Investigation into the circumstances surrounding the death of a man at HMP Whatton in August 2009

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of an investigation into the death of a man who died in August 2009 after collapsing in his cell at HMP Whatton. The post mortem confirmed that the primary cause of death was an acute myocardial infarction (heart attack), secondary to ischaemic heart disease (narrowing of the arteries). The man, who had first suffered a heart attack at the beginning of the decade, was aged 56.

He had been in custody since 2003. He arrived at Whatton on 13 November 2007, following transfer from HMP Birmingham.

The loss of any family member is acutely painful, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends.

The investigation was conducted by one of my investigating officers. In addition, I commissioned a clinical review of the man's healthcare. I would like to thank the clinical reviewer who was appointed by the local Primary Care Trust to undertake the review. I would also like to thank the Governor of Whatton and her Head of Performance, who acted as liaison with the investigator.

I make two recommendations in this report. I also note as an example of good practice the location on every wing at Whatton of defibrillator machines.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2010**

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SUMMARY

The man had suffered a heart attack in 2000, when he was 47 years old. Shortly afterwards he had an operation to help with blood flow to his heart muscle. He was a smoker and continued to smoke 30 cigarettes a day.

Following a period of remand commencing in 2003, he was sentenced to ten years imprisonment in 2004. Held at Birmingham initially, he continued to suffer with chest pains and was referred to a cardiology department in 2005. When he saw a consultant cardiologist in 2006, it was noted that he continued to smoke and that he had severe cardiac disease. He had a further operation to improve blood flow to his heart in 2006, but this was only partially successful as the arteries of his heart were found to be damaged.

When the man was transferred from Birmingham to HMP Whatton in late 2007, his cardiac problems were noted, his medication was reviewed, and plans were made for up to date investigations. He had cut his smoking down to ten cigarettes a day. He saw the consultant cardiologist again.

In August 2008, it was noted that his angina (a narrowing of the coronary arteries) was stable, and there was no mention of any angina when he was reviewed by a nurse in March 2009. The following month he was found to have a normal pulse, normal blood pressure and no heart murmurs. Advice was given about future medical management and no further investigations were planned.

The man did not attend 12 clinic appointments from 26 May, but did collect his medications from the pharmacy on 11 June and 16 July. He was sent a letter by healthcare asking if he still wanted to be monitored. He said he did, but although he was booked in for further appointments he did not attend them. According to a friend, the man was again smoking around 30 cigarettes a day.

In August 2009, the man collapsed in his cell after suffering another heart attack. He was found by prisoners who raised the alarm. Two prison officers attended and, whilst one performed cardiopulmonary resuscitation (CPR), the other asked healthcare staff to attend. Nurses arrived and an ambulance was requested. A defibrillator was connected to him and two shocks were given, with CPR continued in between the shocks. A further eight cycles of CPR were carried out, the defibrillator advising ‘no shock’ after each two minute cycle of CPR.

After the ambulance arrived, the man was connected to its defibrillator and CPR continued for a further four minutes. At 12.52pm, with unanimous agreement, resuscitation was ceased and death was pronounced. He was aged 56.

Two recommendations are made in this report. One concerns the use of radios in emergency situations, and the second the provision of emergency ambulances. The ready availability of defibrillators at Whatton is highlighted as good practice.

THE INVESTIGATION PROCESS

1. My office was notified of the man's death in August 2009. Notices announcing the investigation were supplied by my investigator, and displayed by the prison to staff and prisoners who were invited to contribute relevant information. In the event, no prisoners or staff made contact.

2. All relevant prison records relating to the man were studied by my investigator. They included his main prison record, medical records and statements made by staff. One of my family liaison officers made contact with his mother and his sister.

3. A clinical review of the man's healthcare was undertaken by the clinical reviewer of the local Primary Care Trust. He also made himself readily available to answer any queries during the investigation, and his assistance is much appreciated.

4. Her Majesty's Coroner was contacted by my investigator to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist his enquiries into the man's death.

