



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Northumberland in December 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 Northumberland in December 2012. He was 59 years old and died of heart disease. I offer my condolences to his family and friends.

A clinical review was conducted of the clinical care the man received while in the custody of HMP Northumberland.

The man had diabetes and heart disease. He collapsed suddenly in his cell shortly after breakfast in December 2012. Staff and paramedics attempted to resuscitate him, but he was pronounced dead at 8.57am.

The clinical review concludes that the clinical care the man received exceeded that which he had previously received in the community. His long-term health conditions were well managed, he was encouraged to improve his lifestyle and there were timely and appropriate referrals to secondary services. However, I am concerned about some poor quality risk assessments which led him to be unnecessarily restrained by an escort chain for hospital appointments, despite having only one leg and being reliant on a wheelchair.

The emergency response to the man's collapse appears to have been satisfactory, but officers should not have waited for a nurse before requesting an ambulance. This is a matter that this office has raised with the prison before and it is important that an ambulance is called whenever there are serious concerns about the immediate health of a prisoner.

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

November 2013

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SUMMARY

1. The man was sentenced to 10 years imprisonment on 15 January 2009, and was taken to HMP Preston. He had diabetes and heart disease, and was treated and reviewed for his conditions. He was wheelchair dependent as he had his left leg amputated some years earlier. On 24 February 2010, he moved to HMP Northumberland, where he lived in an adapted cell on a residential wing.
2. The man collected his breakfast in December 2012, but collapsed in his cell shortly after, at around 7.55am. Two prisoners put him into the recovery position and called officers for help. He was breathing and groaning. An officer responded and called a code blue emergency¹. Healthcare staff arrived, and an ambulance was called at 8.05am. His condition deteriorated and he stopped breathing. Nurses started cardiopulmonary resuscitation (CPR) and attached a defibrillator². The nurse used a defibrillator five times before the ambulance arrived and paramedics took over at 8.35am. He was pronounced dead at 8.57am.
3. We agree with the clinical reviewer that the care the man received at HMP Northumberland was at least equivalent to that he could have expected to receive in the community. His long-term health conditions were appropriately managed with medication and he was seen regularly by healthcare staff and at an outpatient clinic at the local hospital. However, restraints were used inappropriately for hospital appointments.
4. While efforts to resuscitate the man were appropriate, officers should have called an ambulance as soon as they realised it was a medical emergency, rather than waiting for healthcare staff. HMP Northumberland's emergency response protocol needs to be reviewed.

¹ A code blue emergency signifies a life threatening situation that requires immediate medical assistance.

² A life-saving machine that gives the heart an electric shock.

THE INVESTIGATION PROCESS

5. The Ombudsman's office was informed of the man's death on 6 December 2012. The investigator issued notices informing staff and prisoners of the investigation and asking them to contact her with relevant information. No one responded.
6. The investigator informed HM Coroner for Northumberland North District of the investigation and a copy of this report has been sent to the Coroner. The post-mortem report concluded that he died of heart disease.
7. The local PCT appointed a clinical reviewer to review the man's clinical care at the prison. He was given a copy of the man's prison medical records. The clinical review was received on 30 January.
8. The investigator reviewed the man's prison records. On 25 and 29 January, and 12 February, she interviewed two prisoners, two wing staff and two healthcare staff. She wrote to the Governor to give initial feedback about the investigation.
9. One of the Ombudsman's family liaison officers (FLO) contacted the man's sister shortly after his death and explained the purpose and scope of the investigation. His sister asked us to consider how her brother was able to fall out of his wheelchair when he collapsed and why no one was with him when he fell.
10. The man's family received a copy of the draft version of the report as part of the consultation period. The family found the report upsetting to read but welcomed the recommendations made. They will consider pursuing any outstanding questions at the inquest.

HMP NORTHUMBERLAND

11. The merger of two separate prisons, HMP Acklington and HMYOI Castington was announced in 2010, and work began to integrate all of the functions in April 2011. On 31 October 2011, the merged prisons became known as HMP Northumberland. HMP Northumberland can accommodate more than 1,300 adult male prisoners. The man lived in the part of the prison which was formerly HMP Acklington. Medical services at the prison are provided by a private company.

Her Majesty's Inspectorate of Prisons (HMIP)

12. The Inspectorate carried out an unannounced inspection of Northumberland in June 2012. The inspectorate felt that the amalgamation of the two prisons had gone well and were impressed with the "energetic and committed management team". The Inspectorate found healthcare was reasonable, and the care of patients with lifelong conditions such as asthma, diabetes and heart disease was good.
13. The report noted that there were ten trained prisoner representatives for equality and diversity, as well as disability representatives on most wings. The Inspectorate described the adapted cells for men with disabilities as excellent and spacious. Lifts and ramps had been installed to allow access to most areas of the prison. The prison employed prisoner carers and wheelchair pushers, who had received basic training for their roles.

