

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Bullington in January 2013**

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. He died in his cell at HMP Bullingdon in January 2013. He was 56 years old. The cause of his death was established by post mortem examination as acute cardiac arrhythmia due to ischemic heart disease (a sudden irregular heart rhythm caused by reduced blood supply to the heart). I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer. Bullingdon cooperated fully with the investigation.

Although he was diagnosed with a number of life long medical conditions, and had experienced frequent fits in the past, the man's death came unexpectedly. Nevertheless, my investigation highlights a number of learning points following his collapse in January 2013. Although I find that an ambulance should have been called earlier, night staff trained in resuscitation techniques, and night patrols more willing to open a cell when a prisoner is very unwell, I cannot say that any or all of these factors would have preserved his life.

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

August 2013

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SUMMARY

1. The man was sentenced to life imprisonment in 1987. During his time in custody he was diagnosed with several life long conditions. Most significantly, he underwent major surgery in 2003 to relieve swelling on his brain, as a consequence of which he was diagnosed with epilepsy. He experienced frequent epileptic fits and seizures following this diagnosis, some of which resulted in hospital admission. His last seizure was several months before his death, and the clinical reviewer concludes that his epilepsy was appropriately managed in prison.
2. After a chest X-ray in July 2012 showed the man's heart was enlarged, a prison doctor made a referral to a hospital specialist. There was a delay of several weeks before he saw a specialist – apparently because the hospital did not receive the original referral – who thought he might have ischemic heart disease (cause by reduced blood supply to the heart). The specialist asked him to return in December, when additional tests confirmed the diagnosis. Plans were made for the man to have a more detailed scan, with a view to future surgery, but no appointment was received before his death. The clinical reviewer considers the delays resulting from the initial misplaced referral, but concludes that this had no bearing on the man's death. Nevertheless, we recommend that the Head of Healthcare ensure that hospital referrals are sent in line with GP instructions.
3. During his morning roll check in January 2013, an Operational Support Grade (OSG) found the man lying on the floor of his cell. His initial impression was that the man was asleep, but he was concerned and called colleagues to attend. On opening the cell, an officer found that the man had no pulse and felt stiff. She made a 'level one' call for emergency medical assistance. A nurse arrived at the cell around five minutes later, began cardiopulmonary resuscitation (CPR) and asked for an ambulance to be called. The man was pronounced dead shortly after the arrival of a paramedic crew.
4. We find that there are several areas where the response to the man's collapse could have been improved, and make several recommendations. The OSG was unsure of local instructions regarding opening a cell at night in an emergency, none of the staff who initially responded were trained or confident in the application of CPR, and there was a delay to calling an emergency ambulance. Nevertheless, we cannot say that any or all of these matters would have resulted in a different outcome, and note the clinical reviewer's comment that evidence suggests he was already dead when he was discovered.

THE INVESTIGATION PROCESS

5. On 1 February 2013, notices were issued at Bullingdon announcing the investigation to staff and prisoners, inviting anyone who had relevant information to contact the investigator. No one came forward as a result.
6. The investigator visited Bullingdon on 13 March. During the visit he interviewed three members of staff. He also visited the Edgcott unit, where the man lived, and spoke to three prisoners who knew him.
7. A review of the man's clinical care in custody was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. He joined the investigator for the visit on 13 March.
8. One of the Ombudsman's family liaison officers telephoned the man's sister, his nominated next of kin, on 28 February, to explain the investigation. She said that she did not have any immediate concerns or questions for the investigation to address.
9. The man's sister received a copy of the draft report as part of the consultation process. She told our family liaison officer that she had found the report helpful, informative and welcomed the recommendations made in the report. The report was also sent in draft to the Prison Service.

HMP BULLINGDON

10. Bullingdon opened in 1992, and combines the two functions of a category C training prison and category B local prison serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. The man lived in a single cell on the Edgcott unit, which holds up to 185 men convicted of sex offences.
11. Healthcare at Bullingdon is commissioned by the Primary Care Trust. During the man's time at the prison, primary healthcare services were provided by Oxford Health and GP services by Cotswolds Medicare. Virgin Healthcare took over the contract for healthcare provision from April 2013. There are at least two nurses on duty at all times, including overnight. A nurse is responsible for leading care for those prisoners aged over 50.

