PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at hospital in July 2013, while a prisoner at HMP Nottingham

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 investigation report into the death of a man, a prisoner at HMP Nottingham, in July 2013. He was 51 years old and died of heart failure. I offer my condolences to his family and friends.

A clinical review was conducted into the clinical care the man received in prison.

The man arrived at Nottingham on the evening of 8 July. He was initially given medication for alcohol detoxification and monitored overnight, but the next morning the prison doctor decided the treatment was unnecessary as he did not have withdrawal symptoms. That afternoon, he had a seizure in his cell. He was taken to hospital but died the next day.

The clinical reviewer concludes that healthcare staff at Nottingham could not have anticipated the man's sudden decline in health and subsequent death from heart failure. He is satisfied that the care that he received was equivalent to that which he could have expected in the community.

However, I am concerned that the prison had not introduced the mandatory national requirement that an ambulance be called immediately in a medical emergency and this led to some delay. I am also concerned that the man's medical condition was not adequately taken into account when assessing his security risk, resulting in him being chained unnecessarily to an officer in hospital until just before he died. Finally, there was a delay in notifying his mother that he had been admitted to hospital as an emergency, which also led to some confusion and delay in notifying her of his subsequent death.

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 **March 2013**

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SUMMARY

1. The man arrived at HMP Nottingham on 8 July. He had spent the previous night in police custody. At an initial health screen, a nurse noted that he had symptoms of alcohol withdrawal and referred him to the prison doctor for an alcohol detoxification programme.

2. A doctor saw the man that evening and decided he should stay in the prison's enhanced care area for observation by healthcare staff overnight. He prescribed him a course of alcohol detoxification medication as a precaution, although he told the investigator that he thought on balance he probably did not need it.

3. Nurses checked the man during the night and no concerns were noted. On the morning of 9 July, a Healthcare Assistant (HCA) recorded that his blood pressure, heart rate and temperature were all normal and that he had no symptoms of alcohol withdrawal. After discussing his presentation with the HCA, the doctor decided to stop his alcohol detoxification medication, but said he should remain in the enhanced care area (ECA) on F wing, where nurses are on duty 24 hours a day, for more observations, and should be reviewed again the next day.

4. At 11.45am, the man ate most of his lunch and officers and nurses noted no concerns. At around 1.30pm, the HCA checked him and found him lying on the floor of his cell having a seizure, so she immediately called for assistance. Officers called a code blue and the emergency response nurse attended. (A code blue is an emergency code used when someone has stopped breathing and requires urgent medical assistance.) Other nurses attended and, after assessing him, requested an ambulance.

5. The man was taken to hospital by ambulance. Escorting officers described him as unconscious, but he was handcuffed to one of two escorting officers by an escort chain. (An escort chain is a two metre long chain with a cuff at each end attached to the prisoner and an officer.) The chain was removed for treatment at the doctor's request, but reattached straight afterwards and he remained restrained until shortly before his death the next morning. His mother was not told that he had been taken to hospital until shortly before his death.

6. The clinical reviewer considers that the clinical care the man received at Nottingham was equivalent to that which he could have expected in the community. However, we are concerned that the prison had not introduced a mandatory medical emergency code protocol which led to some delay in calling an ambulance. We are also concerned that his serious medical condition was not adequately taken into account when assessing his security risk when he was taken to hospital and it is therefore not evident that the use of restraints was justified. Finally, there was a delay in notifying his mother of his admission to hospital, which led to confusion and delay in notifying her of his subsequent death.

THE INVESTIGATION PROCESS

7. The investigator issued notices informing staff and prisoners at HMP Nottingham of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator obtained copies of the man's relevant prison and medical records and interviewed staff at Nottingham on 24 September. He gave his initial findings to the Deputy Governor during the investigation and followed this up in writing on 1 October.

9. The local PCT appointed a clinical reviewer to review the clinical care that the man received at the prison.

10. HM Coroner for Nottinghamshire and Nottingham City was informed of the investigation. The Coroner has been sent a copy of this report.

11. One of the Ombudsman's family liaison officers wrote to the man's mother to explain the purpose of the investigation. She did not raise any specific issues for the investigation to consider.

12. The man's mother received a copy of the draft report and made no further comment.

HMP NOTTINGHAM

13. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds over 1,000 remanded and sentenced prisoners.

