INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING

THE DEATH OF A MALE PRISONER

AT HM PRISON WHATTON ON 28 JUNE 2004

A report by the Prisons and Probation Ombudsman
for England and Wales

October 2004

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1. Introduction

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HM Prison Whatton during the evening of 28 June 2004.

Very sadly, none of the deceased's relatives have been traced. It may well be that he had no close relatives at all.

One of my investigators conducted the investigation on my behalf under the terms of reference shown at Annex A. I also commissioned an independent clinical review of the management of the deceased's healthcare needs for the period he was at Whatton. The review, for which I am most grateful, was carried out by the Rushcliffe Primary Care Trust. The report is at Annex B.

I would like to thank the Governor and staff of HM Prison Whatton for their full and ready co-operation in this investigation.

This published version does not include the original annexes.

2. Summary

At approximately 8.10pm on Monday 28 June 2004, a prisoner in A Wing at HM Prison Whatton, alerted staff to the fact that the now deceased prisoner seemed to be having breathing difficulties in his cell. Staff found him apparently unconscious. They called for an ambulance and administered cardiopulmonary resuscitation. All attempts by prison staff and paramedics to revive the prisoner failed.

The Coroner's Interim Death Certificate, issued on 7 July 2004, records the cause of death as Ischaemic Heart Disease (the most common form of heart disease in which narrowing or obstruction of the arteries occurs, resulting in a reduced blood supply). The prisoner had shown no previous signs that he was suffering from heart disease and had not been taking any regular medication. He had rarely come to the attention of the healthcare staff at Whatton.

The Rushcliffe Primary Care Trust has commented that the prisoner received satisfactory healthcare at Whatton and that, in the hours before his death, prison staff acted promptly and appropriately. I agree with that judgement.

I make one recommendation.

3. Investigation methodology

The investigation was opened on 5 July 2004 when notices announcing the investigation and its terms of reference were issued to staff and to prisoners

at Whatton. The notices included an invitation for staff and prisoners to submit information to my investigator if they wished. No submissions were received.

My investigator later met with the acting Governor of Whatton, the Chair of the prison's Independent Monitoring Board, and members of the local branch of the Prison Officers' Association. My investigator toured the prison and familiarised himself with the cell and wing in which the prisoner had lived.

My investigator was given access to his prison documents, including the Inmate Medical Record (IMR), as well as the statements of staff who were involved in his discovery. My investigator took the view that it was not necessary to interview any members of staff or prisoners.

4. The deceased

The prisoner was born on 8 March 1937. He had no brothers or sisters. He attended a school for children with learning difficulties. After leaving school he left home and eventually lost contact with his parents. He initially worked for a while as a cleaner in a holiday camp and was later took on casual short term jobs in markets and hotels. He formed no close and enduring relationships.

Between 1970 and 1981 he was convicted on three occasions, for theft burglary and criminal damage for which was given non custodial punishments. In 1988, he received a suspended prison sentence which would have expired in 2011.

The prisoner had told staff at Whatton that his next of kin was his father who, he said, was in hospital. Upon his death, the police made extensive enquiries to trace any surviving relatives. They confirmed that his father had died in 1992 and that they could not trace his mother or any aunts or uncles.

5. HMP Whatton

HMP Whatton opened in 1966 as a detention centre for young offenders. Following the Strangeways riot in 1990 it re-roled to a Category C establishment for up to 340 male sex offenders.

