

**Investigation into the circumstances surrounding the
death of a man in December 2009
at HMYOI Deerbolt**

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

July 2010

This is the report of the investigation into the circumstances surrounding the death of the man in December 2009 at HMYOI Deerbolt. He had been recalled to prison after he breached the conditions of his licence. (A licence is a set of rules which a prisoner must adhere to after release from prison whilst under the supervision of the Probation Service.)

The man had been taking part in a weightlifting competition in the gymnasium during the morning. After returning to his cell he became unwell, breathless and was visited by a nurse. A short while later, he was still breathless and the nurse returned to see him. Within a few moments he collapsed and became unconscious. An emergency ambulance was requested and nursing staff started cardio pulmonary resuscitation (CPR). The ambulance's arrival time was estimated at 45 minutes, but it actually took slightly longer to arrive. The delay was due to the distance from Deerbolt and adverse weather conditions, which also meant that an air ambulance could not be deployed. Prison staff trained in CPR assisted the nurses until the paramedics arrived and confirmed that he had died. He was just 21 years old.

I extend my sincere condolences to his family, friends and the staff and prisoners at Deerbolt, at the tragic loss of such a young man.

The investigation into his death was undertaken by one of my investigators. Her Majesty's Coroner for Durham and Darlington, held a post mortem into his death. It was noted his death was of natural causes due to heart disease. The tragic cause of his death is one which affects up to 200 young people each year. His health had been good and no symptoms had been apparent.

A review of his medical care was commissioned with County Durham Primary Care Trust. I am grateful to the clinical reviewer. I would like to thank the Governor of Deerbolt and her staff for their help and assistance with the investigation. I am especially grateful to the liaison officer and family liaison officer for their support.

I make four recommendations. Two of my recommendations relate to medical records, one in the standard of medical entries and the second of dating prisoners being discharged and received into custody. The third recommendation is for a review of guidelines for clinical assessments on prisoners who complain of loss of consciousness. I make one recommendation to the Head of Healthcare and Durham PCT to liaise with the North East Ambulance Service over emergency response times. Finally, I note the good practice of healthcare and prison staff who responded to the man's sudden collapse.

This final report noted that the prison service has accepted the four recommendations and two minor inaccuracies have been amended. However, in their response to the draft report the head of healthcare has recorded that the ambulance service might have received an incorrect coding of the emergency call. It is unclear whether this was from prison service staff or call centre staff. I accept the action taken by the head of healthcare in relation to the recommendation. The man's mother has seen a copy of the draft report and has not raised any issues for further consideration.

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.

Jane Webb
Acting Prisons and Probation Ombudsman

July 2010

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SUMMARY

The man was convicted on 7 September 2007 for supplying drugs and burglary. He served his sentence at Deerbolt and was released on licence on 17 November 2008. However, he was re-called to prison on 17 March 2009, following a further offence and came back to Deerbolt.

A first health reception health screen document was not contained in his medical notes and apparently, he did not report any health problems. On 9 May, he was seen by a nurse in his cell after telling staff that he had passed out and hurt his nose. The nurse cleaned the wound and advised him to tell wing staff if he developed a headache or blurred vision. No observations of blood pressure or pulse rate were recorded in his medical notes.

Twelve days later, the man's blood pressure was checked and noted to be within normal range, (normal range is an average of 130/80). He was well, enjoying exercising in the gym and eating a good diet. Four months later, he attended the smoking cessation clinic and was prescribed medication to help him stop smoking.

On 28 December, the man took part in a weightlifting competition in the prison gym. He had trained and was expected to do well in the competition. He withdrew from the competition towards the end, saying that he felt unwell and tired.

He returned to the wing at 11.30am. An officer noticed that he was looking tired and pale. The officer telephoned the healthcare unit and two nurses visited the man in his cell. One of the nurses checked his blood pressure and recorded it as elevated at 189/89, with a pulse rate of 78 beats per minute, which was in normal range of 60-100 beats per minute. The nurse told the man to rest and she would re-check his blood pressure in an hour's time.