5. My investigator visited HMP Whatton on 24 September to familiarise himself with the general environment where the man was located when he suffered the heart failure. He also visited the wing and cell where he was found collapsed, and spoke with members of staff, including the liaison officer.

6. In October 2009, the family liaison officer was informed by the man's sister that her family had received a letter containing a card from a fellow prisoner that caused them much concern. It suggested that the man had been supplied medications from other prisoners, and that an unlawful assisted suicide had taken place. The family were understandably anxious about this and wanted to know who had written the card and how it had been sent. I hope that this report helps answer those questions. The family did not raise any other concerns.

7. On 9 November, my investigator returned to Whatton where he interviewed a prisoner, a prison officer and a nurse. The interviews were recorded and a transcript was made of each.

HMP WHATTON

8. HMP Whatton first opened as a detention centre for juveniles, but its role changed in the early 1990s to that of a prison for vulnerable adult offenders. During this time, the prison developed as a specialist establishment for adult male sex offenders to enable them to participate in the Sex Offender Treatment Programme. Whatton has recently undergone large expansions in 2006 and 2008, increasing capacity by 500 places. On 6 August 2009, there were 839 prisoners in custody.

9. The regime at Whatton includes education, vocational training, industrial workshops and manufacturing, farms and gardening. There is a large range of offending behaviour programmes, including both Living Skills and Sex Offender Treatment Programmes.

10. The local Primary Care Trust is responsible for healthcare provision within the prison. The healthcare centre is open daily, with healthcare staff on duty between 7.30am and 7.30pm. Outside of these hours, Nottinghamshire emergency medical services are used when required.

11. The healthcare department at Whatton runs a walk-in centre and a nurse-led GP practice. It runs nurse-led triage clinics, blood clinics, specialist clinics and follow up clinics. From initial consultation the nurse will refer on to the doctors or arrange appropriate prescriptions to be made up. There are no inpatient facilities. Nurses take leads in different diseases, so they have various internal clinical specialists. Occasionally, external specialist nurses come in. These include diabetic, COPD (chronic obstructive pulmonary disease) and TB (tuberculosis) nurses.

12. There is a portable automated defibrillator located on each wing. These machines can analyse the heart rhythm, diagnosing the shockable rhythms and then charging to treat. Defibrillation consists of delivering a dose of electrical energy to the affected heart. This halts abnormal electrical activity in the heart and can allow normal beating to be re-established.

Previous deaths at Whatton

13. There have been 15 deaths at Whatton in the past three years. None of the circumstances arising from my office's previous investigations is similar to those in this case.

Her Majesty's Chief Inspector of Prisons' Report

14. HM Chief Inspector of Prisons made a full announced inspection of Whatton in January 2007. In the report of the inspection the Chief Inspector referred to good practice in the health services provided. She wrote:

> "There had been a comprehensive health needs assessment that had sought the views of patients, carers and staff as well as reviewing clinical records, and the results were being used to plan services."

Independent Monitoring Board (IMB) Report

15. Each prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community. They have full access to prisoners and every aspect of the establishment.

16. In its latest annual report, covering the period 1 June 2007 to 31 May 2008, Whatton's IMB said: "Defibrillators are readily accessible for every prisoner with trained staff available." The report also said:

> "The IMB wish to place on record the proactive work of the Healthcare Manager and the dedicated staff who are now providing the best level of care the prison has ever experienced."

KEY FINDINGS

Medical history prior to transfer to HMP Whatton

17. On 1 January 2000, the man suffered a heart attack. He was treated at hospital with a clot-busting injection and told that his heart function had been damaged. He subsequently had an operation to place a stent in his circumflex coronary artery. (A stent is a small tube inserted inside an artery of the heart to help blood flow.)

18. The man was first remanded in custody to HMP Birmingham on 18 September 2003. He was suffering from angina (chest pain that occurs when the heart muscle does not get enough blood), and was taking self administered medication for his heart complaint. He spent a total of 172 days in custody pending trial, and on 30 November 2004 was sentenced to ten years imprisonment. He began his sentence at Birmingham.

