Investigation into the circumstances surrounding the death of a male prisoner in July 2005 at HMP Blakenhurst

Report by the Prisons and Probation Ombudsman for England and Wales

March 2006

This is the report of an investigation into the circumstances of the death of a male prisoner. He died from natural causes in July 2005 at HMP Blakenhurst. He was 51 years of age.

My colleagues and I would like to extend our condolences to his family and friends for their loss.

One of my investigating officers conducted the investigation. I would like to thank the Governor of Blakenhurst, who ensured that all relevant information was made available to my investigator.

I am also grateful to the clinical reviewer, who carried out an independent clinical review on behalf of the Redditch and Bromsgrove Primary Care Trust.

My report makes one recommendation and identifies one example of good practice. The clinical reviewer makes ten recommendations.

My report also commends the duty governor and the detective in charge of the police investigation for the way in which they arranged for his family to be informed of his death.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2006**

Contents

	Page
Summary	**4**
Investigation Methodology	**5**
Background	**6**
HMP Blakenhurst	**6**
Events leading up to the death of the prisoner	**7**
Events of 16 July 2005	**9**
Issues considered during the investigation	**11**
Clinical Care	**11**
Management of his cellmate	**12**
Breaking the news to his family	**12**
Findings and Conclusions	**13**
Recommendations	**14**
Good Practice	**14**

Summary

The prisoner died on 16 July 2005 at the age of 51, while in custody at HMP Blakenhurst. He had been in custody since June 2004, initially on remand and then as a sentenced prisoner.

He died from a myocardial infarction as a result of a coronary embolus. Along with his history of diabetes, he smoked and was overweight, and was therefore considered at higher risk of coronary disease.

The prisoner had a history of diabetes, hypertension and an enlarged heart for which he was receiving treatment prior to arriving at Blakenhurst. His General Practitioner reported that his condition had been poorly controlled whilst in the community.

In January 2005, he had been seen by medical staff when he complained of chest pains.

Prison staff were alerted on the morning of 16 July to the prisoner by his cell mate, who called for staff assistance. Staff arrived almost immediately and tried to resuscitate him. They continued to care for him and assist the paramedics. However, despite their efforts the paramedics decided that he had died and ceased all activity at 7.25 am.

I criticise the treatment of his cellmate who was taken from the cell and locked in the second floor showers while resuscitation attempts were made. I conclude that this was unacceptable.

I commend the duty governor and the detective in charge in charge of the police investigation for the way in which the prisoner's family was informed of his death.

In addition to the recommendations made by the clinical reviewer, I make one recommendation of my own.

Investigation Methodology

1. All the indications were that this was a death from natural causes.

2. My investigator, was given access to all the prisoners prison records, including his medical records.

3. Notices to staff and prisoners were sent to the Governor of Blakenhurst, to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express with regard to his death.

4. My investigator did not conduct any formal interviews during the course of the investigation, but he did correspond with a prisoner and one of the officers involved.

5. One of my family liaison officers, contacted the prisoner's family who decided they did not need to meet with my investigator. They would prefer to wait for my report to be made available to them.

Background

HMP Blakenhurst

6. HMP Blakenhurst is located on the outskirts of Redditch in Worcestershire. It is a category B local prison, serving a number of courts in the West Midlands area. It first opened under private management in 1993, but since 2001 was has operated under the management of the Prison Service.

7. In September 2005, Blakenhurst had an operational capacity (total crowded capacity) of 856 men held principally on four identical house blocks. Most prisoners are held in double cells. There are separate specialist units, including the healthcare centre and a segregation unit. Roughly a third of the population are unsentenced.

Events leading up to the death of the prisoner

8. The prisoner was remanded into custody at Birmingham Crown Court on 16 June 2004. He was convicted and sentenced to five years imprisonment on 14 April 2005.

9. On 30 June 2004, he reported to healthcare staff that he had a history of raised blood pressure, diabetes and an enlarged heart. His medical records identified the prescribed medication that he was taking, and noted that he smoked 15 cigarettes a day as well as being a social drinker.

10. He was then seen on 1 July by the prison doctor, and treatment commenced for hypertension and diabetes control. A record of his blood pressure was also taken at this time. Recommended action from this consultation was a weekly review of his blood pressure and prescribed medication. Background information was to be requested from his GP.

