner, he tried to “get (the man) breathing again”. The officer thought the man took in air and therefore placed him in the recovery position. After about a minute or so, it became apparent to the officer that the man was not breathing and that he had no pulse.

32. In a statement he later submitted to the Governor, the officer explained what happened next. He wrote:

“The prisoner thumped his chest two or three times then gave chest compressions while I cleared his mouth and pulled his tongue away from the back of his throat. I commenced mouth to mouth (without a mask) and continued for about five or ten minutes. During this time the area was cleared of prisoners. The prisoner was relieved by another officer. At about 7.55am, the medical staff and an officer came to the scene carrying resuscitation equipment. I swapped with the officer on the CPR (cardiopulmonary resuscitation) for compressions for about ten minutes and then I was relieved by the third officer. At that stage, there were no signs of recovery, unassisted breathing or pulse. The nurse set up the defibrillator and went through its procedures. The paramedics arrived about 8.10am and joined us all in the effort of reviving the man and eventually took over command. I went to the wing office to have a rest and drink. I returned after about 10 to 15 minutes to assist again and get the man on the trolley for transfer to hospital. The area was then cleared of medical equipment and debris. All Prison Service staff were called for a debriefing in the staff facility.”

33. A Senior Officer, the ‘A’ group manager, also made out a statement to the Governor. He wrote:

“My first sight was of (the man) being given CPR by a prisoner. An officer was beside him. I asked what the situation was to which the officer told me he was not breathing. I asked if anybody was first aid trained. Nobody replied. At this time several other prisoners were in the vicinity. I asked the prisoners not involved to move away from the area, which they did without any fuss. I then returned to the office to check on the progress of the attendance of healthcare. I opened the outside wing office door and saw the nurse walking towards the wing. I called to her to hurry. The time

was now approximately 7.55am. The nurse began to administer CPR to the man. During this time, more staff began to attend.”

34. At interview, the nurse told my investigator she normally started her duties at 8.00am but, on 16 June, she started work 15 minutes early. She explained:

“When I was called over the radio after the man had collapsed, I was told only that he’d had a fit. I hurried to A1 wing without taking any emergency equipment with me. I believe I should have been given more information about the man. Had this been the case, I would have taken the emergency equipment with me straightaway. There is currently no emergency code system for raising an alarm in a life threatening situation. I think there should be one.”
35. Later in the interview, the nurse indicated that only one defibrillator was available at The Verne. She added that it was stored in the healthcare centre which is located at the end of the prison farthest from the accommodation area. An officer was asked to fetch the defibrillator and two face masks.
36. The log of events recorded by the establishment shows that an ambulance was called at 7.47am. At interview, the second officer told my investigator:

“I rang comms [i.e. the control room] at first because we thought the man was having a fit. The nurse received the radio message and she rang me. I said we had a prisoner that had collapsed and we thought he was having a fit. She said, ‘I’ll read and check his notes and I’ll come straight over.’ Then, because he is a non English Spanish national, I raced upstairs to get another prisoner who could speak both Spanish and English and asked him to come and interpret. At that stage, I thought there might have been a need for someone to speak to the man. When I got back I found he wasn’t breathing. It was at that stage I called for an ambulance by calling comms again. I can’t remember exactly what I said but I would have said something like ‘We need an ambulance because we have a prisoner who is not breathing.’”
37. The ambulance arrived at the prison at 8.05am. The ambulance crew left with the man for hospital at 8.43am. Further attempts were made to revive him on the way to hospital but he was pronounced dead at the hospital at 9.20am.
38. The officer told my investigator he did not have a face mask with which to protect himself from the transfer of body fluids whilst applying CPR. He confirmed that he had been trained in CPR and felt competent to give first aid to the man. During the interview, the officer’s trade union representative offered the view that there should be more refresher training for staff in emergency first aid.
39. The nurse confirmed that she had been trained in CPR and had undergone refresher training in March 2008. She added that she was not aware that a

