PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

# Investigation into the death of a man at HMP Wayland in October 2012

## ***Our Vision***

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man at HMP Wayland in October 2012. The man's death was due to chronic ischaemic heart disease, resulting from severe coronary artery atherosclerosis. I offer my condolences to his family and friends.

The investigator undertook this investigation and a clinical reviewer reviewed the man's clinical care at the prison. HMP Wayland cooperated with the investigation.

The man had been at Wayland for almost two months before his death. During this time, healthcare staff assessed and treated his significant mental health needs but also addressed his physical health needs, including diagnosing and treating his high cholesterol level. Nevertheless, it would have been difficult to foresee or prevent his sudden death and I am satisfied that he received appropriate care at Wayland.

We do not know the exact time the man was taken ill, nor whether earlier discovery would have made any difference, but the investigation has identified that officers at Wayland do not actively check on prisoners' wellbeing when they are first unlocked – and they should. Nevertheless, when the man was eventually found, staff handled the resuscitation attempts promptly and efficiently. Sadly, it was not possible to resuscitate him.

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.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **May 2013**

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**SUMMARY**

1. The man was convicted of theft and sentenced to 12 months imprisonment in August 2012 and arrived at HMP Wayland on 10 September 2012.

2. The man had severe and enduring mental health problems, which staff at Wayland assessed and frequently reviewed. There were no significant concerns about his physical health and he seldom mentioned any physical problems. The clinical review concluded that Wayland provided good continuity of care and ongoing support for his condition.

3. During a health check on 2 October, healthcare staff gave the man advice about smoking and undertook blood tests. At a follow up appointment on 19 October, a nurse explained that he had a high cholesterol level. She prescribed simvastatin to help reduce this and advised him about diet and exercise.

4. In October, two officers unlocked prisoners on the man's wing at around 8.45am. There is no evidence that they saw him at that time. At approximately 9.00am, a prisoner told the officers that the man was lying on the floor of his cell and was unresponsive. They immediately went to his cell. The man was not breathing and there was no sign of a pulse. The officers requested medical assistance and an ambulance, and began cardiopulmonary resuscitation (CPR). A nurse attended and continued to treat him until paramedics and staff from the East Anglian Air Ambulance service arrived at approximately 9.30am.

5. A doctor from the air ambulance team took over the management of the attempts to resuscitate the man which continued for a further 15 minutes. He did not respond to treatment and he was pronounced dead at 9.45am. A post-mortem examination established the cause of death as chronic ischaemic heart disease resulting from severe coronary artery atherosclerosis.

6. We are concerned that officers at Wayland do not check the welfare of prisoners when they unlock them and made a recommendation about this, which has been accepted by the Prison Service.

7. The clinical reviewer concluded that, although the man's cardiovascular risk was not proactively managed prior to his arrival at Wayland, once there his healthcare was well managed and the emergency response was appropriate and timely. We agree with her findings.

## THE INVESTIGATION PROCESS

8. One of our investigators carried out the investigation. After the PPO was notified of the death, he contacted HMP Wayland and arranged for the man's prison and medical records to be prepared for him. He visited Wayland on 6 November, to speak to staff and collect the documents. Notices were issued to staff and prisoners to inform them of the investigation and invite them to provide any relevant information for the investigation to consider. No responses were received.

9. A clinical reviewer was commissioned to review the medical care given to the man while in custody.

10. One of our family liaison officers contacted the man's sister, his nominated next of kin, on 15 November and explained the scope of the investigation. The man's sister had no specific issues she wished the investigation to cover. The family were sent a copy of the draft report and given the opportunity to respond to its findings. However, the man's next of kin indicated to the family liaison officer that they had no comments to make.

11. The investigator returned to Wayland on 7 and 11 December, and interviewed two members of staff. After the interviews, he gave verbal and written feedback to the Governor.

12. The investigator informed HM Coroner of the investigation. The Coroner provided a copy of the post-mortem report. A copy of this investigation report has been sent to the Coroner.

## HMP WAYLAND

13. HMP Wayland is in Norfolk and comprises 13 residential units holding over 1,000 prisoners. The man lived on B wing, a standard residential wing.

14. Nurses are on duty in the prison between 7.30am and 7.30pm. The local out-of-hours service provides medical cover at other times.

### Previous deaths at Wayland

15. Since this office took over responsibility for investigating deaths in prison custody in 2004, there have been six deaths at Wayland attributed to natural causes, including that of the man. Recommendations made in those earlier investigations are not repeated in this report.

### Her Majesty's Inspectorate of Prisons

16. HM Chief Inspector of Prisons conducted an announced inspection of Wayland in June 2011. The inspection report found that Wayland was "generally a safe prison". It says:

> "… Wayland was generally a safe prison. Arrangements for a prisoner's first few days were adequate but prisoners had long waits with little to do in reception before being moved to first night cells that had broken furniture and graffiti. The induction programme covered the necessary information but prisoners spent too long locked in their cells between sessions."

About health services the report says:

> "Strategic management of health care was poor and partnership arrangements were weak. Staff shortages had a detrimental effect on the care of prisoners and chaotic arrangements for the administration of medication had a negative impact on the regime of the prison as a whole..."

