PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man in November 2011 at outside hospital, while in the custody of HMP Hewell

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Hewell, who died in November 2011. He was 40 years old. A post mortem recorded that his death was caused by heart disease. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. Worcestershire Primary Care Trust appointed a clinical reviewer to conduct a review of the clinical care the man received while in custody. Hewell prison cooperated fully with the investigation. I am sorry this report is late.

An officer discovered the man unresponsive when unlocking in the morning, resuscitation attempts were quickly started and an ambulance called. He was taken to outside hospital where he was pronounced dead shortly after his arrival.

While I do not believe that prison staff could have predicted or prevented the man's death, the investigation found some areas for improvement particularly the need to follow up health issues indicated on arrival at the prison, such as identified alcohol problems and raised blood pressure readings. There is also a need for the prison routinely to obtain community GP records to get the full background of prisoners' health. Sadly, as the man had no previous known history of heart disease, this would not have affected the outcome in his case.

The recommendations made in the draft report have been accepted by HMP Hewell. I have included the prison's response to the recommendations at the end of this report.

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 **October 2012**

CONTENTS

SUMMARY

1. The man was born in 1971. He was 40 years old when he died in November 2011 at outside hospital. He died from heart failure caused by heart disease.

2. On 31 October 2011, the man was arrested for assault. He was given bail and, as part of his conditions, he was not to visit his home address. He breached these conditions the following day and was arrested for a second time. On 2 November, he was remanded into custody and arrived at HMP Hewell later that day.

3. During his reception health screening interviews, the man disclosed a history of alcohol dependency and a family history of diabetes. He also smoked.

4. On a morning in November, prison officers found the man apparently unconscious in his cell. They immediately began to attempt resuscitation and asked for medical assistance and an ambulance to be called. Paramedics arrived and he was taken to hospital. He was escorted by two officers and no restraints were used. Despite extensive efforts to resuscitate the man at the prison and the hospital, he was pronounced dead at 9.29am.

5. The clinical review considered the care provided for the man throughout his time in prison and the emergency response when he was discovered. Although the clinical reviewer believes the man's disclosed alcohol misuse could have been assessed and treated differently when he arrived, she concludes that his death could not have been foreseen or avoided. She notes that the emergency response was well organised and efficient. We make three recommendations about following up screening results, referrals for alcohol misuse and the need to obtain community GP records.

THE INVESTIGATION PROCESS

6. This office was informed of the man's death on 15 November 2011. The investigator issued notices to staff and prisoners at Hewell informing them of the investigation and asking anyone who had relevant information to contact him. No responses were received. The investigator examined the man's relevant prison and medical records.

7. A clinical reviewer was appointed by Worcestershire Primary Care Trust to review the medical care provided for the man during his time in custody. The purpose of the review was to establish whether the care which he received in prison was comparable with that he would have been offered in the community and to identify any points of learning. The clinical reviewer's report was received on 3 May 2012.

8. The investigator contacted Her Majesty's Coroner to inform him of the investigation and to request a copy of the post mortem report. This report will be sent to the Coroner to assist his enquiries.

9. Another investigator visited HMP Hewell on 15 November to begin the investigation and spoke to staff involved in the man's care. The investigator with overall conduct of the case visited Hewell on 13 December to interview a staff nurse and a prisoner in the cell next to the man's. The investigator returned again on 12 January 2012 and interviewed an officer and Senior Officer. The investigator discussed the emerging issues with the Governor on 13 December and subsequently confirmed this in writing.

10. We are sorry this report is later than anticipated. This is because we needed to make further enquiries with both the clinical reviewer and Department of Health relating to the trigger points and assessment for alcohol treatment.

11. One of our family liaison officers contacted the man's brother. He was informed about the purpose of the investigation and offered the chance to raise any concerns or questions that he wished to be considered. His brother had concerns about his brother's care while he was in custody as he seemed in good health before he arrived at Hewell and wanted to know if he was assessed and treated for his alcohol problem appropriately. The man's brother was also concerned about an injury he appeared to have suffered to his head. The man's family received a copy of the draft report and did not raise any further concerns.