HM Inspectorate of Prisons (HMIP)

12. HMIP conducted an unannounced inspection of Bullingdon in July 2012. The Inspectorate found the healthcare provision was good but limited in breadth, and waiting times to see a GP were too long. Prisoners surveyed by the Inspectorate were dissatisfied with several aspects of healthcare provision, including the availability of repeat medications.

Independent Monitoring Board (IMB)

13. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their annual report for 2011-12, the IMB expressed concern about the "inadequate and inefficient" provision of healthcare services.

Previous deaths at HMP Bullingdon

14. The man was the third prisoner at Bullingdon to die since January 2012. We found that the emergency response, following the collapse of the second man to die, was rapid and professional.

KEY EVENTS

15. The man was convicted of manslaughter and sentenced to life imprisonment in 1987. His medical history included type 2 diabetes, high blood pressure, and chronic obstructive pulmonary disease. (COPD encompasses a number of lung diseases including chronic bronchitis and emphysema. Patients with COPD have trouble breathing due to long term damage to the lungs, usually due to smoking.) In 2003, he was diagnosed with a brain abscess (swelling of the brain) and underwent a significant surgical procedure, known as a craniotomy, to relieve the swelling.
16. As a consequence of this surgery, the man was diagnosed with epilepsy and experienced frequent seizures and corresponding left sided weakness. He was prescribed Epilim to treat this condition, which is used to control electrical activity in the brain and reduce the risk of seizures. While in HMP Parkhurst (now part of HMP Isle of Wight) from 2007 to 2010, he sometimes stopped taking his medication for periods of a few days or weeks at a time, seemingly in protest at various issues around the prison that concerned him. The man sometimes experienced seizures during these periods, although he also experienced seizures when he appeared to be taking his medication as prescribed. On some occasions he was sent to hospital after a seizure. If he recovered more quickly, treatment was provided at the prison.
17. The man moved to Bullingdon on 29 December 2010. His medical history was identified at a reception health screen, and an introductory appointment was made with a prison doctor in his first week. On 12 March 2011, an ambulance was called when he had a fit and reported weakness on his left side. He returned to Bullingdon later the same day, with his Epilim prescription increased. The discharge note advised that similar future episodes did not require admission if they settled untreated. However, the note also advised that an ambulance must be called were the man to suffer right sided weakness, lose consciousness, or if all four of his limbs were to jerk during a fit.
18. On 4 April, the man had an appointment with a diabetes specialist at hospital. He had been referred earlier in the year due to concerns about his blood sugar levels, which were described as “erratic and uncontrolled”. The specialist advised changes to his insulin dose.
19. A nurse was called to the man’s cell on 20 July, when he experienced shortness of breath and difficulty speaking. He recovered following the arrival of the nurse, and no further action was required. In the first week of August, the man was unwell and diagnosed with a chest infection, for which he was prescribed antibiotics. Further concerns were raised about his blood sugar levels in July and August and, following a review, it emerged that he had not been following advice regarding his insulin dose and diet. The man’s blood sugar appeared to be better controlled in the autumn and, other than a second chest infection in December, he reported no further significant healthcare concerns in the remainder of the year.

