



**Investigation into the death of a man at
HMP Hewell in December 2011**

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

August 2012

This is the report of an investigation into the death of a man who died at HMP Hewell, in December 2011. The post-mortem examination into his death concluded that he died from a heart attack. I offer condolences to his family.

The investigation into the man's death was carried out by one of my investigators. A clinical review of the man's medical treatment was conducted by a clinical reviewer who was appointed by Worcestershire Primary Care Trust (PCT). Hewell prison cooperated fully with this investigation. I apologise for the delay in issuing this report.

The man had arrived at the prison only the night before to begin a four week sentence. He collapsed in the prison's healthcare unit while he was waiting to see a doctor as part of the prison's routine reception health screening. Despite swift medical intervention, the man died less than an hour later.

The investigation concludes that staff could neither have foreseen nor prevented the man's death. When he collapsed he received rapid and comprehensive assessment and treatment. In her clinical review, the clinical reviewer says that the man would not have received better urgent care had he been in the community.

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.

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August 2012

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SUMMARY

1. On 19 December 2011, the man was sentenced to four weeks imprisonment and taken to HMP Hewell. On his arrival at the prison, he was assessed by a prison nurse. The man told the nurse that he had no concerns about his health, but was taking medication for acid reflux and arthritis. She made a referral for him to be seen by the prison doctor the following day in order to review the treatment he had been receiving for a hand injury.
2. Due to the nature of his offence he asked to be located on the vulnerable prisoners' unit (VPU - where prisoners are located separately from the rest of the population for reasons of safety, as a result of the nature of their offence or at their own request). There was no vacant accommodation in the VPU so he was held in the segregation unit overnight.
3. The following morning, the man moved to the VPU. When he got to the VPU, staff realised that he had not yet seen the prison doctor and he was taken to healthcare for his appointment at around 11.00am.
4. At approximately 11.40am, while in the holding cell in the healthcare unit, the man collapsed on the floor, in an apparent seizure. He was placed in the recovery position and the prison doctor was called.
5. After less than three minutes, the man stopped breathing, so healthcare staff started cardiopulmonary resuscitation (CPR) and an ambulance was called. Resuscitation continued until the paramedics arrived and took over, ten minutes later. Paramedics continued in their attempts to resuscitate him for a further 26 minutes before he was pronounced dead at 12.25pm.
6. In her clinical review, the clinical reviewer says that the man's death was wholly unpredictable and was entirely unavoidable. She concludes that he received an exceptional level of care during the attempted resuscitation and was given the best possible chance of survival in the circumstances. This report makes no recommendations.

THE INVESTIGATION PROCESS

7. My investigator conducted the investigation into the circumstances surrounding the man's death. Another investigator was at Hewell when this office was notified that the man had died, and made preliminary enquiries about the circumstances.
8. Notices explaining the investigation were issued. No-one came forward with any information in response.
9. My investigator reviewed the man's records relating to the short time that he spent at Hewell. After delay obtaining staff incident statements, another investigator conducted a number of interviews with staff at the prison on 22 March. During the investigation verbal feedback was provided.
10. The clinical reviewer reviewed the clinical care that the man received while he was at the prison on behalf of Worcestershire PCT. The clinical review is the first annex to this investigation report. The clinical review was not received by this office until 21 May 2012 which has delayed the issue of this report.
11. One of the Ombudsman's family liaison officers, contacted the man's sister shortly after his death to explain the investigation process. The man's sister had no issues to be considered as part of the investigation, but asked for a copy of the draft report.
12. In response to the publication of the draft report the man's sister confirmed that she had no further issues to raise.

HMP HEWELL

13. HMP Hewell was created on 24 June 2008, when three separate prisons located on adjacent sites were merged. Hewell primarily accepts prisoners from courts in the West Midlands, Worcestershire, and Warwickshire. The prison holds up to 1,431 men who are either on remand or already convicted and sentenced. Healthcare is provided by Worcestershire PCT. The unit has 24 hour nursing staff, with in-patient care situated on the lower floor of the unit.
14. Since 2004, the Ombudsman has investigated a number of investigations at each of the establishments which were merged to create HMP Hewell. None of the previous investigations raised any issues which are relevant to this investigation.