19. On 5 August 2005, the man went by ambulance to hospital with non-cardiac chest pains. Following an overnight stay, he was advised about cardiology referral, but was not referred to a cardiologist at this time. He returned to the hospital on 16 August to have a cyst removed from his forehead under local anaesthetic. Because of increasing chest pains, he was referred to cardiology on 24 November.

20. On 5 January 2006, following a doctor's review of his medication and continuing chest pains, a first consultation was arranged with a consultant cardiologist at hospital. This took place on 24 February. The doctor noted that the man continued to smoke and that he had severe cardiac disease. He was listed for a cardiac catheterisation (a procedure that examines the structures of the heart and surrounding vessels in detail, allowing an accurate diagnosis of their condition).

21. At a review by a nurse on 3 March, it was recorded that the man was suffering anxiety and insomnia regarding his cardiac problems and the planned operation. Following a cardiology review with the consultant cardiologist on 2 May, he had an operation on 24 August. He received stents in three arteries during successful catheterisation, but dilation of the damaged arteries was unsuccessful.

22. Findings from the procedure were that there was "severe diffuse coronary artery disease [a condition in which plaque builds up inside the coronary arteries and reduces blood flow to the heart muscle], with previous left anterior descending artery occlusion [a blocking of that artery], severe ventricular impairment with ejection fraction of 18% [this measures the blood pumped out of a ventricle with each heart beat, typically 50% to 65% for healthy individuals], and diffuse ischaemic cardiomyopathy [heart muscle disease]."

23. The man continued to have regular hospital appointments at hospital following the operation. On 21 December, following another cardiology review with the consultant cardiologist, he was found to have pneumonitis (lung wheezing).

Further investigations were ordered. He had exercise tolerance tests on 8 February 2007, and respiratory tests on 14 February. A heart scan on 19 April was followed by an echocardiogram (ECG) on 15 May.

Medical history at Whatton

24. On 13 November 2007, the man was transferred from Birmingham to Whatton. During his reception health screening the long history of cardiac problems and current medication was noted. He was smoking 10 cigarettes per day. There were no problems with his mental state and no allergies were identified. His vaccination history was up to date, including an annual influenza immunisation. A referral was made for him to see a doctor.

25. The prison's general practitioner saw the man on 26 November as a new reception. Cardiac problems were noted, a medication review performed, and plans made for up to date investigations to be conducted. His anxieties were also noted and plans were made to change medication if required.

26. Other cardiology reviews were undertaken by the consultant cardiologist at hospital on 10 December and 21 December. The man's diagnosis was diffuse coronary artery disease, severe left ventricle impairment and worsening breathlessness.

27. At a review by the prison doctor on 11 January 2008, the man had his medication changed to mirtazapine (an anti-depressant) to help with his anxiety and sleep problems. When reviewed by the GP on 22 January and 7 February, it was noted that he was sleeping better now he was on mirtazapine and was less anxious. He was also given different medication for high cholesterol (simvastatin) and acid reflux (lansoprazole).

28. On 3 April, the man's blood test results showed low haemoglobin (haemoglobin is a protein found in red blood cells and is responsible for transporting oxygen; it is measured as part of a blood count) and low blood vessel size. His cholesterol was satisfactory for someone with cardiac disease. Potential infection with helicobacter (bacteria) was also found, which is linked to gastric ulcers. On 21 April, following a GP review, he was found to have low ferritin (a protein in which iron is stored) consistent with iron deficiency.

29. At a further GP review on 9 June, medication changes were made as recommended by the cardiologist. The man had recently injured his shoulder on a metal door, so ibuprofen (a pain killer and anti-inflammatory) was prescribed for his shoulder pains. Lansoprazole (which prevents the stomach from producing acid) was also prescribed to protect his stomach.

