

**Circumstances surrounding the death of a man
at a hospital in Nottingham on 6 January 2006
whilst a prisoner at HMP Whatton**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES**

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This is an anonymised report of an investigation into the death of a man who died from natural causes at a hospital in Nottingham on 6 January 2006 whilst a prisoner at HMP Whatton. He was 52 years old.

The prisoner was serving a 14-year sentence and had been in custody for over four years at the time of his death. He apparently suffered a heart attack on 4 January, and was taken to hospital by ambulance. Sadly, his condition failed to improve and his life support machine was switched off with the consent of his family during the evening of 6 January.

The death of a loved one is always painful. However, in this case, where the man's family are also coping with the loss of his brother, their grief is hard to imagine. I would like to add my condolences to the prisoner's family and loved ones to those already expressed by one of my Family Liaison Officers.

This investigation has been undertaken by a member of my fatal incident team. I would like to thank the Governor of HMP Whatton and the staff there for their participation in this investigation. Particular thanks go to the designated liaison officer for making the arrangements and facilitating the smooth running of the investigation. Rushcliffe Primary Care Trust was commissioned to undertake a review of the man's care, and I am grateful for its assistance. I was pleased to learn that the medical response to the prisoner's collapse was both prompt and appropriate, and I recognise that the efforts of the nursing staff at Whatton on 4 January gave the man who died a fighting chance of survival.

I make one recommendation and cite two examples of good practice. All of these relate to the actions and subsequent good treatment of one of the man's fellow prisoners.

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Summary

1. The man who is the subject of this report was sentenced to a term of 14 years imprisonment in September 2002. He served time in HMP Lincoln and HMP Rye Hill before being transferred to HMP Whatton in August 2005.
2. In October 2005, he was identified as having a problem with high blood pressure and he commenced a course of preventative treatment in early November. The medication had a positive impact on the man's blood pressure levels and, by early December, his readings were just above 'safe' levels.
3. On 4 January 2006, the prisoner who died presented himself to the healthcare department, complaining of cramps in his legs. An appointment was made for him to see the visiting doctor two days later, after which he returned to his duties as a cleaner before having a social visit in the afternoon.
4. Around 4.30pm, the man returned from his visit and made his way to the A2 landing. Whilst going through the landing gate, he clutched at his chest and complained to a member of staff that he had been suffering from pains for a couple of days. He was asked whether he wanted to go to the healthcare department, but replied in the negative. He was then spoken to by a fellow prisoner who recommended that he go to healthcare. The man replied that he had already made an appointment for 6 January, before joining the other prisoner in his cell for a cup of tea.
5. Minutes later the man collapsed, having apparently suffered a heart attack. He was tended to by the prisoner who administered emergency first aid before nursing staff arrived and commenced Cardio Pulmonary Resuscitation (CPR). They managed to stabilise the man before he was taken by ambulance to a hospital in Nottingham.
6. Sadly, his condition deteriorated and he died at 6.10pm on 6 January in the company of his family.

The investigation process

7. My investigator considered the man's prison records, including his medical notes, before formally opening the investigation at HMP Whatton on 6 February 2006. He met with the Governor and interviewed various members of staff. He also had contact with a representative of the Independent Monitoring Board.
8. Prior to my investigator arriving at Whatton, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigator. One prisoner came forward and another was interviewed by prior arrangement.
9. One of my Family Liaison Officers contacted the man's next-of-kin to offer them the opportunity to participate in the investigation. They raised a number of concerns, particularly about the quality and timeliness of the healthcare received by the prisoner who died. I hope this report goes some way towards addressing these concerns and answering any outstanding questions they may have.
10. A review of the healthcare the man received whilst a prisoner was carried out by Rushcliffe Primary Care Trust.
11. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries.

The prisoner

12. On 3 September 2002, the prisoner who died received a 14-year prison sentence at Lincoln Crown Court for a series of serious offences. He quickly progressed through the prison system and was granted Category C status in March 2005. He was transferred from HMP Rye Hill to HMP Whatton on 17 August 2005, where he settled in well and enjoyed positive relationships with both staff and fellow prisoners.