20. A nurse was called to see the man on 20 January 2012, when he experienced “spasmodic movement of face”. He recovered and no further action was taken.
21. On 4 March, the man had a more significant seizure. He experienced left sided weakness, particularly in his face, and his speech became slurred. An ambulance was called, and he was admitted to hospital amid fears he had suffered a stroke. The man returned to Bullingdon two days later, when his symptoms had resolved. Tests at hospital showed no evidence that he had had a stroke, and specialists concluded that his symptoms were most likely the result of an epileptic fit.
22. On 20 June, the man reported symptoms that suggested an exacerbation of his COPD. He was prescribed prednisolone (a steroid used to reduce inflammation) and an antibiotic. At a review a week later, his symptoms were said to be resolving.
23. The man saw a prison doctor on 12 July, and said his ankles were swollen and he was short of breath. (Such swelling is known as oedema and is often caused by heart failure.) The doctor examined his chest and referred him for a chest X-ray. She saw him again on 18 July, to review the results. These showed that the man’s heart was enlarged (cardiomegaly), and the doctor therefore asked that he be referred to a cardiologist (heart specialist) for further investigation.
24. On 23 August, a healthcare administrator contacted the hospital to check on the man’s cardiology referral. She was told that the referral had not been received at the hospital, and therefore faxed it again. She contacted the hospital several times in the following week to see if an appointment had been made. A letter was received on 19 September, with an appointment date later in the month.
25. In the meantime, the man saw the doctor for a review on 29 August, and said he was still short of breath. The doctor noted that the man’s ankles were less swollen, but his abdomen was now swollen too. She recorded that she would await the outcome of his upcoming cardiology review.
26. During the night of 26-27 September, the man told wing staff that he had a headache, chest pain and had been sick. He was admitted overnight to the healthcare centre inpatient unit for observation. On the afternoon of 27 September, he went to the hospital for his planned cardiology appointment. The cardiologist concluded that the man might have ischaemic heart disease (caused by reduced blood supply to the heart), and asked that he be prescribed additional medication ahead of a review in three months time.
27. The man refused to take his medication on 22 October, because it was packaged in a nomad box¹ rather than in separate cartons. There is no record in his medical notes of the reason why his medication was now supplied this way. There is no further record of him refusing his medication although, on 31 October, he complained to wing staff that he was not getting the correct

¹ A nomad box is a way of packaging medication so it is separated into slots by day and time. The main advantage is to help patients take the right medication at the right time, but it also allows healthcare professionals to more easily monitor the patient’s compliance.

medication. This was reported to a nurse, who arranged to see him that afternoon to talk through any discrepancies. He did not attend this review.

28. At a review with the doctor on 16 November, the man said the issues with his medication were now resolved. His legs were still swollen, although not greatly so, and he had no new or worsening symptoms. The doctor noted that they would continue to monitor him ahead of his follow up appointment with the cardiologist.
29. In December, the man was given a job tuning old television sets in a storeroom on his wing. Officers reported that he was enjoying this work and did not have any issues to raise with them.
30. The man returned to hospital on 3 December for a scan which confirmed the presumed diagnosis of ischaemic heart disease. An appointment was made for 27 December, to discuss the findings with the consultant cardiologist. The cardiologist concluded that the findings of the scan, combined with his symptoms, meant that further intervention was warranted. He asked that the man return for an angiography (a more detailed scan of the heart) with a view to performing a surgical procedure known as angioplasty (insertion of a stent to widen the arteries and allow blood to flow more freely). No appointment was received for these procedures before the man's death.
31. In January 2013, the man continued to help out with tuning televisions and various other jobs on the wing. At a review with the diabetes specialist nurse on 24 January, his blood sugar was described as "ideal". His last recorded contact with healthcare staff was on 27 January, when he collected a supply of needles and lancets, for taking insulin and testing his blood sugar level. There is no record that the man raised any issues about his health at this time.
32. A friend of the man's remembered speaking to him on the evening of his death. He said that they had coffee and a chat, and the man appeared fine with no sign that anything was wrong. Another prisoner recalled seeing the man the same day and thought he seemed his usual self.
33. One member of staff, an operational support grade (OSG, the grade below prison officer), is on duty on each wing overnight. The OSG works a shift from 8.45pm to 7.45am and prisoners are always locked in their cells before the shift starts. OSGs work permanent night shifts, working a pattern of one week on and one week off.
34. The OSG carried out a roll check at 9.45pm. He told the investigator that he remembered nothing out of the ordinary on checking the man. He began his morning roll check at around 4.50am, and arrived at the man's cell at around 5.10am. He said he found the man lying on the floor "as though he was sleeping". The OSG said the man had not been on the floor when he did his evening roll check. He said that, although it was difficult to tell because the man was on his front, he thought he could see some chest movement and "assumed he was on the floor sleeping". The OSG added that prisoners occasionally sleep on the floor if the heating is on and it is too hot in their cells.