30. During a GP medication review on 13 August, it was recorded that the man's angina was stable, and he had stopped taking his beta-blocker tablets, bisoprolol (used to treat cardiovascular diseases). He still complained of shoulder pains and an x-ray was arranged. This confirmed some irregularities of the left acromioclavicular joint (a joint at the top of the shoulder).

31. On 27 August, the man was given reassurance by a nurse after he was found to be extremely anxious. He described having panic attacks and was concerned they would bring on another heart attack. They discussed triggers, coping, distraction techniques, and breathing exercises.

32. At a GP review on 14 November, the man's medication was altered in respect of his ongoing left shoulder pains. This was still a problem at the time of a nurse review on 3 December, and anti-inflammatories were ineffective, making him feel dizzy and ill. The following day, following earache symptoms, he was prescribed ear drops and analgesics (pain killers) and told to return if he became concerned.

33. The man did not attend any of his nurse clinic appointments again until he went for blood pressure monitoring on 13 February 2009. On that occasion, he said he had had a chest infection for the past few weeks and had been suffering light headedness for the previous two or three days. He was given blood tests on 18 February. These showed his blood count improving, but that his cholesterol had increased.

34. At a nurse review on 27 March, the man was noted to be stressed, and complained again of having shoulder pains. There was no mention of any angina. The following week, on 3 April, he was reviewed at hospital. Another ECG was performed showing moderate dilatation [enlargement] and impairment [loss of function] of the left ventricle. He had a normal pulse, normal blood pressure, and no heart murmurs. Advice was given about future medical management and no further investigations were planned.

35. A medication review by a doctor was carried out on 26 May. The man's shoulder pains were discussed and mild anaemia, which needed follow up blood tests, was identified. The doctor increased medications to include dihydrocodeine (an opioid analgesic), diclofenac (an alternative and stronger anti-inflammatory to ibuprofen) and paracetamol.

36. He did not attend 12 clinic appointments from 26 May, but did collect his medications from the pharmacy on 11 June and 16 July. He was sent a letter by healthcare asking if he still wanted to be monitored. He said he did, but although he was booked in for further appointments he did not attend them.

Events in August 2009

37. The man spoke to his sister by telephone at about 10.00am. He mentioned that he had a niggling pain in his back and chest, but did not feel it was anything to worry about. His sister advised him to speak with a doctor if he was worried.

38. At about 10.30am, he was in his cell with a fellow prisoner who had become a good friend. They worked together in the servery. Also present was another prisoner. They were all playing on the man's games machine (a PlayStation), whilst waiting to go to work. At this time he complained to both prisoners of pains in his chest and back. He went to his locker, removed some tablets (which the second prisoner believed to be paracetamol), took them and then carried on playing his game.

39. The first prisoner told the investigator he was aware that the man had previously had a heart attack and was on medication. He said the man had told him he had been refusing his blood tests as he was fed up having to travel across the prison to get them done. The prisoner said the man told him he was getting fed up with healthcare, as every week they kept on at him to have his blood tests.

40. At about 11.00am, staff called down the servery workers as normal to prepare for serving lunch. The man did not report any problems to staff that morning. The first prisoner told the investigator that before they went to work the man looked fit and well.

41. Just after midday, the man and the first prisoner went back up to their cells. They went into the man's cell, sat down and talked for seven or eight minutes. He then told the prisoner that he needed the toilet, so the prisoner left and went to see someone else. The man closed his cell door behind the prisoner.

42. The second prisoner has said he was in his cell when he heard a single bang, which he described as if something heavy had hit the floor. He told the other prisoner he had heard a bang in the man's cell. They went to the cell, which still had its door closed. They looked through the window of the cell door and saw him lying on the floor. The second prisoner then pressed a cell activation alarm and waited by the cell, while the other prisoner went to tell officers that the man had collapsed.

43. In a statement, a prison officer said that at approximately 12.11pm he was starting lock up on landing one in A wing when he heard the cell bell activation. He discovered that it came from landing two above, and together with a second officer immediately went upstairs. On arrival they were met by the first prisoner who told them that the man had collapsed on his cell floor.

