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 in February 2013 at HMP Oakwood

***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 a report of an investigation into the death of a man in February 2013 at HMP Oakwood. He was 54 years old. The cause of death was ischeamic heart disease. I offer my condolences to his family and friends.

A clinical reviewer reviewed the man's clinical care in prison. HMP Oakwood cooperated fully with this investigation.

The man had been in custody since May 2012. He was first held at HMP Birmingham, where he was prescribed medication for high blood pressure in October 2012. He had little other interaction with prison healthcare staff, either at Birmingham or Oakwood, where he was moved to in November. One morning at the beginning of February 2013, he alerted officers that he did not feel well. The officers said that he declined to have an out of hours doctor called but would wait until the morning to see healthcare staff. When officers checked his cell later, they found him unresponsive. There was a delay before staff began attempts to resuscitate him, and it took over 50 minutes for an ambulance to be called. When paramedics arrived at the prison, there was a further delay in getting them to the cell, by which time it was apparent that he had died.

The clinical review concludes that the man did not receive a good standard of care in relation to the screening and management of his high blood pressure, either at Birmingham or Oakwood. Similarly, when he reported chest pain at night, further advice should have been sought. I am particularly concerned about the poor standard of the emergency response. It is not possible to know whether a better and faster response would have affected the outcome for him, but it took too long to begin resuscitation and staff did not have access to, nor had they been trained to use, automated defibrillators. In addition, there was unacceptable confusion and delay about calling an emergency ambulance.

The man's death was the first that I have had to investigate at Oakwood. Unfortunately, the investigation identifies some serious failings and the Director needs to ensure that lessons are learned and emergency procedures improved as a matter of urgency.

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**

**CONTENTS**

Summary

The investigation process

HMP Oakwood

Key events

Issues

Recommendations

## SUMMARY


1. The man was charged with drugs offences and remanded into custody on 21 May 2012. He was sent to HMP Birmingham. On 9 October, he was convicted and sentenced to six years in custody.

2. On 29 October, the man saw a prison doctor at Birmingham who diagnosed that he had high blood pressure and prescribed medication. On 5 November, he was transferred to HMP Oakwood.

3. On 5 February 2013, the man saw another prison doctor who monitored his blood pressure and assessed that there were no health issues that would prevent him from using the gym.

4. One morning at the beginning of February, the man reported to prison staff that he had pains in his chest. Officers said they offered to call the out of hours doctor but he said that he would wait to see healthcare staff later in the morning. They did not seek further advice. At 4.52am, staff checked on him and found him unresponsive and not breathing. They did not start cardiopulmonary resuscitation (CPR) until 12 minutes later and, because of a communication failure it was a further 51 minutes before an emergency ambulance was called. Paramedics arrived at the prison by 6.11am but it was 6.20am before they got to his side. The paramedics confirmed that he had died.

5. The investigation has identified that the emergency response when the man was found unresponsive in his cell was unacceptably poor. We make recommendations about resuscitation, defibrillators and calling an emergency ambulance.

## THE INVESTIGATION PROCESS

6. The investigator visited Oakwood on 14 February 2013 and obtained relevant records about the man. Notices were issued to staff and prisoners inviting anyone with information to contact the investigator. No one came forward as a result. He met the Deputy Director and subsequently interviewed five members of staff. Written feedback about preliminary findings was given to the Director on 12 March.

7. A clinical reviewer was appointed to review the man's clinical care. The review is attached to this report.

8. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report. The investigation report has been sent to the Coroner.

9. A family liaison officer contacted the man's family to inform them about the investigation and to invite his family to ask any questions or raise any concerns. The man's partner believed that he had not seen a doctor in prison and that he had not seen an optician. His daughter was concerned that there had been no formal inspection of HMP Oakwood since it opened, that the staff were inexperienced, that there is no medical staff onsite 24 hours a day and that defibrillators were locked away at night. These points are addressed in the report.