11. His blood pressure was not checked again for over three weeks. A letter was received on 5 July from his community General Practitioner. This listed his medication and also confirmed that he suffered from diabetes and hypertension, which were both rather poorly managed prior to arriving at Blakenhurst. During this time, he was seen at the Well Man clinic and had his blood glucose monitored.

12. He was advised about nutrition on several occasions, as well as being reminded to take his medication.

13. On 1 September, the prisoner medication was reviewed. The clinical reviewer says it would appear that medication reviews were often conducted without the patient being seen by the doctor. On this occasion, it is not certain if he was seen or not. The clinical reviewer suggests that his medication was changed. However, it would appear from prescription sheets that his original medication was not stopped and he ended up with two similar drugs being given at the same time.

14. His blood pressure was checked regularly throughout the rest of the year and his hypertension remained steady at 180 over 105 but was not at the expected level for a man of his age and condition. The clinical reviewer concludes that his hypertension was therefore uncontrolled. During this period, there were two recordings of non-compliance with medication and a failure to attend for appointments.

15. On 20 January 2005, he returned from court complaining of chest pains, which he had been experiencing for approximately three hours. He was seen by one of the prison medical officers who recorded his blood pressure and asked that blood tests be done. One test was to identify an enzyme marker, found in the blood following a cardiac event, and which is routinely used to identify whether those with chest pains have had a heart attack. The blood was taken on 21 January but it would appear that the enzyme test was not carried out as the nurses were not aware of one of the

tests required, and they had not been trained in its diagnostic properties. Along with the blood test, the clinical reviewer states that an Electro Cardio-Gram (ECG) should have been requested, but there is no record that one was asked for or that one was performed.

16. During January 2005, the prisoner was frequently attending court and most days would be out of the prison. On a daily basis, his medical record noted that he was fit to go to court. The clinical reviewer comments that this is just a routine procedure carried out by the nurses and that it would be extremely rare for a prisoner to be considered unfit for court. My investigator was concerned, however, that following this episode of chest pain he was still considered to be fit without his blood pressure being regularly rechecked, or there being any record of him being asked about his symptoms.

17. On 14 February, his blood test results were reviewed and they were considered to be within normal limits. During the remainder of February and March it would appear that he attended court on a daily basis. There is no record of his blood pressure being checked throughout that period of time.

18. His medical records show that another review of his medication took place on 23 March, but it is not possible to read who carried out the review. However, whoever conducted the review noted some confusion over his medication and felt that a more in depth review was urgently required.

19. There are no further entries in his medical record until 2 June 2005, when his blood pressure was checked and recorded. The following week his blood pressure was taken and recorded again.

20. On 16 June 2005, he was seen by one of the doctors, although the signature is illegible. The medical records are very difficult to read but it would appear that the focus of the consultation was whether he could stop some of his medication at his own request, as he had reported feeling weak at times. His blood pressure was taken and recorded. The recommendation from this consultation would appear to be general lifestyle advice, and that his blood pressure should be reviewed in two to three week’s time.

Events of 16 July 2005

21. At approximately 6.09am on 16 July, the night patrol officer, who was a new member of staff, started to do routine checks on the wing. At 6.18am, she noticed that a cell call light at cell B219 was lit. She went to the cell to see why the light was on. Upon arrival at the cell door, she opened the observation flap and could see two prisoners. One was standing near to the door while the other was lying on his bed foaming from his mouth and nose. He appeared to be having a severe asthma attack.

22. The night patrol officer immediately called to a second night patrol officer that was also on the wing. At 6.20am, the second officer went straight to the cell and when he saw the prisoner lying on the floor, he immediately called for help using his prison radio and the term Code Yellow. The term Code Yellow is used when calling for assistance in a medical emergency. At this point, the other prisoner in the cell was clearly distressed and both night patrol officers remained at the door to reassure him. They did not enter the cell as they were waiting for the orderly officer to arrive. I judge that this was appropriate in the circumstances as it could have been unsafe to enter the cell without the support of fully trained staff.