44. The first officer went past the prisoners who had gathered outside the man's cell and entered with the second officer. He saw that the man was lying on his back on the floor and looked unconscious. He could not see anything out of place or anything that looked suspicious. The man's trousers were undone. The officer checked his head and face and could not see any injuries.

45. The man was making a gurgling sound and taking sharp inhalations of breath as he did so. The first officer squeezed his cheek but got no response. The man then vomited from his mouth and nose. The officers placed him into the recovery position. The second officer went down to the wing office to telephone for healthcare to attend (this was despite the fact that he had a radio).

46. Shortly after the second officer left, the first officer saw that the man's colour had changed. His face had turned blue and he appeared to have stopped breathing. The officer rolled him onto his back as the second officer returned. The second officer gave his face shield (which is used to prevent the transfer of fluids during resuscitation) to the first officer who then started chest compressions (cardio-pulmonary resuscitation, CPR).

47. The second officer returned to the wing office to telephone again for healthcare staff to attend, but they were already on their way. He returned to the cell and found that the situation had worsened. The officers agreed that the man had stopped breathing. The first officer continued with CPR until healthcare staff arrived within a few minutes.

48. The nurse told the investigator that at approximately 12.15pm healthcare were alerted to reports that a prisoner had collapsed, and was conscious but incoherent. She responded to the wing together with a second nurse and a student nurse, taking the two emergency response bags with them.

49. They were met on A wing by the first prisoner who escorted them up to the man's cell. The nurse saw that the two officers were performing CPR on him and immediately called out to a third officer to call for an ambulance, to ask other healthcare staff to attend, and to bring the wing's defibrillator.

50. The nurse opened the response bag, removed a valve mask, connected it to the oxygen and handed it to the second officer to use instead of a face shield. She then got out a guedel airway (a device used to maintain a person's airway by preventing the tongue from covering the epiglottis, a piece of cartilege at the back of the tongue), but did not have time to put it in before the defibrillator arrived. She cut away the man's T-shirt and connected the defibrillator, asking the student nurse to make a note of the number of cycles and shocks given.

51. As she applied the defibrillator pads, she noticed that they had expired in March 2008. As there were no other pads available, she elected to use them rather than not defibrillate. The defibrillator began to analyse and advised that a shock be given. The first defibrillation (electric shock) was given at 12.22pm. Two minutes of CPR followed, and the guedel airway was introduced. Despite this, air was still not getting into the man's lungs as his chest was not rising. The nurse proceeded to suction using a hand suction pump to ensure that his airway was clear of fluid.

52. A further shock was given as instructed by the defibrillator at 12.25pm. CPR then recommenced. A further eight defibrillator cycles were completed, each advising "no shock". CPR was continuous in between defibrillator cycles, and eventually they were able to get air into the man's lungs. He vomited on at least two occasions, after which suction was used to clear his airway.

53. An ambulance was dispatched at 12.25pm and arrived at the prison gate at 12.40pm. It arrived, with two crew members, at the man's cell at 12.48pm. The nurses continued CPR while the ambulance crew attached him to their defibrillator.

54. CPR was continued for a further four minutes after which time it was agreed by all present to cease resuscitation attempts. Death was pronounced by the technician at 12.52pm. Residual pulseless electrical activity (PEA, where there is electrical activity in the heart, but this is not producing a pulse) was present on the ECG but it was not a rhythm conducive to life. PEA finally ceased at 1.11pm.

55. Shortly after the man's death, the prison activated its death in custody contingency plan. Nottinghamshire Police, the Governor, the Independent Monitoring Board, and the Ombudsman were informed. A prison family liaison officer was appointed. The police visited the prison at 2.20pm, interviewed staff and prisoners and took several statements, copies of which were given to my investigator.