35. The OSG said he knocked on the man's door, but received no response. He told the investigator that the man had poor hearing and he did not therefore think he would have been able to hear the knocking. He was concerned and contacted a Senior Officer (SO), the night orderly officer (a senior officer who is in charge of the prison overnight), by telephone to ask for staff to come to the unit to provide assistance. Three officers were asked to attend. (Unlike OSGs, the night orderly officer and prison officers do not work permanent night shifts. They are required to work one week of nights around once every 20 weeks.)
36. On their arrival, Officer A unlocked the man's cell, and he and Officer B went in. Officer B told the investigator that she spoke to the man and then shook his arm, but received no response to either. She checked for a pulse, but was unable to find one. She described the man's condition as follows:

“He had [food] coming out of his mouth and out of his nose. His face looked quite purple but his skin was marbled and he just felt clammy and cold and quite stiff.”
37. Both officers agreed that they should make a 'level one' radio call for emergency medical assistance. The prison's control room log (through which radio calls are received) records that this call was made at 5.20am.
38. As healthcare staff do not carry keys at night, the SO went to the prison's healthcare centre to collect a nurse and her colleague. The nurse took the emergency bag (containing equipment such as oxygen, mouth guards, and adrenaline) with her, and a defibrillator. Officer B stayed in the man's cell while she waited for the response nurses to arrive, and estimated that this was less than five minutes after the call was made. The nurse agreed that it was around five minutes after the call was made that she arrived at the cell.
39. On her arrival, the nurse asked Officer B to help her move the man onto his back. The nurse told the investigator that the man's arm was stiff, although she was not sure if this meant that rigor mortis had begun to set in. She said that there was some cyanosis (blueness, due to a lack of oxygen) in the man's face, although his neck was slightly warm. She and her colleague commenced cardiopulmonary resuscitation (CPR). They applied the defibrillator, which showed a flat line (indicating an absence of electrical activity in the heart) and advised that no shock be carried out. The nurse also asked that an ambulance be called. The control room log records that this call was made at 5.26am.
40. The first response paramedic arrived at Bullingdon at 5.30am, with the second response arriving twenty minutes later. At around 6.00am, the paramedics instructed that CPR should stop and declared the man dead.
41. The man's next of kin was listed as his sister. As she lives some distance from Bullingdon, a family liaison officer from a local prison visited her later to break the news of her brother's death. A family liaison officer was also appointed at Bullingdon. The funeral took place in the Republic of Ireland, and Bullingdon

contributed to the costs of both repatriation and the funeral in line with national guidance.

42. The nurse and OSG said they felt sufficiently supported after the man's death. Officer B said she did not receive any support and, at the time of her interview, felt that she still needed to talk through the events. The investigator spoke to a prison chaplain, a member of the prison's care team, who agreed to speak to her.

ISSUES

Clinical care

Epilepsy

43. The man was diagnosed with several long term medical conditions during his time in custody. Of most obvious concern were the frequent seizures he suffered as a result of epilepsy diagnosed following brain surgery in 2003. Some of these seizures resulted in hospital admission, whereas others were treated in prison if the man's symptoms resolved quickly. We note that the last recorded seizure was some months before the man's death, and the post-mortem report finds it unlikely that his death was epilepsy related. The clinical reviewer concludes that his seizures were appropriately managed, with referral to hospital specialists when required.

Diabetes

44. The man had also been diagnosed with type 2 diabetes. The control of his blood sugar level was a common theme during his time at Bullingdon, and he did not always follow the specialist's advice. Nevertheless, his blood sugar level appeared to become less of an issue during his time at Bullingdon and, a week before he died, it was described as "ideal". The clinical reviewer concludes that the man's diabetes was appropriately managed with effective referrals to the specialist nurse.

Heart disease

45. The cause of the man's death was acute cardiac arrhythmia (a sudden, irregular heart rhythm) due to ischaemic heart disease. He was formally diagnosed with ischaemic heart disease in December 2012, as a result of a referral initially made in July. He was scheduled for further scans and, most likely, surgery to widen his arteries and improve blood flow. These procedures did not take place before his death.