**HMP OAKWOOD**

10. HMP Oakwood is managed privately and began to take prisoners on 24 April 2012. It is adjacent to HMP Featherstone and HMP Brinsford near Wolverhampton. Oakwood is one of the largest prisons in England and Wales, providing places for up to 1,605 Category C male prisoners.

11. A NHS Trust provides the heathcare services at Oakwood. The service is provided between 7.30am and 8.00pm with a minimum of two surgeries each day. Dental services are provided four days a week and an optician visits three times a month. There are nurse-led clinics for long-term conditions such as for diabetics. An out of hours doctor service is provided by a private company, which provides telephone advice and visits to the prison.

12. Each prison has an Independent Monitoring Board made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. As a new prison, at the time of writing this report the IMB at Oakwood had not yet published an annual report. Neither had the prison been inspected by HM Inspectorate of Prisons.

13. The man's death was the first to occur at HMP Oakwood.

## KEY EVENTS

14. On 21 May 2012, the man was remanded into custody at HMP Birmingham charged with serious drug offences. When he arrived, a nurse carried out a routine initial health screen to determine any immediate physical and mental health needs. He told the nurse that he had been in custody before, had never used drugs and did not smoke but that he experienced shortness of breath on exertion. He said that he had been prescribed omeprazole (for excess acid in the stomach) by his community doctor but he had not seen a GP for several months.

15. On 22 May, the man declined to have a second healthscreen (a more in-depth assessment of physical and mental health conditions) but gave his consent for the prison to contact his community doctor.

16. A health centre provided the prison with a summary of the man's medical history and prescribed medication on 24 May. This confirmed that he had been prescribed omeprazole on 30 March 2012, for gastro-oesophageal reflux. He had also suffered a stab wound to the chest in 2007 which had resulted in shortness of breath and chest pain.

17. On 27 June, the man saw the visiting optician, who completed a full eye test and prescribed reading glasses. He received his glasses on 4 July. On 4 October, he requested an appointment to see a doctor. The appointment was on 8 October but he chose to go to an IT course instead.

18. On 9 October, the man appeared at Crown Court and was convicted of drug offences and sentenced to six years in custody. On his return to HMP Birmingham, a nurse saw him to see if he had any concerns following his sentence. He told the nurse that he was fine. On 12 October, he was given another doctor's appointment for 16 October but again he did not attend.

19. On 23 October, a nurse saw the man and recorded his blood pressure as 175/108. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) The nurse arranged for his blood pressure to be taken again two days later, when it was 165/112. The next day, 26 October, a nurse recorded his blood pressure as 175/113. The nurse arranged for him to see the doctor the next day and for another blood pressure reading to be taken.

20. On 27 October, a nurse recorded the man's blood pressure as 191/118. That afternoon a prison doctor saw him. He prescribed bendroflumethiazide for high blood pressure and arranged a review.

21. On 29 October, a doctor saw the man and recorded his blood pressure as 158/96. He told the doctor that his father had suffered from high blood pressure but died from bowel cancer, as did his sister who died at the age of 50. He also told the doctor that as a result of being stabbed in 2007, he got out

of breath when he ran upstairs. Later the pharmacy queried the appropriateness of the prescription of bendroflumethiazide. Another prison doctor changed this to indapamide, another medication for high blood pressure.

22. On 5 November, the man transferred to HMP Oakwood. A nurse recorded his blood pressure as 156/106 and noted that he had been prescribed omeprazole and indapamide. He told the nurse about his family history and said he did little exercise.

23. In February 2013 a prison doctor saw the man to review his medication and his suitability to use the gym. The doctor recorded his blood pressure as 120/85 and requested blood tests and an ECG (electrocardiogram) to monitor his blood pressure. He told the doctor that he was happy to go to the gym and the doctor noted that this would be appropriate.

