Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Noel, a prisoner at HMP Leyhill, on 18 January 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Kevin Noel died of congestive cardiac failure due to hypertensive heart disease with cardiomegaly on 18 January 2024, at HMP Leyhill. He was 63 years old. We offer our condolences to Mr Noel's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Noel received at Leyhill was equivalent to that which he could have expected to receive in the community.

5. The staff who found Mr Noel on the night that he died promptly alerted the emergency services and started cardiopulmonary resuscitation. They did not use a defibrillator, and some told us that they did not know where they were stored in the prison. There was no immediate debrief following Mr Noel's death, and the staff who responded to the emergency left the prison without any of the expected support.

Recommendations

- The Governor should ensure that all staff are aware of the location of defibrillators and that they understand how to access and use them during a medical emergency.

- The Governor should ensure that a senior manager debriefs all relevant staff immediately following a death in custody and that they receive appropriate support afterwards.

The Investigation Process

6. HMPPS notified us of Mr Noel's death on 18 January 2024.

7. The investigator issued notices to staff and prisoners at HMP Leyhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Noel's prison and medical records.

9. The investigator interviewed four members of staff at Leyhill on 21 March.

10. NHS England commissioned a clinical reviewer to review Mr Noel's clinical care at the prison.

11. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. The Ombudsman's office contacted Mr Noel's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

13. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.

Previous deaths at HMP Leyhill

14. Mr Noel was the twelfth prisoner to die from natural causes at Leyhill since January 2021. To the end of May 2024, there have not been any further deaths at the prison. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

15. On 29 April 2008, Mr Kevin Noel received an indeterminate sentence for public protection (IPP) for sex offences, with a minimum tariff of five years.

16. On 25 February 2019, Mr Noel was transferred to HMP Leyhill.

17. Mr Noel had a history of hypertension (high blood pressure), hyperlipidaemia (elevated levels of lipids, like cholesterol and triglycerides (a type of fat) which causes atherosclerosis (hardening of the arteries) and other serious heart conditions), angina, pre-diabetes, gastro-oesophageal reflux disease (GORD - stomach acid which causes heartburn), benign prostatic hypertrophy (BPH - an enlarged but not cancerous prostate) and left knee pain.

18. On 2 May 2023, a GP at Leyhill carried out Mr Noel's annual hypertension review. He recorded Mr Noel's QRisk score (a tool to calculate the likelihood of having a stroke or heart attack in the next 10 years) as around ten per cent. The clinical reviewer noted that most of Mr Noel's blood pressure readings at Leyhill were within acceptable parameters.

19. On 24 October, Mr Noel reported a crushing pain in his chest, a tingling feeling in his left arm and some breathlessness. A nurse sent him to hospital by ambulance. Mr Noel had an electrocardiogram (ECG), which showed that he had an underlying cardiac pathology (a collection of diseases that involve the heart or blood vessels). Hospital staff referred Mr Noel to the Rapid Access Chest Pain Clinic for further investigations and sent him back to Leyhill.

20. On 31 October, a GP at Leyhill saw Mr Noel because blood test results showed that his lipids were elevated. Mr Noel told him that he had not been taking his atorvastatin (medication used to treat high blood cholesterol) in recent months. The GP advised him to restart his medication.

21. On 15 November, Mr Noel had a telephone consultation with a cardiologist and told him that he had recurring episodes of left-sided chest pain and episodes of breathlessness. The cardiologist arranged for Mr Noel to have a CT angiogram (an imaging test that looks at the arteries that supply blood to the heart).

22. On 16 November, a GP at Leyhill prescribed Mr Noel amlodipine (for angina) to reduce his episodes of chest pain.

23. On 18 November, a nurse sent Mr Noel to hospital because he had another episode of acute chest pain. Mr Noel's symptoms settled after he had several doses of glyceryl trinitrate spray. (GTN- which dilates the coronary arteries and gives relief for symptoms of angina.) Hospital staff sent him back to Leyhill.

24. ON 18 December, Mr Noel had the CT angiogram, which showed that there was "trivial coronary calcification" and "no other visible disease". The report of the CT angiogram was not received by the prison until after Mr Noel's death.

Events of 17-18 January 2024

25. At 11.00pm on 17 January 2024, an Operational Support Grade (OSG) and an officer carried out a routine roll check on Ash Unit, where Mr Noel lived in a single cell. (All cells at Leyhill are single cells, although there are some dormitories. Unlike most prisons, there are no observation panels in the cell doors.) The OSG opened Mr Noel's cell door to carry out the check. He said that he could not remember the check or what Mr Noel was doing, but that he always made sure that prisoners moved or were breathing. He said that roll checks at Leyhill are both a count and a welfare check.