### Independent Monitoring Board (IMB)

17. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community, who monitor standards to help ensure prisoners are treated fairly and decently. In the most recent IMB annual report, in May 2012, the IMB was generally positive about the management of the prison and noted that Serco, the healthcare provider, had delivered a sustainable reliable service. The IMB noted that mental health team appeared to be delivering a good service.

## KEY EVENTS

18. The man was convicted of theft and sentenced to 12 months imprisonment on 17 August 2012. This was not his first time in prison.

19. The man had initially been remanded to HMP Pentonville on 16 July 2012, before transferring to HMP Wandsworth a week later. He then transferred to Wayland on 10 September. While at Pentonville and Wandsworth, it was recorded that he suffered from severe and enduring mental health problems, and had been receiving care in the community. The prison's mental health in-reach team (MHIRT) followed this up with his community mental health team (CMHT), who had regular contact with him. No significant concerns were raised about his physical health at either prison.

20. When the man arrived at Wayland on 10 September, Nurse A completed an initial health screen, and noted the man's past mental health problems and current treatment. There were no concerns about his physical health. The next day, Nurse B, a mental health nurse and member of the primary care mental health team (PCMHT) at Wayland, reviewed the man and said that he had very good insight into his mental health problems. During the assessment, the man said that he had an ongoing problem with his left shoulder, but had never seen a doctor about this while in the community. The nurse referred him to the prison's mental health in-reach team, as well as the primary healthcare department for further assessment of his physical health concerns.

21. Another mental health nurse from the primary care mental health team, Nurse C carried out a 72-hour review with the man on 13 September. He told the nurse that he had difficulty sleeping and had booked an appointment with the prison GP to request medication to help him sleep. Dr A, a GP at Wayland, saw him on 17 September and agreed to prescribe sleeping tablets for a few days. She also advised him on ways to improve his sleep pattern.

22. The primary mental health team continued to review the man frequently and the in-reach team also took him on as a patient and liaised with his community mental health team.

23. On 2 October, the man attended a health check with Nurse D, who recorded that his cholesterol was high and referred him to the nurse practitioner. Nurse practitioners are registered general nurses who have advanced training in a specialist area. He told the nurse that he smoked about five cigarettes a day and she gave him advice about the benefits of giving up smoking.

24. Dr B, a locum GP, saw the man, on 5 October. He repeated his concerns about sleeping and said that he had requested further medication. The doctor recorded that she planned to discuss the man's request with the mental health in-reach team. She explained to him that sleeping tablets were not good for him and that having them in the past was not a good reason for them to be prescribed again. The man was also supposed to be seen by the nurse practitioner but left without doing so. The nurse practitioner therefore contacted the wing and re-arranged the man's appointment.

25. Officers at Wayland said that the man caused them no concerns and generally kept himself to himself on the wing. He was given a job as a cleaner as he was

considered unsuitable for other employment due to his mental health problems. However, entries in his wing record indicate that he struggled to complete the cleaning tasks.

26. The man had regular contact with the in-reach team and the nurse practitioner, Nurse Manager, also followed up concerns about cholesterol and physical health. On 19 October, Nurse D discussed with the man the results of recent blood tests. She recorded that he did little exercise but that his diet was okay. She gave him further advice on giving up smoking. The man was prescribed a course of simvastatin, a drug to help lower cholesterol and other fats in the blood, to reduce the risk of heart disease.

27. The last contact the man had with primary healthcare staff was on 24 October, when he attended an appointment with Dr A. He again mentioned being unable to sleep, and that he was concerned about his release from custody and accommodation issues. The doctor tried to reassure him and again explained the importance of good sleep routine. She agreed to prescribe a short course of sleeping tablets.

**Events of Sunday in October 2012**

28. Officer A, who was on duty on the morning of Sunday the day the man died, told the investigator that he knew the man and described him as a quiet prisoner who caused staff no problems. The last time he had seen the man, before that day was the previous Friday and he could recall nothing unusual about the man on that day.

29. Officer A said that, on 28 October, he had begun his duty at 7.30am, and had received a briefing from the night staff. He then conducted various tasks around the landing. Other staff then arrived for duty and they all attended a morning briefing with the wing manager, before beginning to unlock the prisoners at around 8.45am.

30. The wings at Wayland are separated into ‘spurs’ and Officer A told the investigator that officers would normally just agree among themselves who would unlock each spur. He went onto C spur and Officer B, unlocked A spur, where the man lived.

31. Officer B was unavailable during the investigation, but in a written statement, he said that he had begun unlocking A spur at 8.45am. He returned to the wing office. The officer did not say whether he had seen the man as he unlocked his cell.

32. The investigator asked Officer B to explain the process of unlocking cells. He said that he would work his way along each cell, unlocking the door and pushing it open a few inches. The officer said that officers did not check on each prisoner’s welfare before moving on to the next cell.

33. The Operational Support Grade (OSG) who had been on night duty on 27/28 October, said in a statement that he had counted the prisoners in all cells on B wing at around 7.00am and recalled seeing nothing unusual as he did so.