HMP HEWELL

12. HMP Hewell was created on 24 June 2008 by merging three separate prisons which were located on adjacent sites- the former, HMPs Blakenhurst, Brockhill and Hewell Grange. The Brockhill site was closed in September 2011. Hewell primarily accepts prisoners from courts in the West Midlands. The prison holds up to 1431 men who are either on remand or already convicted and sentenced.

HM Inspectorate of Prisons (HMIP)

13. The last inspection of HMP Hewell by the HMIP was in November 2009. The Chief Inspector noted that:

> "Managers had placed a commendable focus on safety, and most prisoners in the closed part of the prison reported feeling safe … The central reception was enormously busy, but professional and efficient. First night arrangements required development, specifically the new arrangements for Houseblocks 1-6." (The former HMP Blakenhurst was where the man was held.)

14. Inspectors who examined reception procedures at Hewell found that:

> "Healthcare staff screened new arrivals ... Prisoners with alcohol detoxification needs were given necessary medication on the first night with out-of-hours doctors attending where necessary. Acute cases of alcohol withdrawal were referred to the local hospital."

15. Inspectors noted that an administrator on the induction wing contacted prisoners' GPs for a summary of their clinical record and prescriptions, which ensured that clinical information was obtained as soon as possible.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor day to day life in the prison to help ensure prisoners are treated fairly and humanely.

17. The most recent annual report published by the IMB at Hewell covers the period from 1 December 2010 to 30 November 2011. The IMB noted that Hewell had been selected as one of four prisons working on a national project to support prisoners with alcohol misuse issues (although the project had not started at the time of this man's death). The IMB confirmed that the man had not contacted them in the short time he was at Hewell.

Previous deaths at Hewell

18. Before this man's death, the Ombudsman had investigated eight natural cause deaths at Hewell. None of the previous investigations raised any issues pertinent to the circumstances of this man's death.

KEY EVENTS

19. The man was born in 1971. He was 40 years old when he died in November 2011 at outside hospital.

20. On 31 October 2011, the man was arrested for assault and given bail. As part of his bail conditions he was not allowed to return to his home address. On the following day, he was arrested for breach of these conditions. He was remanded into custody on 2 November by a magistrates' court and arrived at HMP Hewell the same day. This was his first time in prison.

21. Each newly arriving prisoner is given a first reception health screening interview, which should highlight any immediate mental or physical health problems requiring referral to the doctor or other specialist service. During the man's first reception screening interview at Hewell, he told a nurse that he had history of alcohol dependency. He also said that he was a smoker but chose not to accept help to stop.

22. The nurse said that the man reported that he drank 60 units of alcohol a week. This did not result in a referral to a doctor or specialist services for alcohol detoxification as the first reception health screening tool advises referral when this is more than 20 units daily or if the prisoner is showing signs of withdrawal. The nurse said that the man appeared fit and well and she had no concerns about his health. After his first reception screening interview he was allocated a single cell on Houseblock 6.

23. On 4 November, a nurse conducted a second health screening interview with the man. This is a general health assessment equivalent to a primary care assessment when registering with a GP in the community. It provides an opportunity for gathering further health information, health education and promotion, and importantly checking how a prisoner is settling in. The man's blood pressure was a little high at 136 over 96 (most adults in the UK have blood pressure readings in the range from 120 over 80 to 140 over 90). When interviewed as part of this investigation, the nurse said that "there was nothing on the secondary health screen that would stand out as a problem". He stated that the man had a good body mass index and his blood pressure was within normal limits. He also said that the man said he had a family history of Type 2 diabetes, but that this was unremarkable.

24. During his time in the prison the man lived on Houseblock 6, where most new arrivals at Hewell first live. Staff on the houseblock did not make any records about him during his time there, so there is no recorded information about him after his reception and healthcare screening. A prisoner who lived in the cell next to the man was an Insider at Hewell. Insiders welcome new prisoners and give them information about the routine. He told the investigator that he saw the man the day before his death and he appeared well. He had given the man a cigarette and they had exchanged pleasantries.

25. The investigator checked the electronic cell bell records for the day before the man's death and the day of his death. There is no record of him using his cell

bell to summon assistance after his cell door was locked at 8.00pm on the evening before his death. At that time the day shift staff on Houseblock 6 handed over responsibility to an Operational Support Grade (OSG).