Informing the man's next of kin

40. The prison's family liaison officer arranged for the man's next of kin – his brother, who lives in Gran Canaria – to be informed of the man's death by the Spanish Embassy. This was achieved on 20 June.
41. Later, the man's brother was given an opportunity to view the man's room at The Verne and to meet senior members of staff.
42. With the consent of his brother, arrangements were made for the man to be cremated on 23 June. The man's brother was able to travel to Weymouth to attend the service. Representatives from the prison also attended. Flowers were sent to the service by the Governor, who also offered to meet the costs of the cremation.

Support for prisoners and staff

43. The prisoners in A1 wing were asked to assemble in a large room in the wing where they were told of the man's death and offered support by staff.
44. The prison officers who were involved in the discovery of the man's collapse and who attempted to revive him were debriefed on the same day and offered appropriate support. However, the nurse told my investigators she was not aware a debrief had occurred.

ISSUES

45. Here I examine:

- Whether the man's health needs were satisfactorily met while he was in custody.
- Whether the response to his collapse on 16 June was prompt and appropriate.
- Whether appropriate courtesies and support were offered to the man's next of kin in the aftermath of his death.

Were the man's health needs satisfactorily met while he was in custody?

46. Here I rely heavily on the findings of the clinical review.

47. The clinical reviewer concludes as follows:

"I believe that the man had good care at The Verne. He was given pain relief for his back and his visual and dental problems were dealt with. Very few people (about 1:100) who sustain a fatal heart attack outside hospital can be successfully resuscitated. One in three people who have a heart attack have the man's experience: they die without prior warning.

"Healthcare staff should be congratulated for persistently encouraging the man to stop smoking.

"The PCT should look at the purpose of the reception screening procedure when prisoners move between prisons. The man had been at The Verne for four weeks before his blood pressure and smoking habits were recorded. Had he died during that time, this report might have been far less mellow in its tone."

48. I agree with this recommendation but suggest it should be expressed as follows:

The Governor, in conjunction with the PCT, should ensure that health screens on newly arrived prisoners at The Verne take place as soon as possible after the prisoner's arrival.

Was the response to the man's collapse on 16 June prompt and appropriate?

49. The clinical reviewer comments as follows:

"When people collapse, they often convulse because of a sudden lack of oxygen to the brain and it appears they are having a fit. The man was appropriately treated for a fit by being placed in the recovery position. When it was realised he was not breathing, resuscitation was started and when the defibrillator was brought from healthcare it was deployed appropriately.

“The officer should be warmly congratulated for performing mouth to mouth resuscitation without protection between himself and the patient. Whilst the risk of being infected by someone who has a serious disease through saliva is minimal, performing mouth to mouth resuscitation is a very unpleasant experience. The officer did so without concern for his own safety.

“Provision of some form of barrier membrane on every wing might encourage the more fastidious to do as well as the officer.”

50. I agree with this recommendation but suggest that it is expressed as follows:

The Governor, in conjunction with the Primary Care Trust, should ensure that protective face masks are issued to all staff likely to come into contact with prisoners for use during the application of cardio-pulmonary resuscitation. These should be carried on the belt. Appropriate training in their use should be provided.

51. The clinical reviewer also comments:

“The nurse should be thanked for arriving at work early. Her presence will have reassured those doing the initial resuscitation and her expertise was quickly brought to bear. I was disappointed that she and her colleagues who attended subsequently were not included in the debrief that was properly given to the prison’s own employees. In my experience, they have been included in the past and should be in the future.”

52. I agree with the clinical reviewer.

The Governor, in conjunction with the PCT, should ensure that healthcare staff involved in the management of life threatening emergencies are debriefed alongside their Prison Service colleagues.

53. During the course of the investigation a Spanish speaking prisoner said to my investigator:

“None of the nurses or staff are trained in CPR. Only one is and he is a fireman. The Governor said the officers are trained in CPR. One of the officers told me that is not true.”