The man rang his cell bell at 12.55pm and an officer went to his cell. He told the officer that he was breathless, so healthcare were contacted and the nurses returned to see him. The man told the nurses that he had a burning sensation in his chest and his blood pressure read 208/129, which was well above the normal range. One of the nurses left the cell to telephone a local hospital for advice, leaving the nurse and an officer with the man. On her return to the cell, the nurse found her colleagues attending to the man who had become unconscious. A radio call was put out for an emergency ambulance to be called.

The man was given oxygen and cardio pulmonary resuscitation (CPR) was started. The nurse was told that an ambulance would take 45 minutes to get to Deerbolt due to the distance and poor weather conditions, so she asked for officers trained in CPR to come to assist with CPR. A defibrillator was used which advised the nurse to shock the man. (A defibrillator sends a shock wave to re start a heart rhythm.) The paramedics arrived at 2.13pm and recorded the man's death at 2.14pm and two hours later, a police surgeon confirmed his death.

I endorse three recommendations from the clinical review in relation to medical records, and clinical assessments. I make one recommendation for liaison with the Ambulance Service over emergency response times. Furthermore, I acknowledge

the response of both healthcare and prison staff in their attempts to resuscitate the man.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 13 January when my investigator visited Deerbolt. She was met by the liaison officer and reviewed the man's medical and prison files. Copies of documents were photocopied for my investigator to take away.
2. The Ombudsman's notices of investigation and terms of reference were sent to Deerbolt in advance of my investigator's visit. No members of the Independent Monitoring Board (IMB) or Prison Officers Association asked to see my investigator. (The IMB are volunteers who visit and monitor the day to day life of the prison.) She left her contact details with the liaison officer should they wish to speak to her. There has not been any responses to notices of investigation. Later, my investigator visited J Wing and spoke to two friends of the man and his personal officer.
3. One of my family liaison officers, made contact with the man's mother. At the time of circulation of this report, they have not raised any points they would like to be considered as part of the investigation. I hope the findings of the report help his family better understand the events leading to his death.
4. A review of the man's medical care whilst at Deerbolt was commissioned with Durham County PCT. The review was carried out by the clinical reviewer on behalf of the PCT.

HMYOI DEERBOLT

5. Deerbolt is a purpose built Young Offenders Institution, which opened in 1973 built on a former Army Camp. It is situated on the outskirts of Barnard Castle in County Durham.
6. Deerbolt is a Category C Training Prison and caters for approximately 500 prisoners between the ages of 18 years and 21 years, generally serving sentences up to four years in length, from the North East of England and Humberside.
7. The gymnasium is a popular resource in the prison. All prisoners receive a comprehensive induction including, training in the use of all the machines and weights, health and safety and personal fitness plans. Physical training instructors oversee the prisoners using the equipment and they are first aid and CPR trained. Prisoners are not allowed to use any of the equipment until they have been through an induction.
8. The healthcare department is a purpose built unit with an in patient unit with 12 beds. Registered general nurses, mental health nurses and healthcare support workers are all employed in the healthcare unit. A local general practitioner's (GP) surgery provides a daily service. Out of normal hours and weekend emergencies are referred to the local GP deputising service. A local pharmacy maintains the computerised patient medication records and administration charts.
9. In August 2009, Her Majesty's Inspector of Prisons carried out an unannounced inspection of Deerbolt. This was a follow up to a previous full inspection held in April 2006. An extract from Her Majesty's report in 2009 said:

“Deerbolt remained an essentially safe, respectful and purposeful establishment, with a sound focus on resettlement. It is commendable that many of our previous recommendations had been achieved and that progress we charted on our previous visit had been sustained. This is all the more impressive given the volatile and challenging nature of many of the young people in the establishment's care.”
10. In Annual Report 2007-2008 by the Independent Monitoring Board an extract from the summary said:

“The Board is able to report a year of gradual but noticeable improvements in the running of the establishment and a much-improved esprit de corps amongst the staff. With the transfer and appointment of more experienced staff Deerbolt has benefited from their deeper understanding of prisoner management. In addition, the implementation of new systems and the aim to make old systems more efficient has been undertaken with a new zeal.”