26. On the day of the man's death, between 5.00am and 5.30am, an OSG conducted a roll check to ensure that all prisoners were accounted for. He noted that all of the prisoners on Houseblock 6 were in their cells. At 8.13am, an officer started unlocking prisoners. He unlocked the Insider before going on to unlock his neighbour, the man. The officer saw the man sitting on a chair in his cell with his head leaning back. He pushed the door open and asked if he was okay. When the man did not reply the officer entered the cell and the neighbour followed him.

27. The officer found that the man was grey and unresponsive. He immediately radioed for assistance. The control log shows that he called for a code blue response (a radio code which is used to indicate an emergency where someone was not breathing) at 8.15am. He asked the man's neighbour to leave the cell and was joined by a Senior Officer (SO) and an officer.

28. They moved the man onto the floor of the cell to begin cardio pulmonary resuscitation (CPR – a mixture of chest compressions and rescue breaths in order to maintain an oxygen flow around the body). They were quickly joined by a nurse in response to the emergency call. A further two nurses and a senior officer also arrived and took over CPR. A defibrillator was used which indicated that CPR should continue, and at one point recommended that a shock should be applied. Healthcare staff continued CPR until paramedics reached the cell shortly after 8.36 or 8.40, when the ambulance arrived at the prison. (There is a slight discrepancy between the prison's and the ambulance service's timings.)

29. At 9.10am, the man was taken to outside hospital accompanied by two officers. Restraints were not used. The ambulance arrived at the Accident and Emergency (A&E) department at outside hospital at 9.20am and hospital staff took over the man's care from the paramedics. He remained unconscious. At 9.29am the officers were informed that the man had died.

30. Staff told the other prisoners of the man's death later that morning. One of the prison chaplains spoke to the man's neighbour on his own. Other prisoners on the man's houseblock were asked whether they required any support or wanted to speak to a Listener (a prisoner trained by the Samaritans to offer emotional support to fellow prisoners who might be at risk of suicide or self harm). All prisoners on self-harm and suicide monitoring were reviewed.

31. An operational manager held a "hot debrief" later that day for the staff involved in finding and attempting to resuscitate the man. The aim of such a debrief is to focus on reassurance, information sharing and mutual support. No specific areas of concern were raised and staff were offered support from the prison's care team.

32. After the man died, Hewell appointed a family liaison officer and she and the governor went to see the man's family at about midday to inform them of his

death. The family liaison officer maintained contact with his family, assisted with the funeral arrangements and offered the prison's support towards the costs. The funeral took place on 2 December 2011.

Post mortem

33. The post mortem report recorded that the man's death was due to natural causes, as a consequence of acute cardiac (heart) failure caused by ischaemic heart disease.

ISSUES

Clinical care

34. A review of the man's medical care was carried out by a clinical reviewer on behalf of Worcestershire Primary Care Trust. In her review, she notes that when the man arrived at Hewell he gave no history of cardiovascular disease in his family and said he had not seen his own GP in the previous few months. The records show that he only had contact with healthcare staff during the reception process and at no other time while he was at Hewell. There is no evidence that he was unwell in any way and, despite his previous heavy alcohol consumption, no evidence that he experienced alcohol withdrawal symptoms.

35. On his arrival at Hewell, the man reported that he consumed approximately 60 units of alcohol a week before coming into prison. The clinical reviewer refers to the Government and British Medical Association Guidelines, saying the recommended levels for alcohol consumption are currently 21-28 units per week for men. Consumption of over 50 units per week is recognised as dangerous and likely to result in illness or long-term damage to health.

36. The clinical reviewer considers that the man should have been referred for assessment by the substance misuse team. In her experience as a prison doctor, she said she would have also offered him advice about his drinking and the likely problems it could cause. The clinical reviewer writes:

> "Whilst this would have been best practice in the management of alcohol abuse there is no evidence to suggest that this would have reduced the risks of [the man] suffering a fatal cardiac arrest or sudden cardiac death, nor could it have changed the final outcome for [the man]."

37. The clinical reviewer notes that, from interviews with healthcare staff, the man's level of alcohol intake was not considered significant according to the national reception screening tool used at Hewell. It was reported that only alcohol consumption of over 100-140 units per week would trigger a referral to the substance misuse team. The clinical reviewer believes this to be a very high trigger point and she confirmed that a comparable local prison used a much lower trigger point for referral.