24. The next morning, at 3.29am, the man pressed his emergency cell bell. Two Prison Custody Officers (PCOs) went quickly to his cell. He told the officer that he had chest pains. PCO 1 asked him to show exactly where the pains were and he indicated towards his throat and said that he had the pain for about twenty minutes.

25. PCO 1 immediately went to the wing office and rang the Night Orderly Officer (NOO - the senior member of staff in charge of the prison duty during the night) to tell him about the man. The NOO asked PCO 1 to ask him what medication he was taking.

26. At 3.31am, both PCOs returned to the man's cell. He showed PCO 1 his blood pressure medication but said that the pain had now subsided. The PCO told the investigator that she had explained to him that an on-call doctor could be called but he had said he was willing to wait to see someone from healthcare later that morning. She told him that she would check on him regularly throughout the rest of the night and he agreed to leave his cell light on.

27. PCO 1 checked on the man at 3.51am and saw him walking around his cell. He told the officer that the pain had returned but gone again and that he was alright at the time. She returned to his cell at 4.11am and saw him sitting up on his bed.

28. At 4.52am, PCO 2 was doing the early morning roll count (a check of all the prisoners in the prison) when she arrived at the man's cell. She looked through the observation panel and saw that he was lying on the top of his bed covers, dressed only in his underwear. She noticed that his skin was slightly pigmented and he appeared not to be breathing. She called to PCO 1, who was on the other side of the wing, to come and see him. PCO 1 looked into the cell and radioed the NOO to tell him she was going into the cell.

29. PCO 1 went into the cell while PCO 2 remained at the door. PCO 1 checked for a pulse but could not find one. PCO 2 pressed her personal alarm which raises an alarm in the control room. As she did not get a response on the radio after 10 seconds, she ran to the office while PCO 1 remained with the man.

PCO 2 telephoned the communication room to get assistance from the NOO and said that the man was not breathing and had no pulse.

30. PCO 2 told the investigator that she had been unable to start cardiopulmonary resuscitation (CPR) as it had been such a shock to see the man. PCO 1 said that she did not start CPR straight away as she had panicked.

31. At approximately 5.05am, the NOO and another PCO arrived at the man's cell and checked him for vital signs, but were unable to find any. PCO 3 said at interview that he then contacted the control room and gave the man's name, his cell number, that he was not responsive and that an emergency ambulance was required. The protocol at the prison was that all requests for ambulances had to go through the control room, which then contacted and liaised with the emergency services.

32. A Prison Security Officer (PSO) was on duty in the control room. As part of that role the officer is required to maintain a log during the night, called the occurrences log, and complete a separate running log for emergency incidents. The officer recorded in both logs, at 5.05am that the NOO and PCO 3 had been asked to attend the man's cell. The PSO told the investigator that PCO 3 had told her that the man was unresponsive and an ambulance had been called.

33. PCO 3 started CPR assisted by PCO 1. PCO 2 was instructed to open the internal gates in readiness for the ambulance. The NOO went to organise other staff in the prison.

34. At 5.28am, the PSO recorded in the occurrence log that the ambulance was on the way. She recorded in the running log recorded an ambulance had been called. PCO 3 and PCO 1 continued CPR and PCO 3 asked the control room when the ambulance was expected. He was told it was on the way.

35. At approximately 5.50am, the NOO contacted the PSO to ask where the ambulance was. The PSO told him that PCO 3 had called the ambulance. The NOO contacted 999 to check the time of arrival of the ambulance but was told that one had not been requested. He asked for an emergency ambulance to be sent as soon as possible. The Ambulance Service records show that the call for an ambulance to attend Oakwood was received at 5.56am and the paramedics were dispatched at 5.58am. CPR continued throughout this time.

36. The PSO entered in both control room logs at 6.02am that the ambulance service was called to check for an arrival time for the ambulance. She recorded that they said that an ambulance had not previously been requested.