The establishment was last inspected by Her Majesty's Inspectorate of Prisons in February 2004. An extract from the report of that inspection , published in May 2004, reads as follows:

"….Whatton provided a respectful environment with good standards of cleanliness, food and healthcare. Staff-prisoner relationships were excellent, which, given the serious nature of many of the prisoners' offences, speaks volumes for the professionalism of the staff…"

6. The discovery of the prisoner's death

At about 8.10pm on 28 June 2004 a fellow prisoner found the deceased in his cell experiencing breathing difficulties. The prisoner approached an Officer and asked that a member of staff should attend A2 landing (where the deceased's cell was located). The prisoner explained that he had seen the deceased "lying on his bed groaning and not looking well". The Officer alerted the Wing Senior Officer, and together they went to the deceased's cell. The Officer reports in his statement that the deceased appeared to be unconscious and that his breathing was very shallow. The Senior Officer states that the deceased looked very distressed and was breathing very erratically. The Senior Officer remained in the cell while the Officer arranged for other prisoners to be locked in their cells.

As the healthcare centre at Whatton closes at 5pm each day there were no nursing or medical staff on duty when the deceased was discovered. My investigator was told that the Senior Officer had been trained in the use of a defibrillator and CPR techniques. (It is understood that, shortly after the prisoner's death, a decision was made by the Governor of Whatton that all Senior Officers were to be trained in the use of the defibrillator, in CPR techniques and as first aiders so that, in the absence of nursing or medical staff, a guaranteed 24 hour presence of trained first aiders could be maintained.) I commend the Governor's actions and refer to them again below.

The Senior Officer checked the deceased's pulse but could find none. He asked the gatekeeper to summon an ambulance. The incident log shows that this took place at 8.10pm. However, according to the Primary Care Trust, East Midlands Ambulance Service received two calls from Whatton prison. The first was at 8.14pm and was assigned a category B response. The second was at 8.17pm when the prisoner stopped breathing. The response was upgraded to category A. Dr Slade reports that the nearest available ambulance was sent to the scene and arrived at 8.35pm. (See also the comments made by the Primary Care Trust at Annex B of the clinical review.)

Meanwhile, the Senior Officer had been joined by another Officer in the prisoner's cell. That Officer was asked by the Senior Officer to collect a defibrillator from the healthcare centre. He did so and returned to the cell with a colleague and helped at the scene. One Officer removed the prisoner's dentures and checked his pulse and breathing. No pulse was found and it was apparent that he was not breathing. He was moved from the cell by three members of staff onto the flat surface of A2 landing. The defibrillator was then connected to the prisoner. Staff continued to apply CPR until the ambulance crew arrived. Paramedics made further attempts at resuscitation but terminated those attempts at about 8.53pm before transferring the prisoner to hospital.

Although no formal pronouncement of death was made at the scene, it is understood that the paramedics decided that further attempts at resuscitation were unlikely to be successful. The prisoner was pronounced dead on arrival at the Queen's Medical Centre by the attending doctor at about 9.53pm.

7. Clinical Review

The Primary Care Trust reports that, during his time at Whatton, the prisoner rarely came to the attention of the healthcare staff. He had no history of ischaemic heart disease, hypertension, diabetes, asthma or mental illness. He did not take regular medication. He did not have any known risk factors for ischaemic heart disease, other than smoking, and had not presented with symptoms prior to 28 June 2004.

The report concludes that the prisoner received satisfactory healthcare at Whatton and that in the hours preceding his death, prison staff acted promptly and appropriately. The Primary Care Trust makes no recommendations.

8. Conclusion and recommendation

I would like to commend those Prison Service staff and NHS paramedics who attempted to revive the prisoner.

I am very taken by the Governor's decision to ensure that, from now on, all Senior Officers will be trained in the use of the defibrillator, CPR techniques and as first-aiders. However, there must be many other prisons like Whatton that do not have 24 hour medical cover. I recommend that the Prison Service's Safer Custody Group draw to the attention of area managers and governors the good practice being implemented at Whatton.

Annex A

Terms of reference

The investigation was conducted under the following terms of reference:

You are to investigate the circumstances surrounding the death of a male prisoner at HM Prison Whatton on 28 June 2004.