38. In the clinical reviewer's opinion, a history of alcohol consumption at this level should have been recognised as a significant health risk by the nurse undertaking the reception screen. She believes that the man should have been questioned more closely about his alcohol intake and history and referred to the substance misuse team. However, she does not consider this needed to have been done urgently.

39. The nurse carrying out the initial reception screening was using the national screening tool, which, in the case of alcohol use, clearly states: "If more than about 20 units daily or showing signs of withdrawal, refer to doctor or relevant

clinic". The purpose of this is to identify prisoners who need urgent clinical support to help with alcohol withdrawal symptoms. The records do not suggest that the man was showing any signs of alcohol withdrawal and he appeared to the nurse to be fit and well. The clinical reviewer is concerned that the screening tool does not recognise 60 units per week as a hazardous level of drinking, and believes that this should be reviewed. We understand that the man did not need an urgent referral to specialist healthcare professionals to deal with alcohol withdrawal on his first night, but we consider that when prisoners report hazardous levels of drinking they should be referred to appropriate services. We make the following recommendation:

The Head of Healthcare should ensure that all staff screening newly arrived prisoners are aware of the guidance on the health risks of excessive alcohol consumption and where necessary refer prisoners to appropriate services, even if they do not reach the trigger for immediate assessment and treatment.

40. The clinical reviewer also notes that when the man's blood pressure (BP) was taken in the second health screen, it showed a rise in the diastolic reading (the bottom number in the blood pressure reading.) Although it is not possible to diagnose high blood pressure from a single reading, and there are many reasons why the man's blood pressure could have been elevated, the clinical reviewer states that diastolic hypertension is known to be more common in younger people. This, in combination with his history of alcohol abuse, should have triggered a routine referral to a prison doctor or at least a repeat of the blood pressure readings. This was not identified during the man's health screening and the nurse stated in interview that his blood pressure was "within normal limits". We agree with the clinical reviewer that during the screening process healthcare staff should be able to identify issues that might need further investigation. We therefore recommend:

The Head of Healthcare should ensure that nursing staff carrying out health screen interviews are appropriately skilled to recognise and act on abnormal or potentially clinically important findings in routine investigations, such as blood pressure readings.

41. The man's family were concerned about how sudden his death was. The clinical reviewer says that in a younger person it is not uncommon for a cardiac arrest to be "sudden and catastrophic" without the early warning signs of angina, hypertension or breathlessness that might be present in someone older. The clinical reviewer says that high levels of alcohol consumption and smoking increase the risk for an individual, as does a family history of early or sudden death. The man gave no history of heart disease in his family but he drank alcohol well above the recommended limit and also smoked.

42. We asked the clinical reviewer whether the man's alcohol misuse could be directly linked to his death. In particular, the fact that he had been drinking around 60 units a week before coming into prison which had suddenly been stopped with no support. The clinical reviewer said that she did not believe any link could reasonably be drawn. Withdrawal symptoms tend to occur within two

to three days and peak at five days without treatment. Death from alcohol withdrawal tends to be from seizures. He had none of these symptoms. The clinical reviewer's view was that the man's alcohol consumption was part of an unhealthy lifestyle which can lead to cardiovascular disease.

43. The post mortem confirmed that the man died of an acute myocardial infarction (heart attack) and that he suffered from ischaemic heart disease. The clinical reviewer states that this is unusual in a man of 40 years of age and was likely to have been exacerbated, if not caused, by his smoking and his alcohol abuse. She writes:

> "Alcohol is known to increase the risk of sudden cardiac death in heavy drinkers and cause heart problems such as cardio-myopathy (enlargement of the heart) and prolonged QT syndrome (an abnormality of the normal cardiac rhythm which can result in sudden death)."

44. The clinical reviewer finds that the man did not report to healthcare or prison staff that he had experienced chest pain, shortness of breath or a feeling of an irregular pulse rate, all possible symptoms of cardiac distress. From his reception screen there was little to suggest that he was at risk of sudden cardiac death. She concludes:

> "[I] believe, however, that the Healthcare Department at HMP Hewell failed to recognise or acknowledge [the man's] alcohol misuse as a significant health problem but I do not believe that this had any impact on [the man's] risks of an acute MI [myocardial infarction – heart attack] nor on his chances of surviving such an event."