37. Ambulance records show that the first responder arrived at Oakwood at 6.08am followed by the paramedics at 6.11am. The paramedics recorded that they were at the man's side at 6.20am and it was immediately apparent to them that he had died. They confirmed this at 6.21am.

## Contact with the man's family

38. At 9.30am, on 6 February, the Director of Oakwood and a prison family liaison officer visited the man's partner to break the news of his death and to offer support. Later that morning, his daughter contacted the prison and spoke to the Head of Safer Custody to ask about the circumstances of her father's death. Oakwood maintained contact with the family to provide ongoing support and financial assistance towards the funeral expenses.

## Support for staff and prisoners

39. A debrief was held at 8.30am for staff involved in the emergency incident to discuss what had happened and to offer support. The services of the care team were made available.

40. Officers and members of the chaplaincy were available to support prisoners affected by the incident. Prisoners subject to suicide and self-harm monitoring (ACCT) had their cases reviewed in case they had been adversely affected by the man's death.

## ISSUES

### Clinical Care

41. The clinical reviewer has considered the man's healthcare provision. He noted that at Birmingham he was not screened for high blood pressure and, when it was eventually diagnosed, was not given any of the appropriate screening investigations (with the exception of a fundoscopy which was carried out coincidentally by an optician). He was also given medication that is no longer recommended for high blood pressure, at a dose that was inappropriate. He concluded that, in his opinion, the care given to him fell well short of that expected in the community.

42. The National Institute for Health and Care Excellence (NICE) issued guidance, *Hypertension: clinical management of primary hypertension in adults (CG127)*, in August 2011, on the care, treatment and monitoring of adults with high blood pressure. We agree with the clinical reviewer that the management of the man's high blood pressure was not to the standard he could have expected in the community and we make the following recommendation:

    **The Heads of Healthcare at HMP Birmingham and HMP Oakwood should ensure that all staff follow NICE guidance for the treatment of prisoners with high blood pressure, and ensure that appropriate medication is prescribed.**

### Emergency response

43. The clinical reviewer commented on the initial response when the man complained of chest pain:

    > 'When he complained of chest pains with radiation up to his throat, he was not referred immediately to hospital and no medical advice consulted as to the likely severity of the symptoms presented. All staff at night are first aid trained, however, so the lack of action/referral is hard to explain.'

44. The NHS advises that if someone has pain in the middle of the chest or pain spreading from the chest to the upper back, neck, shoulder blades and arm, should seek emergency help immediately. When he complained of chest pain, the man told staff that he would wait to see healthcare staff the following morning rather than see an on-call doctor. However, he had also told them that he was taking medication for high blood pressure and later said, when checked by PCO 1, that he had suffered a further bout of pain. In these circumstances, we believe staff should either have called the on-call doctor or an emergency ambulance. It is important that staff are aware of the need for prompt and appropriate action in relation to chest pain, especially at night. We therefore make the following recommendation:

    **The Director and Head of Healthcare should introduce a chest pain protocol which gives guidance for all staff on how to deal with cardiac events.**

45. The man was found unresponsive at approximately 4.53am, but even though all the staff on duty that night were first aid trained, it was a further 12 minutes before CPR started. No automated defibrillator was available as they were all locked in the healthcare department. Even if the defibrillators had been accessible, none of the staff had received training in how to use one. In his report, the clinical reviewer noted that defibrillators should be available in each houseblock, and staff trained to use them. We agree and make the following recommendation:

    **The Director should ensure that all staff receive 'Heart Start' training and that defibrillators are readily available on each houseblock.**

46. Oakwood's policy for requesting an emergency ambulance states:

    > 'Any member of staff arriving at the scene of a medical emergency, including self-harm or attempted suicide, have the authority to summon an ambulance via Control using either the correct radio procedures or the telephone.'