11. This is the first death at Deerbolt since the Ombudsman's office took responsibility for the investigations into deaths in custody in 2004.

KEY FINDINGS

12. The man was convicted of supplying drugs and burglary at Crown Court in September 2007, and received into HMP Hull. A first reception health screen document showed that he did not have any health issues although, it was noted that he smoked cannabis. The document further noted that he had no thoughts of self-harm, was calm and relaxed. In September, the man was seen by a CARAT worker but declined any assistance with his cannabis use. A week later, he was transferred to Deerbolt.
13. He settled into the regime at Deerbolt and participated in educational courses and fitness sessions in the gym. On 23 December, the man was prescribed ibuprofen for toothache. He was further prescribed ibuprofen for continual toothache from March through to May 2008. However, he declined a dental appointment on 17 April as he had a social visit. On 14 May, he was seen by the dentist and received treatment for his toothache.
14. Following a gym session on 10 July, the man saw a member of healthcare staff after complaining of muscle pain in both arms. The healthcare staff wrote in the man's medical notes that his blood pressure was seemingly high on 25 September at 11.00am. The reading was recorded as 147/83 (an average reading for blood pressure is 130/80). No further blood pressure monitoring tests are included in the man's medical notes.
15. Later that day at 7.04pm, the man was seen by the first staff nurse who wrote in the man's medical notes that ibuprofen had been prescribed as he had sustained a knee injury whilst playing football earlier in the day. The staff nurse examined his knee and saw bruising and some tenderness to the area. A support bandage was put in place and he was advised to rest for a week. Five days later, it was written that the man's knee had been examined and he was now fit to resume the gym sessions.
16. The man was prescribed paracetamol and eardrops in November for ongoing earache. He was released from Deerbolt on licence on 17 November.
17. On 17 March 2009, the man was received back into Deerbolt following a recall of his licence by his offender manager. He was 21 years old. The man had been convicted of a further offence by a Magistrates Court. On his reception his medical notes did not indicate any health problems. The following day he was prescribed paracetamol for a headache.
18. On 19 March, a health screen was undertaken and it recorded that whilst the man was in good health there was a family history of heart disease and hypertension. A week later, the man asked healthcare staff for a urine screening test as he had pain when passing urine. At the beginning of April, he was prescribed paracetamol for earache. He was seen by a healthcare worker on 15 April, the result of his urine test had indicated an infection and the doctor prescribed an anti-biotic.

19. A week later, the first staff nurse saw the man on the wing. He told the nurse that he was still having problems with his ear. The staff nurse could not find any sign of infection in the ear and advised him to see healthcare staff the following day. There is nothing recorded to show whether the man was seen the next day.
20. The man was seen in his cell by the first staff nurse on 15 May at 9.10am, after wing staff reported that he had passed out and banged his nose. On examination the nurse noted a small superficial cut to the man's nose which was cleaned. He did not complain of headache or blurred vision and no other injuries were seen. The staff nurse told him to remain in his cell and rest, however he should tell staff if he developed a headache. The nurse made an appointment for him to be seen in the healthcare unit on 18 May to check his blood pressure. There is nothing recorded in his medical notes to show whether the appointment took place on that date.
21. On 27 May, a second staff nurse wrote that the man had reported to healthcare with concerns over his blood pressure. The nurse noted that when lying down his blood pressure was 141/78 and when standing was 142/87. The man said he was eating, drinking, sleeping and exercising well.
22. A Healthcare Support Worker saw the man on 7 September in the smoking cessation clinic. He was prescribed nicotine replacement patches. It was later noted that he was doing well with the patches with a good degree of success in giving up smoking. The first staff nurse saw the man on 5 October, and prescribed olive oil to put in his ear prior to them being syringed a few days later.
23. The man was a competitor in a weightlifting event in the gym on the morning of the 28 December. One of his friends, told my investigator that the man was looking forward to the event. He ate his breakfast with his friend and went to the gym.
24. The event consisted of several weight competitions as well as endurance tests. The competition was supervised by three Physical Education Instructors (PEIs). A gym orderly and friend of the man's, whose cell was directly opposite to him on J wing, told my investigator that the man was doing well in the event. (A gym orderly is a prisoner who assists the gym staff.) However, towards the end he sat down and said he felt unwell and tired. He did not complete the competition.
25. The gym orderly said that it was a tough competition and that a couple of competitors felt unwell. When asked if the man had told any of the PEIs that he was unwell, gym orderly said that the man had not. However an incident report form by the first PEI noted that the man had seemed fine during the morning of the competition in the gym. The PEI wrote:

“The last event was the tyre flip, however the man declined to take part saying he was tired. We tried to encourage him to take part but he said he couldn't. We told him to take a seat and rest which he did. Throughout

the competition the prisoners were given opportunity to rest and get a drink, the toilet facilities were available for the majority of the time. The sports hall door was closed during the weights class change over, for security reasons.”

26. A second PEI noted in an incident report that when he asked the man if he wanted to take part in the tyre flip, he declined. He did not tell the second PEI why he did not want to continue in the competition.
27. After the event was completed the competitors went to the gym showers, the man did not take a shower but sat down on a chair before returning to J wing at 11.30am. The first officer who saw the man noted that he looked tired and pale. The man asked the officer if he could collect his lunch and take it back to his cell. The officer told him that the lunch was not ready so he went to his cell.
28. The gym orderly, asked the first officer if he could collect the man’s lunch for him when he came to collect his own. The officer agreed and the gym orderly took his friend’s lunch to him. The gym orderly said that when he put his friend’s lunch into his cell, he did not see him and thought he might be in his shower.
29. The first officer went to the man’s cell after he had completed his lunch duty to see how he was. The man told the officer that he felt better, however the officer thought he looked worse than when he saw him previously. The officer returned to the wing office and telephoned the healthcare unit to ask a member of staff to come over to J wing to see the man straight away.
30. The second staff nurse and a healthcare assistant HCA came to J wing at 12.25pm. The officer took the nurses to the man, who was in the shower, and they waited until he was dressed. The nurse asked the man what his symptoms were. He told her that he had taken part in the weightlifting competition and felt unwell.
31. The second staff nurse took his blood pressure which read 189/89, his pulse rate was 78 beats per minute (a normal reading is 60 -100 beats per minute) and his oxygen level was 99 per cent. He told the nurse that he did not have a headache, pain or nausea, however he felt some burning sensation in his chest. The nurse advised him to rest on his bed, take some fluids and she would return in an hour’s time to re-check his blood pressure and see how he was. The officer then left the man’s cell with the nurse and HCA.
32. The first officer finished his duty and handed over to a second officer. The second officer said he would keep an eye on the man and check him every 15 minutes. At this time all the prisoners were locked in their cells and the prison was in patrol state. (Patrol state is when all prisoners are in their cells and their doors can only be opened by a senior member of staff.)
33. The man rang his cell bell around 12.55pm. The second officer went to his cell and spoke to the man through the observation panel of his cell door. The

officer saw the man sitting on his bed with his legs over the side. He told the officer that he was having problems breathing and the officer could see this. The officer told him to relax and he would telephone for a member of the healthcare staff to come back to see him.