46. There was a delay of several weeks from when the doctor first requested a cardiology referral to the receipt of an appointment. It appears that the hospital did not receive the original referral, and it was therefore resent a month later. The clinical reviewer considers this delay, and concludes that the investigations undertaken following referral would suggest that the delay had no bearing on the circumstances of the man's cardiac arrest. Nevertheless, the Head of Healthcare will wish to ensure that such delays do not occur in future.

The Head of Healthcare should ensure that hospital referrals are sent in line with GP instructions, and promptly followed up if receipt is not initially acknowledged.

Emergency response

Opening the man's cell

47. When he checked the man's cell during the morning roll check, the OSG found him lying on the floor. The OSG explained that the man's bedclothes were neatly folded back and he appeared to be sleeping on the floor. He thought he could see chest movement, but said it was hard to tell as the man was lying on his front. The OSG knocked on the door, but the man did not respond. The OSG explained that this did not surprise him, because the man was hard of hearing. (Although there is no note in his medical record to suggest he had poor hearing, the man's personal officer confirmed that the man had some difficulty hearing, particularly if his back was turned.) However, because he was concerned that something might be wrong the OSG called the night orderly officer for assistance.
48. Local instructions at Bullingdon² state that a cell will only be opened at night with the authorisation of the night orderly officer and in the presence of at least three members of staff. However, the instructions provide one exception to this rule:
- “The need to assist a prisoner must be balanced against any security risks, preservation of life is paramount and under life threatening circumstances a cell may be opened by the member of staff and without the authority of the night orderly officer.”
49. The investigator asked the OSG if he considered opening the man's cell before support arrived. He said that he would “never” consider this, because he considered the man to be a “dangerous man”. The OSG earlier said that he was warier when a prisoner was in a single cell as this meant that they presented a higher risk.
50. From his description of what he saw, it is difficult to judge whether the OSG should have opened the cell before his colleagues arrived. However, it is apparent that he had some concerns and, rather than simply asking for assistance from the night orderly officer, it might also have been appropriate to request medical help at the same time.
51. In addition, we are concerned by some aspects of the OSG's response. There are many reasons why a prisoner might be in a single cell, and the risk an individual presents to others is just one factor. Given his answers at interview, it is apparent that he would be very reluctant to open a single cell without support in any circumstances. Although we cannot say whether earlier assistance would have made a difference on this occasion, in other circumstances this could be vital and it is essential that night staff are aware of local procedures.

The Governor should ensure that all operational support grades are aware of local procedures for entering a cell at night and understand that they

² Notice to Staff 119/2012: Entering a cell during night – staff roles and responsibilities.

may open a cell immediately if there are grave concerns about the health of a prisoner.

Emergency code system

52. When both officers opened the cell and assessed the man, they quickly made an emergency call for medical assistance. They used the emergency code 'level one' which, as the nurse explained, could mean one of any number of serious incidents. (Levels two and three are for less serious medical incidents.) The nurse added that she did not therefore know what the nature of the emergency was when she made her way to the cell.

53. Prison Service Instruction (PSI) 03/2013³ provides the following mandatory instruction to Governors:

“Governors of all prisons must ensure that a Medical Emergency Response Code protocol exists that enables staff discovering a prisoner who is exhibiting any of the [listed serious conditions] to clearly and concisely convey the nature of the medical emergency simultaneously to all interested parties ... Local protocols must clearly define the nature of the medical emergency with a two level code system that differentiates between a blood injury and all other injuries.”

54. The PSI goes on to recommend that 'code red' be used for incidents involving blood or burns, with 'code blue' for those involving difficulty breathing or collapses. The aim off these distinctions is, firstly, to help staff effectively communicate the nature of an emergency and, secondly, to assist medical (and other) staff who respond to identify the nature of the emergency and the relevant equipment required.

The Governor should ensure that a two level medical emergency response code is implemented and that this is communicated to and understood by all staff.