47. PCO 3 told the investigator that he made a request for an ambulance to the control room, at approximately 5.05am. However, the PSO thought that PCO 3 had called the ambulance. It was only when the NOO contacted the Ambulance Service after 5.50am that it became clear that an ambulance had not previously been called. This means that there was a 51 minute delay in calling an ambulance from the time that staff started CPR. Such a delay is wholly unacceptable.

48. When the ambulance arrived it then took 12 minutes for the paramedics to reach the man's cell. This is also too long.

49. National guidance, titled '*Responding to Medical Emergencies'*, was issued to all prison staff in October 2012. This guidance states:

    > ''It is essential that an ambulance is called in all cases where there are serious concerns about the immediate health of a prisoner and that access to both the prison and the individual prisoner is not delayed."

    This guidance is also now reflected in Prison Service Instruction 03/2013 about medical emergency response codes.

50. While it is not clear whether the immediate investigation by acute specialists would have made a positive difference to the outcome for the man, the failure to call an emergency ambulance is a serious lapse in care. In some cases it would make the difference between life and death. There was also an unacceptable delay before the paramedics reached him after they had arrived at the prison. We therefore make the following recommendation:

**The Director should ensure that an ambulance is called quickly whenever there are serious concerns about the immediate health of a prisoner and that there is no delay in ambulance staff reaching prisoners when they arrive.**

51. In his report, the clinical reviewer comments on the actions of PCOs 3 and 1:

> 'I would commend the actions of both officers for continuing CPR for one and a quarter hours, when they believed an ambulance had been called, and was on its way.'

We agree with him that the officers acted commendably in difficult circumstances.

## RECOMMENDATIONS

1. The Heads of Healthcare at HMP Birmingham and HMP Oakwood should ensure that all staff follow NICE guidance for the treatment of prisoners with high blood pressure, and ensure that appropriate medication is prescribed.

   *Accepted by Birmingham and Oakwood*

   *Medical Staff at HMP Birmingham are aware of NICE Guidelines. The first line medication will need blood taken before prescribing (ACE, ARB) to monitor kidney function.*

   *If we do not have recent blood tests then another medication may be prescribed in the short term if required.*

   *We will ensure that all GPs are aware of NICE guidelines*

   *The Head of Healthcare at HMP Oakwood will ensure that all staff follow NICE guidance for the treatment of prisoners with high blood pressure, and ensure that appropriate medication is prescribed.*

   *NICE guidance for the treatment of prisoners with high blood pressure will be adhered to and audits will be undertaken annually to ensure compliance. This is existing practice in HMP Oakwood.*

2. The Director and Head of Healthcare should introduce a chest pain protocol which gives guidance for all staff on how to deal with cardiac events.

   *Accepted*

   *The Director and Head of Healthcare will introduce a chest pain protocol which gives guidance for all staff on how to deal with cardiac events. This will be prepared by Healthcare in conjunction with the Director.*

   *Guidance will be given to staff during staff briefing and pocket guides will be issued.*

   *An emphasis will be placed on the protocol in all future initial training of PCOs.*

3. The Director should ensure that all staff receive 'Heart Start' training and that defibrillators are readily available on each houseblock.

   *Accepted*

   *Funding will be sought to purchase appropriate numbers of Defibs Including training for Operational Staff.*

   *Clarification has been received from the PPO that the First Aid at Work Course completed by all operational staff at HMP Oakwood includes CPR of a*

*standard equal to that in Head Start courses. Our operational staff will therefore, only be required to complete the additional Defibrillator training.*

4. The Director should ensure that an ambulance is called quickly whenever there are serious concerns about the immediate health of a prisoner and that there is no delay in ambulance staff reaching prisoners when they arrive.

   *Accepted*

   *The Director will ensure that an ambulance is called quickly whenever there are serious concerns about the immediate health of a prisoner.*

   *Protocol to be in place in accordance with PSI 03/2013.*

   *Guidance will be given to staff during staff briefing and pocket guides will be issued. An emphasis will be placed on the protocol in all future initial training of PCOs.*