26. At about 5.25am on 18 January, the OSG and officer carried out the morning roll check. The OSG opened the door to Mr Noel's cell and saw him lying in bed on his back with his mouth and eyes open. The OSG said that he was very pale and cold to touch. He thought that Mr Noel was dead. He called the officer, who entered the room and checked for a pulse. The officer said that Mr Noel looked lifeless. He said that Mr Noel's eyes were half open, he was very pale in the face, and he was cool to touch. He said that he also thought that Mr Noel was dead. The OSG radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). The control room operator radioed for an emergency ambulance. (Healthcare staff are not contracted to work overnight at Leyhill and were not therefore available to attend the emergency.)

27. The OSG and officer started chest compressions. A Custodial Manager (CM) and another officer went to the cell. When they saw Mr Noel, they both said that he looked like he had died. The officers rotated chest compressions. The officer said that even though they thought that Mr Noel was dead they carried out cardiopulmonary resuscitation (CPR) as it was standard practice, and they were not qualified to say that a prisoner was dead. The prison staff did not bring a defibrillator to Mr Noel's cell.

28. At 5.46am, ambulance paramedics arrived at Mr Noel's side. They moved him onto the landing and took over life support. At 6.09am, the paramedics confirmed that Mr Noel had died.

Contact with Mr Noel's family

29. On 18 January, Leyhill appointed a CM as the family liaison officer and a Supervising Officer (SO) and an officer as the deputy family liaison officers. As Mr Noel's daughter, his next of kin, lived in the Channel Islands, the CM arranged for local police to inform her he had died.

Support for prisoners and staff

30. The staff involved in the emergency response were not debriefed before they finished their shift and left the prison. They did not have the opportunity to discuss any issues arising and were not offered support.

31. A CM said that it was unfortunate that the staff involved in the incident were coming to the end of their 13-hour night shift and that they would not have wanted to be further delayed in going home by attending a debrief. The Head of Residence, who

was the duty senior manager that day and therefore responsible for holding the debrief, has since left the prison.

32. The Governor later wrote to the prison staff involved in the emergency response thanking them for their actions and offering support.

33. The prison posted notices informing other prisoners of Mr Noel's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Noel's death.

Post-mortem report

34. A post-mortem examination established that Mr Noel had died of congestive cardiac failure (where the heart is unable to pump blood efficiently, leading to a build-up of fluid in the body) caused by hypertensive heart disease with cardiomegaly (an enlargement of the heart due to long-term high blood pressure).

Findings

Clinical care

35. The clinical reviewer concluded that the clinical care Mr Noel received at Leyhill was of a good standard and was equivalent to that that which he would expect to receive in the community. He found that Mr Noel's hypertension was managed in line with national guidelines.

36. Mr Noel was sent to hospital twice in the three months before he died. The clinical reviewer said that after this he received appropriate follow up with a cardiologist. He also found that, in the last few weeks of his life, Mr Noel did not report any symptoms that indicated a need for readmission to hospital or an escalation of his treatment.

Emergency response

37. The prison staff who responded to the medical emergency promptly radioed a medical emergency code blue and promptly started CPR. The clinical reviewer found that Mr Noel might have died very recently, and, in the circumstances, it was appropriate to initiate CPR and continue this while awaiting the arrival of the paramedics.

38. However, the prison staff did not bring or use a defibrillator to the emergency, which is crucial when a prisoner is unresponsive and not breathing. They told us that they did not think to bring a defibrillator, and some were unsure of where it was kept. Of the four staff who responded, two had up to date life support training. The other two were out of date with their training. Local guidance is that at least one member of staff on duty at night has in-date training. We make the following recommendation:

    The Governor should ensure that all staff are aware of the location of defibrillators and that they understand how to access and use them during a medical emergency.

Debrief and support for staff

39. Prison Service Instruction (PSI) 64/2011, on managing prisoner safety, instructs that a 'hot debrief' must be held immediately after all deaths in custody.

40. The prison staff who were involved in the medical emergency were not debriefed by a senior manager and were not offered support before they went off duty. We make the following recommendation:

    The Governor should ensure that a senior manager debriefs all relevant staff immediately following a death in custody and that they receive appropriate support afterwards.

Inquest

41. The inquest into Mr Noel's death concluded on 6 August 2024, and returned a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **June 2024**

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