HMP Whatton

13. HMP Whatton is a Category C establishment, for up to 340 vulnerable male offenders. It is currently undergoing an expansion programme that will see it more than double in capacity. It was last inspected by Her Majesty's Chief Inspector Of Prisons in February 2004. She found that:

“Whatton ... provided a respectful environment with good standards and cleanliness, food and healthcare. Staff-prisoner relationships were excellent which ... speaks volumes for the professionalism of the staff.”

14. Since 2003, Whatton has held the status of a 'high performing prison'. A Standards and Security Audit carried out by the Prison Service during September 2004 endorsed this assessment, placing Whatton in the top five per cent of prisons in England and Wales.
15. Due to the offending histories of some of the prisoners held at Whatton, a protocol exists between the prison and local hospitals which specifies the security measures that must be in place before a prisoner will be accepted for treatment. Currently, at least two prison officers accompany each prisoner treated at outside hospital.

Key findings

16. The man who died was sentenced to 14 years imprisonment on 3 September 2002 following his conviction at Lincoln Crown Court. He started his sentence at HMP Lincoln, where he had previously been held on remand, before being transferred to HMP Rye Hill in July 2004. After completing an intensive offending-behaviour programme at Rye Hill, he was reclassified as a Category C prisoner. He was transferred to HMP Whatton on 17 August 2005.
17. In early 2003, the man started experiencing chronic pain in his testicles, a problem that would persist right up until his death. Whilst detained at Rye Hill, he was being seen on an outpatient basis at the St Cross Hospital in Rugby, and had an appointment at the Urology Department scheduled for 19 October 2005. The man who died was offered the opportunity of returning to Rye Hill on a temporary basis in order to attend the appointment. He declined and the appointment was therefore cancelled. A new urology referral was made to the local hospital by the healthcare department at Whatton on 18 October. The first available appointment was 6 February 2006.
18. On 17 October 2005, the prisoner reported to the healthcare department, complaining that he had been suffering from a chronic headache for the past week. As part of the medical examination, his blood pressure was taken and the reading was found to be higher than is desirable. It was decided that the man's blood pressure needed to be monitored closely and, on 4 November, he was prescribed propranolol, a drug used to lower blood pressure.
19. The prisoner's condition continued to be monitored regularly by the healthcare department and, by the time of his appointment on 2 December, his blood pressure showed signs of improvement. During this session, the man agreed with the healthcare staff that he would participate in a smoking cessation programme in order to reduce his blood pressure further. However, he failed to turn up for his scheduled smoking cessation appointment on 9 December and did not present himself to the healthcare department again until 4 January 2006.
20. During the morning of 4 January, the prisoner who died went to work as usual, cleaning the A Wing dining room. Around 10.30am, he attended the healthcare department, requesting to see the doctor. As Whatton does not have a doctor permanently on site, he spoke with one of the Registered General Nurses (RGNs). He stated that his propranolol medication was giving him leg cramp. The nurse advised him that the visiting doctor would need to review his medication and she put him on the list for 6 January. He did not bring any other medical complaints to

her attention, although he did ask whether he could resume nicotine replacement therapy to help him stop smoking.