54. My investigator ascertained that the person described as a fireman was one of the officers who helped in the attempts to revive the man. During an informal discussion with my investigator, the officer confirmed he was trained in CPR. The nurse and the first officer also confirmed they were similarly trained. The investigation found no evidence to suggest that any of the healthcare or discipline staff who were involved in attempts to revive the man were impeded by any lack of training. However, the trade union official who accompanied the officer at his interview suggested that there should be more refresher training for staff in emergency first aid. I consider that this is a matter the Governor may wish to explore further.

55. The investigation found that there was, at the time, only one defibrillator available in the prison and that it was stored in the healthcare centre, a building sited farthest from the accommodation area of the prison. (I understand that since the man's death, a second defibrillator has been purchased.) Although there was no evidence that the length of time taken to fetch the defibrillator from the healthcare centre was relevant to the man's death, it is clear that matters were not helped by the distance involved.
56. The clinical reviewer points to the need for a review of the siting of defibrillators. I agree and recommend as follows:

The Governor, in conjunction with the PCT, should consider relocating one of the defibrillators to a more central point in the prison.

57. The nurse told my investigator that she did not know the precise details of the man's collapse when she was first asked to go to A1 Wing to tend to him. She believed that a code system should be used to alert staff to different types of emergency so that appropriate first aid equipment is deployed from the outset. Although there is no evidence that the delay in deploying a defibrillator altered the outcome for the man, any such delay in a future emergency could be critical.

The Governor should consider the merits of introducing a code system by which staff can be alerted to life threatening emergencies such that appropriate emergency first aid equipment is rapidly deployed.

58. Notwithstanding the points I have made above, I am satisfied that every effort was made to save the man's life. I commend those involved, including the other prisoner, for their attempts to do so. The Governor will wish to ensure that the other prisoner's actions are noted in his prison file and should consider whether any more formal commendation should be made.

Were appropriate courtesies and support offered to the man's next of kin in the aftermath of his death?

59. I consider that the news of the man's death was communicated as speedily as possible to his next of kin, given the difficulties experienced by the prison and the Spanish Embassy in tracing him.
60. The Governor wrote a letter of condolence to the man's brother. The Governor also offered to meet the full costs of the cremation. Flowers from the prison were on display at the cremation service and representatives of the prison were present. The man's brother was later given an opportunity to view the man's room in The Verne and to meet senior members of staff.
61. I consider that the family was offered appropriate kindness, support and courtesy by the Governor and her staff. This reflects very well both upon the establishment and upon the Prison Service as a whole.

LIST OF RECOMMENDATIONS

1. The Governor, in conjunction with the PCT, should ensure that health screens on newly arrived prisoners at The Verne take place as soon as possible after the prisoner's arrival.
2. The Governor, in conjunction with the PCT, should ensure that protective face masks are available to all staff likely to come into contact with prisoners to use during the application of cardio-pulmonary resuscitation. These should be worn on the belt. Appropriate training in their use should be provided.
3. The Governor, in conjunction with the PCT, should ensure that healthcare staff involved in the management of life threatening emergencies are debriefed alongside their Prison Service colleagues.
4. The Governor, in conjunction with the PCT, should consider relocating one of the defibrillators to a more central point in the prison.
5. The Governor should consider the merits of introducing a code system by which staff can be alerted to life threatening emergencies such that appropriate emergency first aid equipment is rapidly deployed.

(In addition to these recommendations, I have suggested in para 58 that the Governor ensures that the other prisoner's actions in coming to the aid of the man are noted in his prison file, and that consideration is given to a more formal commendation.)

Good practice

1. The officer should be warmly congratulated for performing mouth to mouth resuscitation without protection between himself and the man.
2. Healthcare staff should be congratulated for persistently encouraging the man to stop smoking.
3. The nurse should be thanked for arriving at work early on 16 June.