34. The officer returned to the wing office and rang the healthcare unit for a member of staff to return to J wing. The second staff nurse and the HCA set off for J wing and enroute radioed for a senior officer to attend the man's cell so the door could be opened.
35. On arrival at the man's cell, the staff nurse first spoke to him through the observation panel and saw that he was lying on his bed with his hands behind his head. The man told the nurse he was feeling short of breath but the pain in his chest was no worse. The nurse advised him to sit up on the edge of bed and lean forward to expand his lungs. At 1.05pm, a Senior Officer (SO) arrived at the man's cell and unlocked the door. The second staff nurse and the HCA went inside.
36. The man told the nurse that he had a burning sensation in his chest, which felt like heart burn but there were no other symptoms. The staff nurse took his blood pressure which read 208/129, (this is an exceptionally high reading and much higher than recorded earlier) and his oxygen level was noted to be 98 per cent. The nurse told him that she was going to telephone for advice and left him with HCA and the SO.
37. The staff nurse went to the wing office and rang the Accident and Emergency Department at a hospital. She spoke to a sister at the hospital and described the man's symptoms and his participation in the weightlifting competition earlier in the day. The sister advised that his pain might be muscular and the cause of his high blood pressure. She advised the staff nurse to give him some paracetamol and re-check his blood pressure again in 20 minutes.
38. Whilst the staff nurse was telephoning the hospital, the SO spoke to the man about the weightlifting competition and HCA re-checked his blood pressure which had dropped slightly to 188/98.
39. After several minutes, the SO and HCA saw the man start to jerk, his body went rigid and he slumped against a wall. The staff nurse arrived back to the man's cell as he lost consciousness she assisted the HCA to hold his head, place him in the recovery position and connected the oxygen mask to the man's face. The staff nurse asked the SO to pass an urgent radio message for a Code Blue (urgent assistance needed when a patient has stopped breathing) and for the communications room to telephone for an emergency ambulance. The time was recorded at 1.20pm.
40. The staff nurse noted that the man's pupils were fixed and dilated and he did not respond to her voice. The nurse rubbed the man's sternum (breastbone) which resulted in him taking a deep breath however, his breathing was slow and laboured. The staff nurse took his pulse which was 98 beats per minute and his oxygen level was 80 per cent.

41. As the nurses tried to make the man more comfortable on the bed, they noted that his breathing was worsening and there were long gaps between each breath. The staff nurse again applied stimulus to his sternum but there was no improvement. Within five minutes, a second nurse arrived at the man's cell with a Code Blue trolley containing the emergency equipment. The first staff nurse placed an airway into the man's mouth, then to his windpipe and oxygen was then passed directly into his lungs.
42. The second nurse checked the man's wrist for a pulse but could not find one and checked in the groin area. When no pulse was detected, the nurses immediately connected a de-fibrillator machine to his chest, (a de-fibrillator is a machine that sends a shock wave to the heart) and moved him onto the floor. The de-fibrillator indicated that a shock was needed, therefore the first nurse pressed the shock button and started cardio pulmonary resuscitation (CPR) with HCA and the second nurse assisting.
43. At about 1.34pm, the first nurse asked for an update on the arrival of the ambulance and was told that it would be 45 minutes. The first nurse was not satisfied by this answer and asked other prison staff who responded to the emergency, to take over CPR, whilst she went to find out why the ambulance was delayed. (It was later found that the nearest ambulance was at Stockton on Tees, some 33 miles from Deerbolt.)
44. A radio call was sent out for prison staff trained in CPR to report to J wing to assist healthcare staff with the man's resuscitation. (Carrying out chest compressions for any length of time is tiring and can become less effective, so extra help was needed to maintain the continued attempts at CPR.) Six members of staff responded to the call and took it in turns to administer chest compressions and oxygen. The HCA and the second nurse remained with the man and it was noted that he vomited.
45. At 1.52pm, the police arrived at the prison and the possibility of calling an air ambulance was discussed. However, the air ambulance was grounded due to poor weather conditions. Despite there being no sign of life from the man, the staff continued with CPR.
46. At 2.13pm, the ambulance arrived at Deerbolt and the paramedics were taken immediately to the man's cell. The paramedics examined the man and confirmed his death at 2.14pm.
47. A hot debrief was held for all those members of healthcare and prison staff who had been involved. The governor spoke to all the prisoners individually on the man's landing, then other prisoners on J wing were told of the man's death. All the prisoners were offered support from staff should they need it. This was confirmed by the gym orderly and the man's friend who told my investigator that staff had been very supportive after their friend died.
48. The prison's family liaison officer, and the Governor of Deerbolt, went to an address in York at 6.00pm, to inform the man's mother of her son's death. On

arrival at the address, there was no one at the house. Following a call to Deerbolt, the prison's family liaison officer and the Governor of Deerbolt went to a second address and again no one was in. They made their way to a local police station to continue their enquiries and see if the police could assist with any recent contacts.