Previous deaths at Northumberland

14. The man's death was one of three deaths in the last two years at Northumberland. We have commented in this report on the need for an ambulance to be called as soon as a code blue emergency arises, an issue that we identified in a previous investigation report in 2012.

KEY EVENTS

15. The man was sentenced to 10 years imprisonment on 15 January 2009, and was taken to HMP Preston. On 24 February 2010, he moved to HMP Northumberland to be closer to his family.
16. The man took insulin and metformin³ for diabetes. He had heart disease, for which he took ramipril⁴ and aspirin⁵. His left leg had been amputated many years earlier because of complications caused by his diabetes, so he used a wheelchair. He was accommodated on a standard residential wing and had an adapted cell. He was able to move around his cell independently and could wash and dress himself.
17. The man's diabetes and heart disease appear to have been well managed using medication. Officers and healthcare staff encouraged him to stop smoking and eat more carefully to help with the control of his diabetes, but he admitted that he ate whatever he wanted. He had ulcers on his right foot which were closely monitored and dressed regularly to avoid infection.
18. During his time at HMP Northumberland, the man had outpatient hospital appointments with his diabetes consultant. As part of the duty to protect the public, prisons make judgements about the level of security needed when prisoners are taken out of the prison for any reason. An individual risk assessment should be completed on each occasion. The risk assessment should be based on an assessment of the prisoner's actual risk at the time, taking into account his health and physical condition. His person escort records (PER)⁶ show that he was escorted to hospital by two officers and an escort chain⁷ was used to restrain him. The risk assessments varied as to the amount of information they contained about his physical condition. However, they all arrived at the conclusion that he was an escape risk and a risk to the public, despite the fact that he was suffering from two chronic health conditions and was wheelchair bound with only one leg.
19. The man's last medical interaction in his clinical record was on 3 December. He had the wound to his leg cleaned and dressed. There is no record of him complaining of feeling unwell. The investigator spoke to two prisoners on the wing and two officers. No one thought he was particularly unwell in the few weeks or days before he died.

³ Medications used to help control diabetes

⁴ Used to treat heart disease and high blood pressure.

⁵ Blood thinning medication used to help manage heart conditions.

⁶ A document that accompanies prisoners on all journeys outside prison. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort.

⁷ A six foot chain with a handcuff at each end. One handcuff is applied to the prisoner and the other to an officer.

6 December 2012

20. At 7.45am on 6 December, the man went to collect his breakfast from the wing kitchen. The prisoner who served him his breakfast said that he seemed fine. He went straight back to his cell.
21. At about 7.55am, Prisoner A was walking back to his cell when he called to the man to get himself ready to go to the healthcare centre. The prisoner often pushed his wheelchair for him and was going to take him to collect his medication. The prisoner said that the man did not reply as he usually would, so he went straight to his cell to check on him. The prisoner said that he was in his wheelchair, clutching his stomach. He asked him if he was alright, and he grunted. He then fell forward out of his chair and hit his head on his table, before slumping onto his bed. The prisoner said that he tried to catch him, but did not get to him in time. He then shouted for help.
22. Prisoner B heard Prisoner A calling for help and went to the man's cell. He helped the prisoner slide him onto the floor and put him in the recovery position. (Both prisoners had been first aid trained.) They then shouted for someone to get an officer. An officer left the wing office when he heard shouting. A prisoner asked him to go to the cell. The officer said it was around 8.00am and it would have taken him less than a minute to get to the cell. When he arrived, he saw the man in the recovery position. He called a code blue emergency over the radio, but did not ask for an ambulance, as he was waiting for a nurse to assess his condition first. The communications log shows that a code blue was called at 8.01am. Another officer responded to the code blue and arrived at the cell less than a minute later.
23. The man was breathing and groaning, but was not fully conscious. A nurse was on the next wing when she heard the emergency call, so arrived at the cell minutes later. She examined the man and found that he was still breathing, but his pulse was weak and he was unresponsive. She said that she thought an ambulance had already been requested and asked an officer to radio the communications room to ask them to tell the paramedics they would be responding to a cardiac arrest. The communications log shows an ambulance was called at 8.05am, as a result of the nurse's request.
24. The nurse gave her keys to the officer and asked him to collect the red emergency bag, which was in the locked treatment room, as she had forgotten to bring it with her. As the officer was leaving the wing, he said another nurse arrived with an emergency bag, but he went to collect the other one as well. Two more nurses arrived at the cell just after 8.05am.
25. The man's condition deteriorated and his complexion went blue. He was rolled onto his back and the nurse said that he stopped breathing. She started cardiopulmonary resuscitation (CPR) and another nurse attached a defibrillator. They continued CPR for around half an hour and used the defibrillator to try to re-start his heart five times, before ambulance staff arrived at 8.35am. The paramedics took over resuscitation attempts from the nurses. A prison doctor arrived for duty at the prison and was asked to go to

the man's cell. When she arrived at the cell she was told that, despite the actions of the prisoners, healthcare staff and paramedics, he had not responded to CPR. The doctor pronounced him dead at 8.57am.