KEY EVENTS

15. On the morning of 19 December 2011, the man received a 12 month suspended sentence. The man was under the influence of alcohol and behaved inappropriately during his court appearance. As a consequence of this behaviour, he was sentenced to serve four weeks imprisonment, which was to run concurrently with his suspended sentence.
16. Later that morning, he was received into police custody at Aberystwyth police station. At around 1.45pm he was seen by a nurse. The nurse noted on Heddlu Dyfed-Powys Police's Detained Person's Medical Form that the man was a 67 year old male who had a history of alcoholism and gout. She wrote:

“Has been drinking today. Mood calm and sociable. Has injury to left hand – this will require seeing to re dress today. DP [detained person] states he's on numerous medications though unable to give me the information...”

The nurse noted that a medical review was not required until his arrival at prison.

17. A Person Escort Record (PER) was completed. It noted that the man was to be transferred to HMP Swansea, that he was an alcoholic and registered sex offender. In the 'health risks' section of the form it was recorded that he had a number of medical issues, but was unable to say what medications he took. (The PER accompanies all prisoners on journeys from and between prisons, courts and police cells, and serves as a communication tool for all staff working at such establishments. It provides a chronological record of events and records any risks that prisoners may pose to themselves or others during a transfer.)
18. At 4.00pm the man was transferred into the custody of the prison escort services and he left Aberystwyth Police Station for Swansea. However, at 5.20pm the prison escort service was informed that the man was to be taken to Hewell, which is in Redditch, just south of Birmingham. The man arrived at Hewell at 8.55pm, four hours and 45 minutes after his departure from Aberystwyth. During his transfer it is recorded that he twice declined the opportunity to take a comfort break.
19. My investigator spoke to a member of staff in the Population Management Unit, which manages the movement of prisoners, in order to clarify why the man was diverted from Parc to Hewell. He was told that the courts in Aberystwyth send all prisoners to Swansea, unless they have committed a sexual offence, in which case they are sent to Parc. If Parc is unable to accept prisoners, due to being full, the prisoner would be taken to Cardiff as a second option. In the unlikely event that Cardiff is full, they are sent to Hewell. We understand that on the day of the transfer six prisoners, including the man, were not accepted at Cardiff and as a consequence were sent to Hewell.
20. On his arrival at Hewell, the man was seen in reception by Officer A. The officer recalled him well and said he was quite jovial despite his long journey. He said that the man did not look particularly unwell, except one of his hands was in a cast.
21. During the reception process, the man was given a first reception health screen by Nurse A, Registered General Nurse (RGN), one of the prison's nurses. (All

prisoners are given a first reception health screen when entering prison. The aim of the screen is to identify any health concerns or needs that the prisoner might have.) The man told her that he drank 30 units of alcohol a week, two units more than the recommended weekly amount for adult men. He did not say that he was an alcoholic and the nurse made no referral for further investigation of his alcohol use. The nurse recorded that the man appeared well.