23. At approximately 6.25am, the orderly officer arrived at the cell along with two Nurses. They entered the cell to attend to the prisoner. At this time, the staff took the cellmate from the cell and he was located in the shower room on the second floor landing. After approximately 30 minutes, the cellmate was taken to be supported by a Listener (a prisoner who has been trained by the Samaritans to support other prisoners). Once inside the cell, the orderly officer sent a radio message to the control room and requested that an emergency ambulance be called.

24. The nurses checked the prisoner's vital signs and put in place an airway to assist with his breathing. The nurses tried to use the small suction pump to remove the copious amounts of foam coming from his mouth and nose but this was unsuccessful. A nurse and one of the night patrol officers then went to the medical block to collect a portable suction pump that was powered electrically. When they returned to the cell, they began suction to help clear his airway.

25. The heart start monitor was connected to the prisoner and it displayed that no shock was required and there was a regular steady heart beat. The nurse returned again to the medical block to collect some more oxygen while the other nurse maintained his airway until the paramedics arrived at 6.38am and took over. The paramedics continued to care for him. At 7.10am, they commenced Cardio Pulmonary Resuscitation (CPR) as well as connecting defibrillation pads to him.

26. The paramedics requested assistance from staff to move the prisoner onto the floor. Three officers entered the cell and placed him on the floor. At

7.15am, the paramedics who were continuing with CPR noted that he had no readable heartbeat and the nurses were unable to intubate.

27. At 7.25am, the paramedics ceased all resuscitation attempts and decided that he had died. The cell was vacated and sealed by staff.

28. At 7.35am, the doctor was contacted and informed of the prisoner's death. He was asked to attend the prison, but he declined to attend until the Police Scenes of Crime Officer had attended. He was contacted again at 7.55am, but still declined to attend. The prison liaison officer confirmed that the doctor was expected to attend the cell prior to the Police Scenes of Crime Officer.

29. At 8.45am, the doctor arrived at the cell and confirmed that the prisoner had died. At 9.17am, Bromsgrove CID and the Police Scenes of Crime Officer arrived, entering the cell at 9.19am and leaving at 10.30am. The Coroner's Officer arrived at the cell at 12.42pm to remove the body from the prison.

30. Following a discussion between the duty governor and the detective in charge of the police investigation, it was decided that the Imams would inform the family of the prisoner's death. This would take place in the presence of the Police Family Liaison Officer. A Police Constable was identified as the most suitable as he was a trained Family Liaison Officer and a Muslim. The Imams met with the two police constables and travelled to the home of the prisoner's brother. The Imam informed the prisoner's family of his death. Both Imams returned to the family at approximately 8.00pm the same evening and attended the funeral.

31. The post mortem report concluded that the prisoner died of a heart attack.

Issues considered during the investigation

Clinical Care

32. Standards of healthcare in prisons are intended to mirror those available in the outside community. It is considered that all appropriate actions were undertaken in the attempted resuscitation.

33. The clinical reviewer found that the care and treatment on the day of his death were of a proper standard, with staff and paramedics making all appropriate attempts to resuscitate him.

34. Prior to his death, the prisoner had a number of medical conditions for which he was being treated. The clinical reviewer has stated that changes need to be made with prisoner care to ensure that a better healthcare service can be offered.

35. The recommendations of the clinical review are:

- The PCT should put in a place a policy in relation to non-compliance with requests to attend for medical checks or screening.
- Where prisoners do not attend for appointments, this should be recorded in the medical records.
- The National Service Framework for Coronary Heart Disease recommends that 'if a suspected heart attack, with 30 minutes plus of central chest pain, a 999 call should be made for assessment.' It is not clear from the records whether there was a serious concern of a suspected heart attack. However, it is recommended that these guidelines should always be followed.
- Prisoners who report chest pain should have an ECG to exclude cardiac events.
- When writing in the medical / health care record all entries must be dated, legible and signed. Where there is a significant event a time should be added as well as date.
- The pharmaceutical contract should be reviewed to establish why it took three days to get emergency stock of a straightforward potassium replacement medication.
- Records must make it clear whether the in-patient is actually seen.
- Systems must be put in place to ensure patients are followed up as requested by either medical officer or nurse.
- Where there are clinical issues such as uncontrollable hypertension, the records must clearly state what clinical plan is in place to resolve the clinical problem.
- Where medications are complex or not having the desired effect, it may no longer be appropriate to issue in possession medications

Management of his cell mate

36. The cellmate promptly alerted staff to the condition of the prisoner when he woke up on the morning of 16 July. The cellmate was clearly distressed by the situation he found himself in. The night patrol officers remained outside his cell providing reassurance until other staff arrived and the cell could be safely opened. I judge this was appropriate in the circumstances.