Support for prisoners

26. Both prisoners told of the man's death by the duty governor. They were offered support from the chaplaincy, the Governor and Listeners⁸. Notices were displayed in the prison to let prisoners know of his death and the support that was available to them. All prisoners subject to suicide prevention monitoring were reviewed. A memorial service was held in the chapel on 18 December.

Support for staff

27. A residential manager held a hot debrief to offer support to the staff who had been involved in the incident. The officers were asked how they were feeling and were offered the support of the staff care team if they felt they needed it.

Family liaison

28. An officer was appointed as the prison FLO. At 10.00am, the FLO and another trained FLO went to the man's sister's home to tell her that her brother had died. The FLO explained the FLO role and what would happen next, including the inquest process. On 12 December, the family visited the prison and a memorial service was held in the prison chapel. The prison paid reasonable funeral expenses. The funeral was held on 21 December. A prison chaplain conducted the service and both FLOs attended the funeral.

Post-mortem

29. The post-mortem report concludes that the man died of ischaemic heart disease, due to coronary artery atheroma⁹ and diabetes. The report says that ischaemic heart disease is the most common cause of sudden unexpected death in men of his age.

⁸ Prisoners who are selected and supported by Samaritans to offer confidential emotional support to fellow prisoners.

⁹ Accumulation of debris in the arteries, such as fatty deposits, which clog up the artery.

ISSUES

Clinical care

30. The man suffered from chronic diabetes and heart disease. He was also wheelchair dependent as he had his left leg amputated many years before coming into custody. He was seen regularly by healthcare staff and a diabetic consultant at the local hospital.
31. The clinical reviewer concludes that the clinical care the man received was better than the care he had previously received in the community. The clinical reviewer says that referrals to secondary services, such as a diabetic consultant, were appropriate and timely. Following reviews in the outpatient clinic, advice to healthcare staff about his care and medication was actioned appropriately. He notes that staff encouraged him to stop smoking and to take better control of his diet, but he continued to smoke and eat what he liked, so the clinical reviewer considers that his deterioration was highly likely.

Calling an ambulance

32. The Director of Offender Health and the Chief Executive Officer of the National Offender Management Service wrote to all prison Governors and Directors and prison healthcare managers on 17 February 2011 to reiterate previous guidance about the importance of calling an ambulance as soon as possible in an emergency. Any delays can have a significant impact on the patient's chances of survival, so prison staff should not wait for health professionals to attend.
33. HMP Northumberland's emergency response policy does not reflect the guidance and states that emergency ambulances will be arranged by healthcare staff through the communications room.
34. The officer said that he did not ask for an ambulance when he called the code blue as he did not know if it was an emergency situation and waited for a nurse to assess the extent of the man's condition. He radioed the communications room to request an ambulance when the nurse arrived and asked about an ambulance.
35. As a code blue call signifies a life threatening situation, an ambulance should have been requested automatically. It appears that the four minute delay in calling an ambulance would not have made any difference to the outcome for the man, but in other circumstances it could be crucial. This issue has been commented on previously in an investigation in 2012. It is disappointing to have to make a further recommendation about this.

The Governor should ensure that, whenever there are serious concerns about the immediate health of a prisoner, staff are aware that they should call an ambulance without waiting for healthcare staff to attend and that emergency response guidance reflects this.

Escort risk assessments

36. Prisons have a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.
37. When the man went to hospital for his outpatient appointments, he was escorted by two officers and an escort chain was applied. The risk assessments vary in quality for each hospital appointment, but all recorded that he was in a wheelchair and only had one leg. None stipulated how this would have affected his level of risk. There is also no recorded consideration of his chronic illnesses and the impact they would have on his risk. Despite his disability, all concluded that he was a risk of escape, a risk to the public, and an escort chain should be used. It is apparent that his health and mobility were not given sufficient weight during the risk assessment process.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Governor should ensure that whenever there are serious concerns about the immediate health of a prisoner staff are aware that they should call an ambulance without waiting for healthcare staff to attend and that emergency response guidance reflects this.
2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, and are based on the actual risk the prisoner presents at the time.

ACTION PLAN: The Man – HMP Northumberland

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that whenever there are serious concerns about the immediate health of a prisoner staff are aware that they should call an ambulance without waiting for healthcare staff to attend and that emergency response guidance reflects this.	Accepted	<p>HMP Northumberland has implemented PSI 03/2013. This ensures the immediate request for an ambulance once either a Code Blue or Code Red has been called over the radio net/phone.</p> <p>This instruction has been issued via the weekly bulletin and SIN.</p>	Completed	31/09/2013
2	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, and are based on the actual risk the prisoner presents at the time.	Accepted	<p>Escort paperwork is to be reviewed to ensure this information is correctly captured.</p> <p>Health care Manager has been informed of this action and has passed this onto his staff and managers for action.</p>	31/04/2013	31/10/2013