49. Later, the prison family liaison officer and the Governor of Deerbolt returned to the addresses in York but were still unable to find any relatives. They returned to Deerbolt and asked for a list of the man's telephone calls so they could make contact with numbers listed. As it became too late in the day to continue, the prison liaison officer resumed his enquiries the following day.
50. Through information in the prison file, a form was found indicating that the man had been told of a relative dying two weeks earlier. The prison family liaison officer made contact with the funeral directors on the form but they were unable to provide any addresses.
51. The prison liaison officer rang the numbers listed on the man's telephone list and eventually spoke to his mother. She was understandably distressed at the news and the prison family liaison officer spoke to the man's sister. It became apparent that the man's mother was staying at her daughter's address. The prison family liaison officer and the Governor of Deerbolt made their way to the man's sister's home.
52. On 30 December, the man's family visited Deerbolt and were shown his cell and other parts of the prison including the gym. They left flowers in the areas where he had spent time and spoke to some of his friends. A memorial service was held on J wing and was attended by staff and prisoners.
53. The prison family liaison officer, the Governor of Deerbolt and four members of the prison staff attended the man's funeral on 12 January 2010. At the request of his family, The Governor of Deerbolt gave a short address to the congregation. The prison offered full funeral expenses.

ISSUES

Clinical care

54. A review of the man's medical care was commissioned with Durham PCT. The clinical reviewer made a chronology of the events leading to the man's death and commented on relevant issues arising from her review.

Medical Records

55. The man had been in prison at Deerbolt and Hull on several occasions. However the dates of his location at those prisons were not clear from the medical records. The records cover the period from September 2007 up to his death in December 2009.
56. He had been a prisoner at Deerbolt on more than one occasion but the notes do not identify clear discharge or reception dates. The clinical reviewer made an assumption that a full assessment was undertaken on his reception into Deerbolt in March 2009, and this was the date of a reception screening, as opposed to a routine healthcare review. The clinical reviewer said:

“Photocopying of the clinical records has missed the edges of a number of pages with the reproduction of one document impossible to read. It is therefore difficult to assess the quality of prescription and admission record charts because of poor photocopying. Where errors have been made these are simply crossed out. This does not comply with Nursing and Midwifery Council guidance for clinical record keeping which states errors should have a single line drawn through an incorrect entry and initialled by the nurse.”

I endorse the following recommendations made by the clinical reviewer.

Clinical records should record the date of reception and discharge from prison healthcare services, this is especially relevant for those prisoners who frequently leave and re-enter the prison system.

The Head of Healthcare should review electronic health records and audit prescription charts to ensure the name of the prison establishment is recorded and that the Nursing and Midwifery Council standards are consistently met.

Clinical Assessment

57. On 15 May 2009, the man told staff that he had passed out in his cell and banged his nose. He was seen by a nurse who examined him and cleaned his wound. The man was told to rest and tell wing staff if he developed a headache or blurred vision. His blood pressure was either not checked, or not recorded as checked. An appointment was made for a check in three days time. However, it was recorded in his medical notes on 27 May, that the man reported concerns about his blood pressure to staff. A check was undertaken

and his blood pressure recorded as within normal range both when standing and sitting. He told the nurse that he was eating, sleeping, drinking and exercising well.

58. The clinical reviewer said:

“It is easy in retrospect to consider that when he complained that he had passed out in May 2009 further investigations should have been made at that time, but he had just been exercising in the gym, he complained of no other symptoms and there was no subsequent recurrence of any symptoms.”