22. The man told the nurse that he was receiving medication for arthritis and for acid reflux, but could not recall the names of the medication, or the details of his doctor in the community. He had recently received treatment to his hand and the nurse referred him to the prison doctor the next day to follow this up. The nurse said he had no physical symptoms suggestive of cardiac disease, chest pain or shortness of breath.
23. The man asked that he be treated as a vulnerable prisoner. However, as it was late (9.45pm) and there was no accommodation free in the VPU, he was located in the segregation unit. It was noted in the segregation unit's observation book that he was there "pending a space becoming available on the vulnerable prisoners' unit." Nurse A who had earlier assessed the man confirmed in his prison record that there were no medical reasons he should not be held in the segregation unit.
24. According to an entry in the man's prison record, there were no problems overnight and the man spent most of the night asleep. The following morning at about 9.20am the man was seen by another of the prison's nurses who noted in his medical record that no further concerns had been raised.
25. Officer B, who works in Hewell's Public Protection Department, visited the man in the segregation unit at around 10.00am. Officer B saw the man in his cell, explained who she was and talked through with him a number of public protection restrictions he would be subjected to while in prison, in particular that his mail and telephone calls would be monitored. The officer said that no concerns were raised with regard to his health. The man did not mention any pain, including chest pain, and did not look ill.
26. At approximately 10.10am, the man, was told that he was going to the VPU. He arrived on the unit at around 11.00am. Officer C provided him with bedding and showed him to his cell. The officer said that the man asked when he would be seeing the prison nurse or doctor. The officer contacted the healthcare unit and they confirmed that the man was to be taken there for a further assessment.
27. Shortly after 11.00am, the man was taken to healthcare and placed in a holding cell on the lower level of the unit. Registered General Nurse (RGN) B told the investigators that:

"When I got to the cell at 11.15am I spoke to the man. He was alert, coherent. Told me he was here to see the doctor that he'd arrived in to the prison the night before. He said it was due to his arm and I could see his arm was bandaged so I made sure. So I left the cell then to make sure that upper medical were aware that he was in the holding cell, which they were."

Nurse B said that at that time the man was, "... talking to me fine, no problems at all."

28. The man was left by the nurse in the holding cell to wait for his appointment with the doctor. Nurse B said that at about 11.40am she returned to the cell with Officer C to unlock the man. Operational Support Grade (OSG) had arrived to escort the man to his GP appointment on the upper level of the healthcare unit. The nurse said that on opening the cell the man appeared a "bit vague", which was different from when she had spoken with him previously. Officer C said:

"... he seemed to be mouthing words but nothing was coming out. I noticed there was a little bit of dribble coming from the side of his mouth when he was talking or trying to speak and gesticulate."

29. Nurse B asked the OSG to bring the doctor to the holding room. While waiting for the doctor to arrive the nurses and Officer C heard the man groan. They found that he had slumped forward falling to the floor and went into what they described as a possible "fit or a seizure". The nurse and the officer put the man into the recovery position to ensure he would not inflict further injury on himself.

30. The man's seizure continued for approximately two minutes. The prison doctor arrived at 11.41am. The doctor said that when she got to the holding room it was evident that the man was having a seizure. She said she asked for oxygen and diazepam (to be used as a relaxant) in case the seizure was prolonged. After another minute or so, both the doctor and the nurse noticed that the man started to have difficulty breathing and was becoming cyanosed (blue in colour and which occurs with oxygen starvation).

31. At approximately 11.43am, the doctor and the nurse checked the man's vital signs and started cardio pulmonary resuscitation. (CPR is a procedure used when a patient's heart stops beating and breathing stops.) An airway was inserted to administer oxygen more effectively. Healthcare Assistant and RGN C also helped with resuscitation. During the resuscitation staff, the man started to try to breathe by himself and the doctor said that she could feel a pulse. The doctor asked for the airway to be removed. However, within seconds the man stopped breathing again. The airway was reinserted and CPR continued.

32. Nurse B said that she asked for an ambulance to be called when resuscitation started at 11.43am. Officer C told the investigator that he helped the nurses to remove some of the man's clothing, by cutting it away from his chest, after which he telephoned the communications room to call for an ambulance. The Communications Occurrence Log notes that an ambulance was called at 11.45am and that paramedics arrived at the scene approximately ten minutes later. The paramedics continued with CPR until 12.25pm, when they pronounced the man dead.

33. Following the man's death, a hot debrief took place at 1.35pm, during which staff were informed of the support offered by the prison's care and welfare team. (A hot debrief is a meeting to give staff the opportunity to share their feelings following involvement in a traumatic incident.)

Prisoner Support

34. Although the man was only at Hewell for a very short time, the Governor posted notices for prisoners to tell them of his death. All prisoners who were subject to

suicide prevention procedures were reviewed and additional support was offered to prisoners who were affected.