21. After leaving the healthcare department, the man completed his cleaning tasks in the A Wing dining room, finishing as normal around 11.20am. After lunch he had a social visit, before returning to A Wing around 4.00pm. As per prison policy, he was given a 'rub down' search by a prison officer on the wing, who asked the prisoner how he was doing. He replied by saying he was "as well as can be expected".
22. The man immediately made his way to the pin telephones opposite the A Wing office and attempted to make a call, apparently without success. He then walked with an A Wing Operational Support Grade (OSG) towards the A2 landing, during the course of which the OSG asked him whether he had had a good visit. The OSG concerned is the officer in charge of the cleaning party that the man was part of, and as such she knew him quite well. The man's response to this question was that he had had a pleasant visit.
23. Upon reaching the A2 landing, the OSG unlocked the gate and the man made his way through. As he entered the landing, the man clutched at his chest. The OSG asked him what the problem was and the man who died responded by saying that he had been experiencing pains in his chest "for a couple of days". The OSG proceeded to ask him what he had done about this, and he stated that he would be seeing the visiting doctor on Friday (6 January). The OSG asked the man who died whether he needed to go to healthcare, and he said "no, I'm okay". As the OSG is not first aid trained, she had no reason to doubt his assertion.
24. At this point, a prisoner from the man's landing (A2) came out of his cell landing and spoke to the man who later died. The prisoner asked him what the problem was and the man stated that he had indigestion again. The prisoner enquired whether the pain was going into his chin and arm, which the man confirmed. The prisoner from the man's landing then reiterated what the OSG had said moments before, encouraging the man to go to healthcare. He said he had already made an appointment.
25. The prisoner and the man who is the subject of this report then went into cell 1 and the OSG returned to her normal duties. The prisoner offered to make the man a cup of tea, which he accepted, and left the cell with the intention of returning to his own cell further up the landing to fetch his mug. The man took a couple of steps out of the cell before turning around to his fellow prisoner and saying that the pain in his chest was really "killing him". He returned to cell 1, sat down on the bed and then slumped forward, having apparently collapsed. The prisoner from the man's landing grabbed hold of him to prevent him from falling to the floor.
26. Having undertaken an emergency training course through St John's Ambulance in September 2005, the prisoner immediately suspected that the man who later died had suffered a heart attack. He completed this

training whilst a serving prisoner, a practice which reflects positively on Her Majesty's Prison Service. He proceeded to place the man on his back on the bed before starting chest compressions because no pulse was evident. The man also appeared to have stopped breathing. The prisoner from the man's landing called for assistance by activating the emergency bell in his cell. I have been unable to ascertain whether the prisoner rang the bell before commencing chest compressions or vice versa. However, there is no evidence to suggest that anything other than a few seconds would have been gained if the former took place rather than the latter.

27. An officer who was on the corridor between the A1 and A2 landings at the time responded to the cell bell and arrived at the gate to the A2 landing within seconds. He spoke to the prisoner who was attempting to revive the man, who informed him that urgent medical attention was needed. The officer used his radio to issue a message that medical assistance was required on A2. Whilst the officer was doing this, another officer arrived at the landing and proceeded to open the gate. He entered cell 1, which is the first cell on the left-hand side. He observed that the man's face looked blue and realised immediately that he was very ill. The officer who was second to arrive at the cell put out another request on the prison radio system for healthcare assistance to make its way to the A2 landing, and made it clear that help was required as a matter of urgency.
28. Another officer arrived at cell 1 and, together with the prisoner who was attempting to revive the man and the officer who was second to arrive at the cell, they manoeuvred the man in an attempt to improve his breathing which was laboured. At this point, there is a discrepancy in the accounts given by the officer who arrived second and the officer who arrived third, with the former stating that the man was moved on to his back and the latter asserting that he was moved into the recovery position. Either way, it is agreed that this course of action appeared to make the man stop breathing altogether so he was returned to his previous position almost straight away, which seemed to help slightly.
29. At this time, a Principal Officer arrived at the A2 landing and, after making a quick assessment of the situation, he put out a radio call for an ambulance to be summoned. According to the gatekeeper's log book, the 999 call was made at 4.20pm. Moments later, an RGN arrived at the cell (she says that the man was on his back when she arrived). She was followed shortly afterwards by the nurse who saw the man earlier in the day, and together they made an assessment of his situation before continuing Cardio Pulmonary Resuscitation (CPR).
30. Soon after becoming involved in the efforts to revive the man, the nurses realised that their efforts were being hampered by the small size of the cell. Cell 1, like every other cell on the A2 landing, is approximately three metres long and two metres wide, and has very little floor space as it is furnished with a bed, sanitation facilities and a television. A decision

was made by the nurses to remove the man from the cell so that he could be accessed more readily. He was moved by a combination of healthcare staff and prison officers and placed on the floor of the landing, where the nurses resumed CPR. The first nurse to arrive at cell 1 concentrated on providing oxygen via a face mask whilst the nurse who saw the man earlier in the day administered chest compressions. A paramedic response unit arrived at the prison at 4.27pm and was 'fast tracked' through the gates.