45. The post mortem report also refers to the man's "chronic history of alcohol abuse" and refers to his GP records. The prison did not know whether there was anything relevant in the man's GP records that should have been considered by healthcare staff at Hewell as they had not requested them. When the man arrived at Hewell, he said that he was alcohol dependent and had been drinking 60 units a weeks. He said that he had not had recent contact with his GP, but this should not have prevented the prison requesting his GP records. Such records ensure that prison healthcare staff have a full history, confirmation of any health problems and treatment, and ensures continuity of care. HMI Prisons noted in the last inspection of Hewell in 2009 that GP records were routinely requested and it is disappointing to find it did not happen with this man. While we accept that this would not have affected the outcome for him, in other cases it will provide important information about a prisoner's past medical history. We therefore make the following recommendation:

The Head of Healthcare should ensure that General Practitioner records are routinely requested as soon as possible after a prisoner arrives at Hewell.

46. The man's family were concerned that when they viewed his body he had bruising and a cut on the top of his head. Healthcare staff and officers who attended to him on the day he died did not note any bruising or injuries to his head. The clinical reviewer believes this could have occurred after the man died. It is possible that his head was resting against a hard surface, or the trolley he was on was angled slightly downwards. This would cause a natural pooling of blood which would have produced the appearance of bruising or blue-purple discolouration in the skin. However, only a pathologist would be able to confirm the exact or most likely mechanisms which resulted in these markings. The post mortem examination noted the bruising to the man's head but did not give any explanation for this.

The emergency response

47. Staff discovered the man unconscious and unresponsive at morning unlock. An officer immediately radioed for assistance and was joined within moments by healthcare staff who used a defibrillator. This advised that CPR should continue and, at one point, recommended a shock be applied. An ambulance had been called, and attempts continued to resuscitate the man. Paramedics arrived shortly afterwards and took him to hospital where he was pronounced dead shortly after arrival. From both the records and the investigator's interviews with staff it appears that, after he was discovered, all those involved acted quickly and professionally.

48. The clinical reviewer notes that survival from a "significant" cardiac event, even in hospital, is unusual. She states that there was "little doubt that [the man] was given the best possible chance of resuscitation in the circumstances by the prompt and efficient actions of the prison and healthcare staff and commends their actions.

CONCLUSION

49. The man arrived at Hewell in November 2011. During the morning unlock, nearly two weeks later, staff found the man unconscious and unresponsive. An ambulance was called and attempts to resuscitate him began almost immediately. Paramedics decided to take him to outside hospital but he was pronounced dead soon after his arrival.

50. When the man arrived in custody he informed healthcare staff of a history of high alcohol consumption. He did not meet the high trigger point for immediate assessment for alcohol detoxification in the national screening tool. We consider he should have been referred for later assessment. As part of his secondary screening his blood pressure was taken. One of the readings showed a rise which was not followed up. The prison did not obtain his community GP records, which would have given further information on his alcohol use and other health background.

51. However we agree with the view of the clinical reviewer that the man's cardiac arrest could not reasonably have been foreseen and it was not possible for any actions to have been taken by the prison to avoid his death.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included in italics below each recommendation.

1. The Head of Healthcare should ensure that all staff screening newly arrived prisoners are aware of the guidance on the health risks of excessive alcohol consumption and where necessary refer prisoners to appropriate services, even if they do not reach the trigger for immediate assessment and treatment.

   Accepted: The current screening tool will continue to be used to identify prisoners for assessment and treatment. Prisoners stating that they are alcohol dependant will be referred for less urgent intervention.

2. The Head of Healthcare should ensure that nursing staff carrying out health screen interviews are appropriately skilled to recognise and act on abnormal or potentially clinically important findings in routine investigations, such as blood pressure readings.

   Accepted: Staff will be reminded that all prisoners demonstrating clinical observations outside the normal range should be recalled for further assessment within an appropriate timescale.

3. The Head of Healthcare should ensure that General Practitioner records are routinely requested as soon as possible after a prisoner arrives at Hewell.

   Accepted: A protocol will be developed to establish a new process for requesting GP records for prisoners arriving at Hewell.