14. There is no inpatient healthcare unit. Prisoners who need nursing care are located in what is known as an enhanced care area (ECA) on F wing, where nurses are on duty 24 hours a day.

Her Majesty's Inspectorate of Prisons

15. The last report published on Nottingham by HM Inspectorate of Prison was an unannounced short follow up inspection in February 2013. The report raises no concerns relevant to the man's death. In the previous inspection in 2010, the Inspectorate found that reception screening was thorough and, in particular, alcohol dependent prisoners were thoroughly assessed and received treatment immediately.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent report, the IMB reported that reception was well managed, despite a high turnover of prisoners.

Previous deaths

17. The man's death is the third natural cause death since 2010 at Nottingham that the Prisons and Probation Ombudsman has investigated. There is no similarity between these deaths and that of his.

KEY EVENTS

18. On 25 June 2013, the man failed to appear at Crown Court for sentencing. He was arrested by police on 7 July and taken into custody at a police station. He was assessed by a healthcare professional, who noted that he had angina and sunburnt feet, for which he had recently received treatment in hospital. He was assessed as being fit to be held in custody.

19. The next morning, 8 July, the police doctor prescribed flucloxacillin (for bacterial infections), omeprazole (for heartburn) and ibuprofen (for pain relief). The doctor noted that GTN spray (usually prescribed to relieve angina attacks) was to be given as and when required and that the man had been diagnosed with an irregular heart beat. (There is no indication that he was given or requested the use of GTN spray.) He told the doctor he did not have an alcohol problem.

20. At 9.00am, the man was taken to Crown Court. His hearing was adjourned and he was then taken to HMP Nottingham. He arrived in the prison's reception at 6.15pm. Officers completed his personal summary sheet, which included his mother's contact details, as his nominated next of kin.

21. At the man's initial health screen a substance misuse nurse noted that the man had an alcohol problem. At first he denied it, but the nurse considered that he had symptoms typical of alcohol withdrawal, including shaking, agitation and sweating. The nurse noted that his feet were badly sunburnt, so he cleaned and re-bandaged them. The nurse referred him to the prison doctor in order to start an alcohol detoxification programme.

22. A doctor saw the man at 8.14pm. He told the doctor that he drank 36 units of alcohol daily, but had not drunk for two weeks because he had been in custody. The doctor thought it was unlikely that he had been in police custody for so long, but observed very few symptoms of alcohol withdrawal. The doctor recorded that he was not shaky or sweaty and did not have poor balance. Nevertheless, the doctor decided that he should stay in the prison's enhanced care area overnight until he could be reviewed in the morning. The doctor told the investigator that he prescribed medication for alcohol withdrawal (chlordiazepoxide), as he thought that he might need it, but on balance, he though he probably did not. Chlordiazepoxide can help to prevent fits, a common symptom of alcohol withdrawal, and also reduces symptoms of shaking, irritability and confusion. Nurses checked him through the night and there were no identified concerns.

23. At 8.05am on 9 July, the HCA noted that the man's blood pressure, heart rate and temperature were all normal and that he appeared settled, and was drinking tea. She said that although he appeared a little unkempt, he was otherwise fine. She told the doctor that she thought the man had no symptoms of alcohol withdrawal. The doctor therefore stopped the chlordiazepoxide, because of the HCA's observations and his own

assessment that he had lacked symptoms the previous evening. The doctor decided that he should remain in the enhanced care area for 24 hours to monitor for signs of alcohol withdrawal and be reviewed again the next day.

24. At 11.47am, the HCA took the man his lunch. He told her that his feet were still sore, but she noted that he appeared settled, was watching television and was drinking lots of water. Officer A said that he ate most of his lunch and did not mention any concerns.

25. The officer told the investigator that, at about 1.35pm, the HCA asked officers for help to get into the man's cell as she did not have a cell key. She told the investigator that she had seen him lying on his left side on the floor and was breathing. The officer said he was at the cell within seconds and saw through the door observation panel that the man was on the floor. He immediately unlocked the cell and went in, closely followed by Officer B and the HCA.

26. Officer A thought that the man was having some sort of seizure. The officers placed blankets around his head to prevent him from injuring himself further and noted that his breathing was faint. Officer B said that he had four or five seizures and that although his body remained taut, his hands and head were shaking slightly.