Family Liaison

35. The news of a prisoner's death should normally be broken to the next of kin in person by a trained family liaison officer from the prison. However, if the distance is great an officer from a prison nearer the family can be asked to visit the deceased's next of kin. As the man's sister lived in Aberystwyth, some distance from any prison, a police inspector informed the man's sister of his death. We consider that asking the police to break the news was appropriate in these circumstances.
36. Later that afternoon the man's sister contacted Hewell's family liaison officer. Two members of staff attended the man's funeral and returned his property to his sister. The prison also made a contribution to his funeral expenses. The man's sister told our family liaison officer, that she was very pleased with the contact she had received from Hewell following her brother's death.

Post-mortem examination and toxicology

37. A post-mortem examination was conducted by the Consultant Pathologist at Worcestershire Acute Hospitals NHS Trust. He commented that in his opinion the man's death was due to coronary artery thrombosis due to coronary artery atheroma, complicated by left ventricular failure (a major heart attack). Toxicology results revealed that the man had no alcohol or drugs in his system when he died.

ISSUES

First reception health screen

38. On the evening of his arrival at Hewell the man was assessed by a nurse in line with prison healthcare procedures. Although, when he was in police custody he had been described as having a history of alcoholism, he told the nurse that he usually drank 30 units of alcohol a week, two units more than the recommended weekly allowance. In her clinical review, the clinical reviewer writes that the symptoms of alcohol withdrawal do not manifest themselves for two to five days after alcohol is withdrawn. Therefore, she would not have expected the man to experience acute withdrawal until the day after his collapse and does not think that alcohol withdrawal contributed to the man's death.
39. The clinical reviewer concludes that the man's stated use of alcohol was not sufficient to warrant a referral for clinical detoxification:

"Had the man declared an alcohol abuse history he would have been referred for assessment but is unlikely to have received any different or additional treatment on that night or the following morning."
40. The nurse who carried out the man reception health screen appropriately referred him to one of the prison's doctors to check his hand injury. His general practice records were not requested because he could not remember the contact details. The clinical reviewer raises no concerns with the first reception health screen, and we are satisfied that the nurse acted appropriately with the information she was given.

Emergency Response

41. The following morning, 20 December, the man was taken to the healthcare unit so that he could be assessed by one of the prison doctors. It was while waiting to see the doctor that he collapsed. In her clinical review, the clinical reviewer, comments that there was a slight delay in the nurse entering the room to undertake an assessment when she first noticed the man's condition, but as the doctor also arrived within three minutes, the clinical reviewer concludes that the delay did not result in any additional harm to the man.
42. The man was seen and assessed while in his collapsed state by both nurses and doctors and it is the clinical reviewer's opinion that appropriate treatment measures were rapidly undertaken. The clinical reviewer notes that the man's post-mortem examination revealed a complete blockage of a major artery in his heart and resuscitation was unlikely to be successful.
43. The clinical reviewer notes that when the man collapsed he received, "...rapid and comprehensive assessment and treatment" and believes that he would not have received better care in the community. She adds that such a rapid response would not have been possible anywhere but in a healthcare environment. The clinical reviewer concludes that:

"The man's death was wholly unpredictable and, to all intents and purposes, wholly unavoidable. I believe that the man received a good level of care on his arrival ... I believe he received an exceptional level of care during the attempted resuscitation and was given the best possible chance of survival in

the circumstances. I would like to commend the healthcare department for their rapid response and the prison for their efficiency in facilitating the ambulance and crew who arrive within minutes ...”

We agree with the clinical reviewer that the man’s was effectively screened when he arrived at Hewell. The circumstances of his death were unforeseeable and staff efforts to resuscitate him were prompt and appropriate.

CONCLUSION

44. The man spent less than fifteen hours at Hewell before he collapsed suddenly and died. The clinical reviewer, concludes that the man's "... death was wholly unpredictable and, to all intents and purposes, wholly unavoidable." We make no recommendations.