56. At the time of the man's death his current prescribed medication was aspirin, paracetamol, diclofenac sodium, dihydrocodeine (all of which are painkillers), lansoprazole (to stop the stomach producing gastric acid), mirtazapine (an anti-depressant), ramipril (for hypertension and congestive heart failure), simvastatin (to control elevated cholesterol levels), miconazole (an antifungal cream) and a glyceryl trinitrate pump spray (for relief of chest pain). No other medicines were found in his cell by police.

57. At 3.00pm, a debriefing about the man's death took place at the prison. Support and counselling were offered by the prison to those healthcare staff, prison officers and prisoners who had either been directly involved or who had been affected by the death. Notices to inform prisoners and staff of the man's passing were issued throughout the prison. Prisoners on A wing were informed individually.

58. The prison family liaison officer and the Deputy Governor drove over to the man's family home in Coventry and informed his mother at about 4.30pm of his death. His mother became distraught and the FLO called her GP to attend. The FLO then spoke to the man's sister by telephone. They stayed at the house for around two hours.

59. At approximately 6.00pm, undertakers were instructed to collect the man and take him to the Infirmary. They arrived at the prison at 7.15pm and left at 7.35pm.

60. At 8.35pm the same day, a post mortem examination was carried out at the Infirmary by a Consultant in Forensic Pathology and a Home Office Registered Forensic Pathologist. At the external examination, she found that there were no injuries present that caused or contributed to the man's death.

61. On internal examination she identified severe coronary arteriosclerosis (a degenerative process in which fatty material is deposited in the walls of the coronary arteries, leading to obstruction of the blood flow to the heart muscle), with a metal stent (tube) and a fresh thrombus (blood clot) in the left anterior descending branch (coronary artery). An old myocardial infarction (heart attack) with fresh areas was present to the anterior wall of the heart. In her opinion, this resulted in a natural death.

62. Forensic toxicological samples were sent to the Forensic Toxicology Service of the Infirmary. The toxicological examination yielded no evidence of an intoxication that could have caused or contributed to the man's death. His cause of death was from an acute myocardial infarction, secondary to ischaemic heart disease.

63. A memorial service was held at the prison. Prisoners collected a large sum of money. Flowers were bought and placed on top of the man's coffin at his funeral. Together with the man's personal money, the rest was given to his mother to be used to engrave his name on the family gravestone. Prisoners also recorded messages in a book of condolence that was passed onto the family who will forward it to the man's brother in Australia.

64. Funeral expenses were properly offered by the prison. The Deputy Governor and the prison family liaison officer attended the funeral in Coventry. The man's family donated his foodstuffs, electrical items and games to the prison for use by others.

ISSUES CONSIDERED DURING THE INVESTIGATION

Clinical care

65. A heart attack resulting in disturbance of cardiac rhythm may be better survived in a prison than in the community. Assuming the prisoner is found in time, CPR and defibrillation, and the attendance of medical staff, may all be available much more quickly than if someone is in their own home.

66. The man had severe cardiac disease and his life expectancy was not surprisingly reduced. According to the clinical reviewer, his premature death at the age of 56 was understandable. However, while he had severe disease, he did not suffer frequent angina attacks and did not require repeat prescriptions of his angina-relieving medication. He was never given standard angina medication with beta-blocking tablets (bisoprolol) because of side effects. Targets for cholesterol lowering were also not reached.

67. The clinical reviewer has found that the man's blood count was slightly low, and there was evidence of an iron deficiency anaemia which can be caused by chronic blood loss from the gastrointestinal system. This is commonly attributed to aspirin medication but, although the low haemoglobin was noted and repeat checks were made, continued prescriptions of aspirin together with anti-inflammatories were made. According to the clinical reviewer, this increased the risk of significant gastrointestinal haemorrhage (a loss of blood in the intestine).

68. In addition, despite a positive test result for helicobacter antigen there was no record of an antibiotic prescription being considered or made. However, the man was started on lansoprazole, to protect against blood loss from the stomach

69. These matters aside, the clinical reviewer has not found any significant shortcomings in the way the man was managed whilst serving his sentence at Whatton. He also judges that the medical care of the man was satisfactory.