27. Officer A said he immediately radioed an emergency code blue, which the control room log recorded at 1.39pm. The HCA collected the emergency response bag, which contained medical equipment including oxygen, a defibrillator and adrenalin, from the nurse's station on the wing.

28. Two nurses responded to the code blue and arrived about two minutes later. Nurse A explained that the man had several seizures, but his condition fluctuated. He said that, although his saturation levels were low, they improved when he was given oxygen, but his heart rate remained high. He made the occasional grunting noise, but it was not clear if he was responding to staff, or if the sound was caused by his condition. The nurses administered midazolam (a relaxant commonly administered orally during a long seizure).

29. Nurse A said he asked for an ambulance to be called when it became clear that the man's condition was not improving. The ambulance was requested at 1.51pm and the first response paramedic arrived at 1.58pm. His condition was stabilised and he was taken to the ambulance in an emergency evacuation chair. The nurse said he could not walk and was not fully conscious.

30. Before his departure from the prison at 3.00pm, a custodial manager instructed Officer C to use an escort chain to restrain the man. The officer told the investigator that he appeared to be unconscious during the journey and wore an oxygen mask throughout.

31. When the man arrived at the hospital, the hospital doctor asked the escorting officers to remove the escort chain so the man could be treated. Officer C sought approval by telephone from the duty governor for the escort chain to be removed, during which time he described the hospital doctor as quite irate. She agreed that the escort chain should be removed for treatment. He was restrained again at 6.30pm and remained cuffed throughout the night.

32. At around 8.13am, a healthcare assistant asked the man if he wanted a drink, but got no response. The escorting officer asked the assistant to get help. He removed the escort chain and nurses attempted to resuscitate him but without success. At 9.00am, a hospital doctor confirmed and certified that he had died.

Family Liaison

33. At 8.30am escort staff rang the duty governor that day to inform her of what had happened. She then rang the man's mother at 8.55am to tell her that her son had been admitted to hospital and his condition was serious. The man's mother, who lived in Greater Manchester, said she wanted to visit her son in hospital, but did not have the means to travel to Nottingham. The prison contacted HMP Manchester for details of a taxi company to take her to Nottingham but, at 9.00am before any arrangements could be made, the escort officers contacted her to say that the man's death had been confirmed.

34. The Head of Operations was appointed as the prison's family liaison officer. He then informed colleagues at HMP Manchester of the man's death and they broke the news of his death to his mother shortly after midday, on behalf of HMP Nottingham.

35. In line with Prison Service guidance, the prison offered to contribute to the funeral.

Post-mortem report

36. The post-mortem report concluded that the man's primary cause of death was heart failure caused by heart disease and acute bronchopneumonia.

ISSUES

Clinical Care in Prison

37. The clinical reviewer comments that the man's location in the enhanced care area and treatment by healthcare staff at HMP Nottingham was appropriate. He considers that the decision to stop his alcohol detoxification was reasonable, because the doctor assessed he did not have symptoms of alcohol withdrawal and his observations were normal.

38. The clinical reviewer concludes that healthcare staff at Nottingham could not have anticipated the man's sudden decline in health and subsequent death from heart failure. He concludes that his care was comparable to that which he could have expected to receive in the community,

Calling an ambulance

39. Officer A called a code blue at 1.39pm, but an ambulance was not called until the nurse asked for one at 1.51pm. The nurse told the investigator that an ambulance was not called sooner as the man's condition appeared to improve, before he relapsed into further seizures. Both the nurse and the officer told the investigator that a prisoner should be assessed by a nurse before an ambulance is requested, although the nurse said that in hindsight an ambulance should have been called immediately.

40. Prison Service Instruction (PSI) 03/2013 (medical emergency response codes) which came into effect from 28 February 2013, requires that the Governor must have Medical Emergency Response Code protocol in place which ensures that an ambulance is called automatically in a life-threatening medical emergency when an emergency code is called. Even a short delay in such circumstances can have a significant impact on a person's chance of survival. It is concerning that prison staff believed that it was necessary for the man to be assessed by a nurse before an ambulance could be called even though Prison Service guidance had made it clear for some years that this should not be the case. It is a serious concern that that the mandatory requirements of PSI 03/2013, which had been in force since February, had not been implemented by the time of his death in July. We make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that HMP Nottingham has a Medical Emergency Response Code protocol in line with the PSI, which all staff follow and which ensures that ambulances are called automatically as soon as an emergency code is called.