37. It is evident that by 6.25am there were at least five staff in the cell treating the prisoner including two nurses. However, his cellmate was locked in a shower room and left alone for about 30 minutes. He was later moved to a new cell where he was supported by a Listener. I believe it would have been more appropriate to move the cellmate immediately into a cell with a Listener or for a member of staff to have remained with him until such time as a Listener could be identified.

38. At approximately 10.20am, the prison says that the cellmate was located in a crisis suite with a friend and a Listener, both of whom are Punjabi speakers. The prison says that, prior to this, the Imam saw him and that he was seen on two further occasions.

39. A letter received from the cellmate states that he felt unsupported by the prison. He further says that he was placed with a Listener, but that the Listener did not speak his language therefore causing him more stress. The cellmate feels that he has not been offered any continued support and has had to cope on his own.

The Governor should remind staff that, when a prisoner has been involved in a distressing situation, they should be offered support without delay. The use of a Samaritans phone or direct support from staff must be considered until a more detailed support plan can be put in place.

Breaking the news to the prisoner's family

Prison Service Order 2710 makes clear that it is best practice for the prison itself to inform the next of kin of a death in prison custody. In the case of the prisoner a decision was taken that the Imams along with a Police Liaison Officer would inform his family. A Police Constable was identified as the most suitable as he was a trained Family Liaison Officer and a Muslim. The Imams met with two police officers at Trinity Road Mosque and they travelled to the home of the prisoner's brother, where the Imam informed the prisoner's family of his death. Both Imams returned to the family home at approximately 8.00pm the same evening and attended the funeral.

Findings and Conclusions

40. The Post Mortem records that there was evidence of the prisoner's suffering previous minor heart attacks and more recent ones. The clinical reviewer considers that he reported chest pains in January 2005 could have been managed more appropriately at that time. In particular, an ambulance should have been called if there were serious concerns that he was suffering a heart attack. The reviewer includes that if he had been transferred to hospital, the outcome might have been different.

41. In my view, the treatment of the cellmate who was locked in the shower room while attempts were made to resuscitate the prisoner was unacceptable. He should have been offered support without delay.

42. I commend the actions of the duty governor and the detective in charge of the police investigation for the way in which they arranged for the family to be informed of the prisoner's death.

Recommendations

I make one recommendation:

- The Governor should remind staff that, when a prisoner has been involved in a distressing situation, they should be offered support without delay. The use of a Samaritans phone or direct support from staff must be considered until a more detailed support plan can be put in place.

The recommendations made by the clinical reviewer are as follows:

- The PCT should put in a place a policy in relation to non-compliance with requests to attend for medical checks or screening.
- Where prisoners do not attend for appointments, this should be recorded in the medical record.
- The National Service Framework for Coronary Heart Disease recommends that 'if a suspected heart attack, with 30 minutes plus of central chest pain, a 999 call should be made for assessment.' It is not clear from the records whether there was a serious concern of a suspected heart attack. However, it is recommended that these guidelines should always be followed.
- Prisoners who report chest pain should have an ECG to exclude cardiac events.
- When writing in the medical / health care record all entries must be dated, legible and signed. Where there is a significant event a time should be added as well as date.
- The pharmaceutical contract should be reviewed to establish why it took three days to get emergency stock of a straight forward potassium replacement medication.
- Records must make it clear whether the in-patient is actually seen.
- Systems must be put in place to ensure patients are followed up as requested by either medical officer or nurse.
- Where there are clinical issues such as uncontrollable hypertension, the records must clearly state what clinical plan is in place to resolve the clinical problem.
- Where medications are complex or not having the desired effect, it may no longer be appropriate to issue in possession medications.

Good Practice

- The use of the term Code Yellow to summon help to medical emergencies is good practice as this alerts everyone carrying a prison radio and those within hearing distance that urgent medical assistance is required.