However, whilst acknowledging the recommendation by the clinical reviewer in the clinical review, I would amend the recommendation to be as noted as follows:

The Head of Health care should review the guidelines for the clinical assessments of patients experiencing sudden collapse to ensure their vital signs, specifically blood pressure, and ensure that prisoners are properly and timely assessed by nurses which is recorded in the clinical record.

Emergency response

59. The second nurse and the HCA saw the man when they were called to his cell at lunchtime. His blood pressure was checked and noted to be higher than a normal reading, however his pulse rate and oxygen levels were within normal range. The nurses advised him to rest and arranged to see him an hour later. However, the second officer called them back to see the man after 30 minutes.

60. In response to the second officer's call the nurses returned to the man's cell. Following his collapse the second nurse immediately put in place emergency medical care and asked for CPR trained prison staff to attend the man's cell when it was found that the ambulance would be significantly delayed.

Delayed ambulance

61. The North East Ambulance Service covers a vast rural area including Tyne and Wear, Teesside, Durham and Northumberland. Deerbolt prison is situated in a rural community which stands 600 feet above sea level. On 28 December, the weather conditions in the area of Deerbolt were severe, with snow, ice and fog. The nearest ambulance was sited at Stockton on Tees, some 33 miles from the prison. An air ambulance could not be used due to the adverse weather conditions.

62. The Department of Health guidelines state that a recommended response time for an emergency ambulance is 19 minutes. However, it took the ambulance over 50 minutes to arrive at Deerbolt from Stockton on Tees. I have no doubt, that the weather conditions were exceptional, but do not know

whether this is a problem Deerbolt has encountered before. I am not qualified to establish whether such a delay could have affected the prognosis for the man. Certainly in some cases it could. Therefore, it seems prudent to establish whether there is anything that can be done to improve response times. I therefore make the following recommendation

The Head of Healthcare and Durham PCT should liaise with the North East Ambulance Service to ensure that the response to calls for an emergency ambulance are within the Department of Health's targets.

63. The emergency response to the man's collapse on 28 December was timely and appropriate. Healthcare staff made every effort to resuscitate him, together with prison staff trained in CPR. A defibrillator was used whilst waiting for the arrival of the ambulance.

64. The clinical reviewer said;

“Regrettably, the adverse weather conditions significantly delayed the arrival of the emergency services and in addition the air ambulance could not be deployed. The nurses and prison officers who tried to resuscitate the man should be acknowledged for trying their best to revive him, although sadly they were unsuccessful. I fully recognise that this must have been an upsetting situation for all staff involved.”

I endorse the clinical reviewer's comment and also acknowledge the response by healthcare and prison staff and their efforts in trying to resuscitate the man.

Response from the Governor of Deerbolt to the draft report

In response to the draft report: the Governor of Deerbolt has advised Offender Safety, Rights and Responsibilities that:

“Following receipt of the draft report her Head of Healthcare has advised her that she had heard that one of the reasons for the ambulance delay was due to the “incorrect coding” of the emergency call. The provenance and the accuracy of this information is unclear, and it is not known if this was due to the information passed on from the prison or due to staff at the call centre. In reality a more prompt response from the ambulance would not have made any difference, however, in the interests of completeness and transparency the Governor has asked me to inform you in case you wish to pursue this further.”

I acknowledge this information and note the Governor's response to the relevant recommendation on page 21.

CONCLUSION

65. The man's medical records noted a family history of hypertension and heart disease. However, until the day of his death, he had no chest complaints, no shortness of breath, or symptoms of heart problems, other than slightly raised blood pressure. He received support to stop smoking and was seemingly doing well with the help of the smoking cessation clinic and medication.
66. The clinical reviewer judged that the man received an acceptable level of healthcare at Deerbolt. From the clinical records there was nothing to suggest that any signs or symptoms of a potential heart condition had been ignored by staff. As well neither wing staff, nor his friends and family have suggested that he experienced any symptoms before 28 December.
67. I judge that the man received an equitable standard of medical care whilst at Deerbolt and that staff responded to his collapse in a professional manner. It was an unknown heart condition that caused his death. This tragedy could not have been foreseen. It is known that the condition affects up to 200 apparently fit and healthy young people each year.
68. The late arrival of the ambulance has been discussed and a recommendation has been made to liaise with North East Ambulance Service.