Calling an emergency ambulance

55. The nurse asked for an ambulance to be called shortly after her arrival at the man's cell. The call was made at 5.26am, some six minutes after the level one call for assistance was made. (The nurse and colleagues agreed that it took her around five minutes to make her way to the cell after the level one call was made.)

56. Local instructions at Bullingdon⁴ provide the following guidance to staff:

“All staff should understand that it is their responsibility to request an ambulance when they find a prisoner in a life threatening situation ... In order to avoid undue delay in summoning an ambulance, any member of staff

³ PSI 03/2013 was issued on 1 February 2013 with an effective date of 28 February 2013.

⁴ Notice to Staff 196/2012: Process for staff to summon an ambulance if a prisoner is discovered in a life threatening situation.

finding a prisoner in a potentially life threatening situation must call for medical assistance and request an ambulance using the radio call level one.”

57. Officer B said that she was unable to find a pulse when she assessed the man immediately on opening his cell, and that he felt clammy, cold and stiff. In these circumstances it would have been appropriate to call an ambulance immediately, in line with local instructions, rather than wait for the arrival of the nurse. (The instruction to summon an ambulance immediately when there are serious concerns about the health of a prisoner has since been issued nationally in PSI 13/2013.)

The Governor should ensure that all staff are aware of local and national guidance for calling an ambulance and understand that they should do so immediately whenever there are grave concerns about the health of a prisoner.

Cardiopulmonary resuscitation (CPR)

58. Neither the OSG, nor any of the prison staff who responded to his call for assistance, have up to date training in CPR. The OSG said he had never been trained, whereas Officer B said she had had basic training four and a half years previously, but did not think this was sufficient to deal with the circumstances of the man’s collapse.
59. As is standard throughout the Prison Service, response nurses at night do not carry keys and are collected by the night orderly officer or assistant if they are required to attend an emergency. The logistics of escorting nurses to a cell means that some time can pass before they are able to administer CPR or other appropriate treatment. In this case, around five to six minutes passed from the calling of level one before the nurse arrived at the cell and began CPR. This is a significant time that could potentially have a considerable impact on the final outcome and, as the clinical reviewer comments, the chances of successful CPR decline within minutes.

The Governor should ensure that all operational support grades working permanent nights have at least annual resuscitation training so they are able to respond appropriately to an emergency.

60. Officer B described the man as purple in appearance, and “clammy, cold and quite stiff”. She said she was unable to find a pulse. The nurse said that his arm was stiff and there was some cyanosis, although his neck was slightly warm. She was unsure if this meant that rigor mortis was established.
61. Although we have highlighted several areas where the emergency response might be improved, we cannot say with any certainty that any or all of these measures would have led to a different outcome. The clinical reviewer comments that the observations of staff, together with the post mortem findings, suggest that the man was already dead at the time he was discovered.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that hospital referrals are sent in line with GP instructions, and promptly followed up if receipt is not initially acknowledged.

Accepted

Our new HCC provider will set a system to ensure GP appointments are followed up.

2. The Governor should ensure that all operational support grades are aware of local procedures for entering a cell at night and understand that they may open a cell immediately if there are grave concerns about the health of a prisoner.

Accepted

Night instructions have been placed in all night patrol boxes. Re-published on the intranet 19/6/13.

3. The Governor should ensure that a two level medical emergency response code is implemented and that this is communicated to and understood by all staff.

Accepted

The new two level response code is now in place. It is available on the intranet and a copy has been placed in all night patrol boxes. Published on intranet 19/6/13.

4. The Governor should ensure that all staff are aware of local and national guidance for calling an ambulance and understand that they should do so immediately whenever there are grave concerns about the health of a prisoner.

Accepted

Medical instructions protocol is available on the intranet and has been placed in all night patrol boxes. Published on intranet 19/6/13.

5. The Governor should ensure that all operational support grades working permanent nights have at least annual resuscitation training so they are able to respond appropriately to an emergency.

Accepted

All operational support grades working permanent nights will be trained in basic adult life support, which will include automated external defibrillator (AED) techniques.