70. As noted earlier, the nurses at Whatton lead on different diseases. The first nurse is the clinical lead for cardiovascular disease and the man was on her clinic list. When interviewed by my investigator, she said that he regularly did not attend clinic and blood appointments, and was very uncooperative. She did not know why he was refusing his blood tests and thus had sent him a letter asking if he still wanted to be monitored. He had replied that he did and she had started booking him in for appointments again. However, he never kept them.

71. When she was told that a prisoner on A wing had collapsed, she immediately went to the wing with two other nurses, taking two emergency response bags. One contains an assessment kit, with items such as blood pressure equipment, stethoscope, glucose gel, and pulse oximeter. The other contains an oxygen barrel bag, nebuliser mask, airways etc. Healthcare has a defibrillator, as does each wing. However, as the nurses had been told the prisoner was conscious, they did not take their own defibrillator with them.

72. On the way to A wing, the nurse thought the patient might have had a stroke, but at that stage she did not know it was the man who had collapsed. On arrival, seeing who it was, she immediately shouted for the wing's defibrillator, for an ambulance to be called urgently, and for more healthcare staff to assist her.

73. As she applied the defibrillator's pads to the man she saw that their expiry date was March 2008. The clinical reviewer has said that the out of date gel pads would still have been effective (as they proved to be). However, it is self-evident that in future they should always be kept in date. I am pleased to report that this has already been addressed by Whatton and all defibrillators are now checked weekly. On that basis, I need make no further recommendation about this.

74. As I have recorded earlier, the nurse connected the defibrillator and delivered a shock when indicated by the machine. CPR was continued for two minutes until another shock was indicated and given. A further eight cycles of CPR for two minutes, without prompts to further shock, took place prior to the ambulance staff arriving. Oxygen was given, the man's airway was checked, and when he vomited it was suctioned away. I judge that both the nurse and, earlier, the first officer, carried out CPR most professionally. Sadly, their efforts were not enough to save the man.

75. I would like formally to acknowledge as good practice the location of defibrillators on each wing.

Use of radios in emergency situations

76. When interviewed by my investigator, the second officer said he was aware that the man suffered from angina but did not know he had previously had a heart attack. Asked why he used the telephone to call healthcare and not his radio, he said that he never thought to use his radio and did not think it was warranted on this occasion. Upon returning to the cell and finding the man's condition had deteriorated, he again telephoned healthcare. While the delay is unlikely to have made a difference to the chances of success in resuscitating the man, on other occasions the outcome might be different. It is important that staff recognise emergency situations and use the most effective method of communication that they have at their disposal.

    The Governor should remind all staff to obtain prompt emergency assistance via radio communication when someone is found collapsed, giving the prisoner's name and updating any changes in condition.

The arrival of the ambulance

77. The communication log shows that an ambulance was called at 12.20pm. The ambulance log confirms dispatch at 12.25pm. The gate log shows the ambulance arrived at Whatton at 12.40pm. The ambulance crew then took eight minutes to reach the man. The investigator was concerned that there might have been a delay in getting the ambulance crew from the front gate to the cell.

78. The ambulance crew consisted of a technician and an emergency care worker. The nurse said she was somewhat concerned by this as they could do no more than the nurses were already doing for the man. She had hoped for a paramedic (the Ambulance Service's ambulances are currently split between technician-led crews and paramedic-led crews) as they are able to attempt drug resuscitation, such as adrenaline, atropine or other drugs, depending on their observations.

79. Category A (life threatening) calls should receive an emergency response within eight minutes, with category B (serious but not life threatening) having a 19 minute call target. According to prison and ambulance logs it took the ambulance 15 to 20 minutes to arrive at the prison and between 23 and 28 minutes to reach the man.

80. Ambulances are positioned to respond to the greater population centres and so anyone who lives in a remote location (such as Whatton) may wait longer than those in an urban environment. That said, given the size and age of Whatton's population, the availability of ambulances in that part of the county may be an issue. In order that the Governor can assure herself that the ambulance service is aware of the needs of the prison, I make the following recommendation:

    The Governor should share this report with the Ambulance Service and jointly consider if Whatton's needs are properly provided for.