RECOMMENDATIONS

For the head of healthcare

1. Clinical records should record the date of reception and discharge from prison healthcare services, this is especially relevant for those prisoners who frequently leave and re-enter the prison system.

Accepted – “When a patient is transferred to HMYOI Deerbolt the prisoner’s medical record (PMR) is received in to the Healthcare Administration Department. It is the function of a representative of this department to register this patient on to System One (Electronic Medical Record). Once the patient is registered the care is identified as starting at Deerbolt, which includes the time and date of registration recorded on the clinical system.

A qualified nurse assesses every prisoner who is received in to custody at HMYOI Deerbolt, in order to complete the initial healthcare screening tool (RS1). This assessment is recorded within System One.

Prior to a prisoners release from custody they are seen by a qualified nurse the day before their actual release date, in order to ensure that the prisoner is “medically fit for release”. Furthermore, they are seen in the reception area of the prison on the day of their release, in order to ensure that they are “medically fit for release” and that they are in receipt of the appropriate discharge treatment/medication and understand any aftercare arrangements that may have been organised. All such contacts will be documented on System One.

Plan: Information will be cascaded to all healthcare staff, in relation to the importance of keeping both contemporary and accurate records of patient care and treatment, including in chronological order a prisoners date of reception and discharge from HMYOI Deerbolt. This reflects current healthcare practice within HMYOI Deerbolt. This information will be cascaded to all healthcare staff via a global e-mail including an attachment of “standards for record keeping”. Furthermore, this information will be conveyed in the next healthcare staff briefing/meeting.”

2. The Head of Healthcare should review electronic health records and audit prescription charts to ensure the name of the prison establishment is recorded and that the Nursing and Midwifery Council standards are consistently met.

Accepted - Information will be cascaded to all healthcare staff, in relation to the importance of keeping both contemporary and accurate records of patient care and treatment. This information will be cascaded to all healthcare staff via a global e-mail including attachments re: standards for record keeping. Furthermore, this information will be conveyed in the next healthcare staff briefing/meeting.

All healthcare professionals who prescribe medication for prisoners within HMYOI Deerbolt will be advised to complete all fields of information, including the name of the prison establishment on the prescription kardex.

The healthcare senior management team within HMYOI Deerbolt will ensure that prisoners Electronic Health Records and prescription charts are checked on a regular basis, in order to monitor the quality of these documents and address any shortcomings in a timely manner.”

3. The Head of Healthcare should review the guidelines for the clinical assessments of patients experiencing sudden collapse to ensure their vital signs, specifically blood pressure, and ensure that patients are properly and timely assessed by nurses which is recorded in the clinical record.

Accepted – “A copy of the latest Basic Life Support/Resuscitation Guidelines and Chest Pain Suspected Myocardial Infarction Nursing Guidelines for Prisons will be cascaded to all healthcare staff.

The healthcare senior management team will ensure that all healthcare staff receive an annual update of Cardio Pulmonary Resuscitation (CPR), and will update the current training schedule/record accordingly.

The healthcare senior management team will discuss the use/implementation of the Early Warning Screening Tool (EWS, Darlington NHS) within nursing/clinical practice at HMYOI Deerbolt. The Early Warning Screening Tool will be discussed at the next staff briefing/meeting.”

4. The Head of Healthcare and Durham PCT should liaise with the North East Ambulance Service to ensure that the response to calls for an emergency ambulance is within the Department of Health’s targets.

Accepted – “A copy of this recommendation will be forwarded to (Patient Safety and Governance Manager for Prisons). This information will then be forwarded to the attention of the North East Ambulance Service.”