You are asked to:

- establish the circumstances surrounding the prisoner's death, including the care shown by the Prison Service, and relevant outside factors
- examine any relevant healthcare issues and assess clinical care, in conjunction with the National Health Service
- examine whether any change in operational methods, policy, practice or management arrangements would help prevent a similar death in future
- ensure that the prisoner's family have the opportunity to raise any concerns they may have and that these are taken into account in the investigation and in the report
- assist the Coroner's inquest

You act on my behalf in conducting this investigation

Timescales

You are to present to me a report of your findings, together with any recommendations you may wish to make, by 23 August 2004.

Stephen Shaw
Prisons and Probation Ombudsman for England and Wales

Annex B

Report of a Clinical Review by the Rushcliffe Primary Care Trust

This review was undertaken by a Specialist Registrar in Public Health Medicine at Rushcliffe Primary Care Trust. The review was commissioned by the investigator who is investigating this death on behalf of the Prisons and Probation Ombudsman.

Methodology

In conducting this review I visited HM Prison Whatton on 16th July 2004 and spoke to staff at the Healthcare Department of the prison. I also visited the wing where the deceased had been held where I spoke to the prison officers on duty and reviewed the wing log book. The inmate medical record (IMR) was not available on this day so I returned to the prison on 30th July 2004 to read it.

I also contacted the Patient Services Manager, East Midlands Ambulance Service, to review the ambulance records. The East Midlands Ambulance Service was unable to provide me with a copy of the Patient Report Form for the deceased. However they advised me that the paramedic on duty had already been interviewed by the Police for this investigation and has provided a statement.

Medical Profile

The prisoner was born on 8th March 1937. He had been an inmate at HM Prison Whatton since 20th March 2003. He was generally fit and well. He had a cholecystectomy for gallstones in 2002. He had no history of ischaemic heart disease, hypertension, diabetes, asthma or mental illness. He was not taking any regular medication. He rarely consulted the prison Healthcare Department for minor complaints such as headaches, for which he was prescribed paracetamol. He claimed to smoke two cigarettes a day, and had declined support from the prison health department for smoking cessation.

Events leading to death

At 20:10 on 28th June 2004, a fellow prisoner found the deceased in his cell experiencing breathing difficulties. The prisoner immediately called the Senior Officer on duty. This Senior Officer rapidly assessed the situation and instructed a colleague to call an ambulance. The deceased's pulse was absent, so the Senior Officer commenced cardiopulmonary resuscitation and

instructed a colleague to fetch the defibrillator. This was promptly done and at 20:15 defibrillation was applied with no response.

East Midlands Ambulance Service received two calls from HM Prison Whatton. The first was at 20:14 and was assigned a Category B response. A subsequent call at 20:17 notified the ambulance service the patient had stopped breathing and the response was upgraded to Category A. The nearest available ambulance was sent to the scene and arrived at 20:35.

The ambulance departed at 21:20. On arrival at the Accident and Emergency Department of Queen's Medical Centre at 21:53, the prisoner was pronounced dead by the doctor.

An autopsy was conducted on 30th June 2004 and the cause of death was provisionally reported to be a myocardial infarction. The toxicology report is still awaited.

Judgement

Based on the evidence available to me, my judgement is that the prisoner's healthcare needs were met whilst he was in custody. The fact that he was a smoker increased his risk of ischaemic heart disease. However he had declined support for smoking cessation. He did not have any other known risk factors for ischaemic heart disease and had not presented with symptoms prior to June 28th 2004.

In the hours preceding his death, prison staff acted promptly and appropriately.

There is a national target that 75% of Category A calls to ambulance services should be responded to within 8 minutes. The most likely explanation for the longer response time of 21 minutes in this instance was the heavy demand on the ambulance service at the time. I am unable to comment on the provision of health care to the deceased by paramedic staff before and during his transfer to Queen's Medical Centre.

Conclusion

I believe that the deceased received satisfactory health care at HM Prison Whatton. However I have been unable to review the ambulance records and am therefore unable to comment on the care given to him by paramedic staff on the evening of his death.