Use of Restraints

41. The Prison Service has 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. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 (the Graham judgement) 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. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

42. The man's level of risk was considered to be low according to his escort risk assessment. The medical information section of the risk assessment was not completed. Despite this, the Custodial Manager concluded that he should be escorted by two officers and that he should be double cuffed, but an escort chain could be used if necessary. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of cuffs.) The assessment was endorsed by the Security Manager. Before the man left the prison, the Custodial Manager intervened and decided that only an escort chain should be used. Apart from its removal at the request of the hospital doctor for urgent treatment, he remained restrained by an escort chain almost until the point of his death.

43. When he was taken from the prison, officers and nurses described the man as unable to walk and lapsing in and out of consciousness. The escorting officer described the hospital doctor as irate about the delay in removing the escort chain when he said he had to seek permission from the duty governor, even though he had been assessed as a low risk.

44. Escort officers have the authority to remove restraints when it is considered a life threatening situation and this is clearly stated on the escort document. However, the escorting officers did not feel that they would be supported by the prison if they removed the escort chain, despite the doctor's request.

45. Security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We are concerned that, despite the man's circumstances, assessed low risk of escape and poor physical health, he was restrained when taken to hospital and during his stay. The

risk assessment did not include information from healthcare staff about how his condition impacted on his risk as the High Court judgement requires. We conclude that his physical health was not sufficiently taken into account to justify the use of restraints. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

Informing the man's family of his admission to hospital

46. The man was taken into hospital as an emergency, in a semi-conscious or unconscious state at 3.00pm on 9 July. However, his mother was not informed of his admission to hospital until 8.55am, five minutes before his death was confirmed. HMP Manchester broke the news of his death to his mother several hours later.

47. Prison Rule 22, about the notification of illness or death, states:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

48. The man was taken to hospital in an emergency ambulance, having suffered a number of seizures which rendered him semi-conscious or unconscious. Although his condition was stabilised, it did not improve and he was clearly seriously ill. We accept that it is not practical or necessary to inform families every time a prisoner goes to hospital unexpectedly. However, when a prisoner is admitted to hospital via an emergency ambulance we believe it is likely that the conditions of Prison Rule 22 apply and the next of kin should be informed. The failure to do so meant that his mother had no opportunity to visit him in his final hours.

49. The news of the man's death was broken to his mother in person by appropriate members of prison staff from Manchester, but not until several hours after his death.

50. PSI 64/2011 Safer Custody, chapter 13, states:

> "*Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death.* Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.
>
> "*Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO*

from the nearest prison."

51. The prison acted strictly in accordance with the PSI by asking Manchester to break the news on their behalf, but as the duty governor had only spoken to the man's mother five minutes before the prison was notified of his death, she might have considered ringing her back to break the news, rather than keep her waiting for several hours, which must have been distressing for his mother who believed that arrangements were being made to take her to the hospital to see her son. Had she been informed of his admission to hospital the afternoon before, in line with the Prison Rule, the confusion and delay in breaking the news of his death is likely to have been avoided. We make the following recommendation:

The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.

RECCOMENDATIONS

1. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that HMP Nottingham has a Medical Emergency Response Code protocol in line with the PSI, which all staff follow and which ensures that ambulances are called automatically as soon as an emergency code is called.

2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

3. The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.

ACTION PLAN: The Man – HMP Nottingham – July 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that HMP Nottingham has a Medical Emergency Response Code protocol in line with the PSI, which all staff follow and which ensures that ambulances are called automatically as soon as an emergency code is called.	Accepted	An operational instruction will be produced giving clear guidance of staffs responsibilities in line with PSI 03/2013.	31/03/2014	
2	The Governor should ensure that risk assessments for	Accepted	Advice will be provided to all managers (custodial manager and above) with regards to restraints relating to ill prisoners	31/03/2014	

	prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.		attending hospital.		
3	The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.	Accepted	Advice will be provided to all managers (custodial manager and above) with regards to contacting next of kin following emergency admission to hospital	31/03/2014	