Actions of the two prisoners

81. As I have reported, the man was found collapsed in his cell by fellow prisoners. One immediately pressed a cell activation bell to alert staff, whilst the other went to tell staff that it was the man who required assistance. Their prompt actions gave staff the best chance of saving their friend's life, and I hope the Governor will pass on my appreciation of their efforts.

Letter received by the man's family

82. As I have reported earlier, a letter containing a card was received from the prison by the man's family, the contents of which they found extremely distressing. On one half, the card suggested that he was being supplied with controlled drugs and that an unlawful assisted suicide had taken place. Written beneath this half was a name. The other side the card said how very kind, happy and bubbly the man was. This had a name beneath it. The whole of the card was written in the same handwriting.

83. My investigator interviewed the first prisoner. As noted, he had found the man collapsed in his cell and described himself as a very good friend. When he was shown the card he was surprised by what had been written, and understood why the family were distressed by it. He explained that he had received a letter of thanks from the man's family, following a collection he had made from other prisoners. He wanted to write to the family and share his condolences.

84. He said that, as he could not write very well, he asked another prisoner to write the card for him. This prisoner wrote on the right hand side of the card as dictated by the first prisoner and told him he would also post it. Without the first prisoner's knowledge, the other prisoner added his own words to the other side of the card, placed it in an envelope and posted it to the man's family. My investigator checked this prisoner's writing and confirmed that he had written the whole card.

85. This prisoner was on the same wing and landing as the man and the first prisoner, and he worked with them in the servery. Since these events took place, he has moved from Whatton and the investigator was unable to interview him. However, from speaking to staff, the investigator is aware that he may have been unwell at the time and that this may have contributed to the comments he made on the card.

86. I hope that this information helps explain to the man's family how they came to receive the distressing card. This was clearly not the first prisoner's intention and I believe that he is innocent of any malicious intent. During interview, he asked for his condolences to be passed to the man's family.

87. It is not possible nor desirable to read all the mail that goes in and out of a prison like Whatton. While I very much regret the distress caused to the man's family, I do not think there are any recommendations that I can sensibly make regarding this most hurtful and unfortunate incident.

CONCLUSIONS

88. Upon entering the prison system, the man had already survived a heart attack, was in poor health, and was smoking 30 cigarettes a day. He managed to reduce this to 10 a day at one point, but it would appear that he subsequently returned to smoking about 30 roll-up cigarettes on a daily basis.

89. He regularly refused to attend appointments for blood tests and clinic reviews. He did, however, continue to collect his medication. When he collapsed after suffering another heart attack, he was speedily attended to by two prison officers who knew how to perform CPR, and by healthcare staff (including the clinical lead nurse for cardiovascular disease) who knew how to use the defibrillator. They, and an emergency response ambulance crew, all acted appropriately and in accordance with the information available to them. They made extensive efforts to save his life.

90. The toxicological examination yielded no evidence of an intoxication that could have caused or contributed to the man's death. I conclude, therefore, that the allegations that he was supplied with medications by other prisoners were unfounded.

91. In light of the findings of the clinical review and my own investigation, I conclude that the man's medical care was – with minor exceptions – both appropriate and satisfactory.

RECOMMENDATIONS

1. The Governor should remind all staff to obtain prompt emergency assistance via radio communication when someone is found collapsed, giving the prisoner's name and updating any changes in condition

   The Prison Service has accepted this recommendation. The Governor will issue a notice to staff reminding them of the requirements and procedures for summoning medical assistance.

2. The Governor should share this report with the Ambulance Service and jointly consider if Whatton's needs are properly provided for.

   The Prison Service has accepted this recommendation and has shared the report with the local Primary Care Trust to take forward on their behalf.

Good Practice

Having defibrillator machines available on each wing is good practice