31. The nursing staff continued to administer CPR until the paramedic arrived at the A2 landing, at or shortly after 4.30pm. After making an appraisal of the situation, the paramedic applied the defibrillator machine in order to establish how well the man's heart was working. The nursing staff had not made their own checks as they were satisfied that his condition was improving as a result of using CPR techniques alone. The output showed that the man's heart was still functioning, although it was not as strong as it should have been. The paramedic took the decision to administer an electric shock, and he also inserted an endotracheal tube into the man's throat, a procedure which helps to ensure that oxygen reaches the lungs directly.
32. At 4.45pm, an ambulance arrived at Whatton to take the man to hospital. Working in conjunction with the paramedic and prison staff, the ambulance crew placed him in the back of the ambulance. He was then conveyed to a hospital in Nottingham, escorted by two prison officers. One of the officers was the officer who arrived second, who had assisted the man after he first collapsed.
33. Immediately after the ambulance left Whatton, a governor attempted to contact the man's next-of-kin by telephone to inform her of his collapse. As it happens, the next-of-kin was the person who the man had seen on the social visit and she had not yet returned home. The governor, entirely appropriately in my view, left a message with the next-of-kin's mother, informing her that the man had been taken to a hospital in Nottingham.
34. The man arrived at the hospital at 5.15pm, and spent about an hour in the Accident and Emergency Department, where he received four or five more shocks from the defibrillator. He was then transferred to the Intensive Care Unit. Due to his critical condition, he was not handcuffed or otherwise restrained.
35. At 11.00am on 5 January, Whatton granted the man a technical release on temporary licence (ROTL). In practice, this meant that the protocol agreed with the hospital for the supervision of prisoners in outside hospital could be varied. Due to his life-threatening condition, the number of officers on bedwatch duty was reduced from two to one.
36. Sadly, despite the efforts of hospital staff, the man's condition deteriorated further over the course of 5 January and by 6 January there

was no chance of recovery. His life support machine was switched off with the consent of his family, and he died at 6.10pm.

37. After the man's death, the prison arranged for his family to visit his cell on A2 landing and to speak to staff and prisoners. The prisoner who had attempted to revive the man was subsequently granted a day's release from Whatton in order to attend the man's funeral.

Issues arising from the investigation

The management of the man's cardiovascular disease

38. It is a medical fact that people who suffer from high blood pressure are at higher risk of suffering a heart attack than those who do not. A key question that this investigation has therefore sought to answer is whether the care and treatment the man received at Whatton after 17 October 2005, when he was diagnosed with high blood pressure, was suitable to his needs.
39. On 31 October, the man's blood pressure was taken twice. This procedure is followed to ensure that the first reading does not merely reflect the patient's anxiety about being tested, which can distort the results. The readings were very high, and the man was therefore given a further appointment for 4 November. On this occasion, his blood pressure was checked and he had a sample of blood taken for testing. He was also prescribed propranolol, a drug used to lower blood pressure to safer levels.
40. The man's blood pressure was checked again on 14 November, 28 November, 30 November and 2 December. During the course of his appointment on 28 November, the man who died disclosed that he sometimes forgot to take his medication as directed. In spite of this, by 2 December his blood pressure had reduced significantly and was only just above the acceptable levels. During his appointment on 2 December, the man was also advised about the negative effects of continued smoking. He agreed that he would stop smoking on 4 December and was given one week's supply of nicotine patches to help him give up. A further smoking cessation appointment was arranged for 9 December. However, he failed to turn up for this appointment without explanation and did not come to the attention of the healthcare department again until 4 January 2006.
41. On 4 January, the man who died reported to healthcare, complaining of experiencing cramps in his legs. He expressed a belief that these pains were related to his propranolol medication. As he did not disclose any other health problems and his presenting symptoms were not determined to be serious, his name was added to the list for the visiting doctor. The doctor's next available appointment was on 6 January.
42. It is the view of the medical professional who has reviewed the man's clinical records that the care given to him was appropriate and timely. After high blood pressure was identified as an issue for him on 17 October, he was seen on a further seven occasions by the healthcare department. Not only was his blood pressure regularly checked, he was offered smoking cessation advice and was prescribed a course of

medication which is widely used to treat high blood pressure. It is the opinion of the clinical reviewer that it is unlikely that the man's leg cramps were a side effect of the propranolol medication. The reasons for this are that the medication was prescribed in a low dosage and there was a two-month gap between the man starting the medication and complaining of pains.