34. Officer A said that just after 9.00am, a prisoner from A spur told him the man in cell 16 was not talking, “he’s just lying there”. The officers immediately went to the man’s cell and saw him lying on his back on the floor. Officer A said that the man was wearing a t-shirt, both his arms were raised and his legs were bent. The man was naked from the waist down and his trousers were around his ankles. Officer B removed them so that he could straighten his legs and placed a blanket over his lower half.

35. Officer A said he could get no response from the man. He checked his pulse on his neck but was unable to detect one. While he was doing this, Officer B radioed a medical code blue which indicates a medical emergency where the person is unconscious or has breathing difficulties.

36. Officer A told Officer B that he was unable to detect a pulse. Officer B then updated his message to inform the control room that they could find no pulse and an ambulance was called. The two officers then began cardiopulmonary resuscitation (CPR). Senior Officer A arrived with a defibrillator (a portable unit to analyse heart rhythm and advise whether a controlled electric shock is required to restart the heart).

37. Staff Nurse E was treating prisoners when she heard the code blue emergency call over her radio, at approximately 9.05am. She said that she immediately grabbed an emergency bag and went to the man’s cell, arriving there at around 9.07am. When she arrived, the officers had already attached the defibrillator to the man and started CPR, which they continued while she set up her equipment. The nurse confirmed with the staff at the cell that an ambulance had been requested and then assisted with the CPR. She continued until a first responder paramedic arrived at approximately 9.25am.

38. Nurse E said that the paramedic replaced the prison’s defibrillator with one which was able to give a trace of the heart, commonly referred to as an ECG (electrocardiogram). The defibrillator indicated that there was no shockable rhythm and instructed to continue with CPR. The nurse said that they completed around 40 cycles of CPR. Personnel from the East Anglian Air Ambulance then arrived.

39. The investigator asked Nurse E about the man’s appearance and whether she could estimate how long he had been lying on the floor. She said that he was warm to the touch and that, in her opinion there were no signs of rigor mortis.

40. The man was given medication, including adrenalin, in an effort to restart his heart. A doctor from the air ambulance also inserted an airway into the man’s throat and CPR continued. Sadly, the man did not respond to treatment and, at 9.45am, the doctor pronounced the man dead.

### Actions after the man’s death

41. Prison staff involved in the emergency said that, after the man’s death, they were offered support from the staff care team and attended a debrief. The investigator reviewed the minutes of the debrief meeting and no concerns were raised by staff. Arrangements were made for prisoners on B wing to be notified

and offered support if required. Staff also spoke individually to the two prisoners who had initially discovered the man.

42. The man had nominated his sister as his next of kin. A member of the chaplaincy team and a trained family liaison officer went to the address the man had given for his sister. However, this turned out to be the wrong address and the staff were unable to contact the man's family that day. The next day, the prison obtained another address and the liaison officer and an operational manager, went and broke the news to the man's family.

43. The prison remained in contact with the man's family and offered financial and practical assistance with funeral arrangements.

## ISSUES

### Clinical care

44. NHS Norfolk and Waveney reviewed the man's health care during his sentence. Only those issues relating to his time at Wayland are considered in this report.

45. The clinical reviewer comments that, when the man attended for a health check at Wayland on 2 October 2012, this was his first documented intervention for smoking cessation. As a result of the findings of that health check, he was referred to a nurse practitioner for further investigations, including blood tests. These revealed a high cholesterol level, for which the man was prescribed simvastatin.

46. The clinical review concludes that in prison the man had good continuity of care and ongoing support for his severe and enduring mental health needs. However, previously there does not appear to have been a holistic approach to all his needs and it was only at Wayland that the healthcare department started actively to manage the man's cardiovascular risk factors. We agree with the clinical reviewer's view that the man's healthcare was suitably managed at Wayland, and that officers and healthcare staff responded appropriately when he was found unresponsive on 28 October.

### Procedures for unlocking cells

47. Officer B unlocked the man's cell on the morning of his death. As he was unavailable for interview, the investigator asked Officer A to describe the normal actions when opening cells. He explained that he would open the door a few inches before moving on to the next, but would not usually check the well-being of the prisoner inside. The guidance in the Prison Officer Entry Level Training (POELT) manual says:

    > "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

48. We do not know whether the man collapsed before or after his cell was unlocked. However, it was clear that staff did not consider it necessary routinely to check the welfare of prisoners as they unlocked them in the morning. While the investigation has found no evidence to suggest that earlier intervention would have prevented the man's death, such routine safety precautions could prevent an ill or dying prisoner from going unnoticed in the future. We therefore make the following recommendation:

    **The Governor should ensure that when staff unlock cells, they check the safety of the prisoner and that there are no immediate issues that need attention.**

## RECOMMENDATION

The Governor should ensure that when staff unlock cells, they check the safety of the prisoner and that there are no immediate issues that need attention.

*This recommendation was accepted by HMP Wayland and in response to the draft report they have said:*

**A Governor’s Order has been issued to all staff informing them of their responsibilities when unlocking prisoners.**