Staff response to the man's collapse

43. During the course of the investigation, concerns have been raised by various parties about the time it took for staff to respond to the man's collapse on the wing. Indeed, one source claimed it took 20 minutes before a member of the healthcare team tended to him. This issue was therefore specifically considered as it is known that early medical intervention increases the likelihood of heart attack victims surviving.
44. In order to make an informed estimate of the time it took before healthcare staff arrived at the man's cell, the statements of all the staff who were involved and the account given by the prisoner who attempted to revive him have been considered. The 'best guess' that can be reached using this method is that it took between three and four minutes for nursing staff to attend to the man after he collapsed. This estimate takes into account the time it took the prisoner who attempted to revive the man to activate the cell bell, the time it took the first officer to arrive at the A2 landing and send out a call for healthcare assistance over the radio, as well as the length of time it took the two nurses to react to the radio request and reach the cell. It needs to be borne in mind that the nursing staff were already treating other prisoners when the request came over the radio, and they had to ensure that they were escorted from the healthcare department before making their way to A2 landing, which is approximately 100 yards away. There are also two gates that have to be opened and then secured between healthcare and A2.
45. On the basis of the information available, there is no evidence to suggest that the healthcare response to the man's collapse was anything other than prompt.

The role and treatment of the prisoner who attempted to revive the man who died

46. After the man literally collapsed into the arms of the prisoner from his landing, the latter responded in a way that belied the absolute panic he admits he was feeling. His measured attempts to administer CPR, coupled with his role in actively assisting the prison staff in the most unenviable of situations, are worthy of recognition.

The prisoner who attempted to revive the man who died should be commended by the Governor for his efforts.

47. After the man died at the hospital, the prisoner who attempted to revive him was approached by a governor and asked whether he would like to attend the man's funeral. After the prisoner accepted this offer, Whatton made the necessary arrangements so that he could be released on temporary licence for the day. Although he was quite appropriately accompanied by members of prison staff, the prisoner was permitted to attend the funeral without handcuffs or other restraints. He reports that he was struck by the humanity of this gesture, which meant he could pay his respects to the man who died with a degree of dignity.

Arranging for the prisoner who attempted to revive the man to be released on temporary licence so that he could attend the funeral is an example of good practice.

The role of the officer who arrived second

48. After being heavily involved in the attempts to revive the man on A2 landing, the officer who arrived second at the cell was approached by a senior member of staff and asked whether he would accompany the man in the ambulance to hospital. As he was extremely concerned about his condition, he readily agreed to this request. He subsequently assumed bedwatch responsibilities at the hospital when the man was formally admitted some time later. By the time the officer's bedwatch shift ended at 7am on 5 January, he had been working for 23 consecutive hours.
49. The officer who arrived second subsequently went off sick for reasons apparently unrelated to his involvement in the man's care. Sadly, his absence from the prison meant that he was not contacted by the staff Care Team. This was unfortunate, given his role in tending to the man who died after he collapsed and escorting him in the ambulance. Whatton has acknowledged that their failure to contact the officer concerned was an "oversight" but it stresses that the Care Team routinely contacts staff after an incident. I therefore refrain from making a recommendation.

Recommendations

1. The prisoner who attempted to revive the man who died should be commended by the Governor for his efforts.

Good practice

2. Arranging for the prisoner who attempted to revive the man to be released on temporary licence so that he could attend the funeral is an example of good practice.
3. Giving prisoners the opportunity to undertake a course in emergency first aid, in this case with St John's Ambulance, is a model of good practice.