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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man on  
1 October 2013 while in the custody of HMP Stafford**

## ***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 at the University Hospital of North Staffordshire on 1 October 2013, while a prisoner at HMP Stafford. A post-mortem examination showed that the man died of bronchopneumonia and severe traumatic brain injury. He was 73 years old. I offer my condolences to the man's family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

In February 2013, the man had a mild stroke for which he received hospital treatment to help prevent further strokes. He began to have seizures in June 2013 and, on 19 July, he had a seizure and fell heavily on his head, causing a severe injury. He was taken to hospital as an emergency and remained in hospital until he died.

Overall, I agree with the clinical reviewer that the standard of healthcare the man received while at Stafford was excellent and equivalent to that he could have expected to receive in the community. However, I am concerned that, on at least two occasions, the emergency response did not follow required procedures. While in the man's case there were no significant delays as a result, in other situations the consequences could be serious.

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**

**April 2014**

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## SUMMARY

1. The man was remanded into custody and was sent to HMP Hewell on 10 March 2009. An initial health screen noted he suffered from angina and he had a GTN spray to treat this (GTN – glyceryl trinitrate, which is used to ease the pain of angina) and high blood pressure. He was convicted and sentenced to four years in prison on 28 May.
2. On 9 August 2010, the man transferred to HMP Stafford. Over the next two and a half years he was frequently reviewed by nurses and doctors and received medication for his conditions.
3. On 3 February 2013, the man had a minor stroke and was taken to hospital. He returned to prison the same day. On 9 February, he was taken back to hospital, because he still seemed unwell. He returned the same day after being diagnosed with inflammation of the lungs for which he was prescribed antibiotics.
4. The man had a seizure on 23 June 2013 and was taken to hospital as an emergency. He returned the same day and the doctor made an urgent referral to the neurology service. Nurses and doctors continued to review him frequently. On 1 July, he spent a night in hospital after an angina attack.
5. On the morning of 6 July, the man woke up confused and a prison nurse thought he might have had another fit in his sleep. He continued to be monitored daily by healthcare staff.
6. On 19 July, the man had a fit and collapsed backwards, hitting his head on the floor. He was taken to Stafford Hospital by emergency ambulance and then later that day transferred to the University Hospital of North Staffordshire. He was not expected to live longer than a couple of days. He was released on temporary licence to the hospital and accompanied by a prison officer until 7 August. A move to a care home was discussed, but difficulties in establishing funding for such a move meant the man remained at University Hospital of North Staffordshire, until his death on 1 October.
7. This investigation found that the man's care was equivalent to that he could have expected to receive in the community. However, on at least two occasions when he collapsed, the protocol for responding to medical emergencies was not followed. We are satisfied this did not affect the outcome for him, but make one recommendation about the use of emergency codes.

## THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited the prison on 7 October and collected copies of the man's relevant prison and prison medical records. The investigator interviewed four members of staff and the man's cellmate.
10. The investigator contacted West Midlands Ambulance Service, who provided details of the contact they had with Stafford on 19 July.
11. NHS England commissioned a doctor to review the man's clinical care at the prison.
12. The investigator informed HM Coroner for South Staffordshire District of the investigation and the Coroner provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
13. One of the Ombudsman's family liaison officers wrote to the man's wife to explain the purpose of the investigation. His wife did not have any specific issues for the investigation to address.
14. The man's family received a copy of the draft report as part of the consultation period. Having had the opportunity to consider the findings of the investigation, the family made no further comments.

## **HMP STAFFORD**

15. HMP Stafford is a category C training prison which holds more than 700 prisoners across seven wings. Healthcare is provided by Staffordshire and Stoke-on-Trent Partnership NHS Trust

## **HM Inspectorate of Prisons**

16. The most recent inspection of Stafford was in July 2011. The Inspectorate found the prison was reasonably safe, with a respectful and purposeful training regime. Health services were judged to be good, although identification and formal care plans for prisoners with disabilities were lacking.

## **Independent Monitoring Board**

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to May 2013, the IMB noted that health care services were good. The IMB commended the support given to staff, prisoners and families after a death in prison.

## **Previous deaths at Stafford**

18. The man's death was the third at HMP Stafford in 2012 and 2013. In both previous investigations, we made recommendations about the use of an emergency response code.

## KEY EVENTS

19. The man was remanded to HMP Hewell on 10 March 2009. At his initial health screen, he said he had high blood pressure and unstable angina, for which he used a GTN spray. He was convicted and sentenced to four years in prison on 28 May.
20. The man had suffered two heart attacks before he came to prison. In December 2009, he experienced chest pain and was taken to hospital and diagnosed with epigastric pain (pain in the abdomen, just below the ribs) and acute coronary syndrome (a term used to describe a number of heart conditions including unstable angina). He was prescribed antibiotics and pain relief and, after a stay in hospital, returned to the prison.
21. On 9 August 2010, the man moved to HMP Stafford. That night, he fell over and was taken to hospital the next morning. X-rays showed he had a fracture to the pelvis. He did not require any treatment and he returned to the prison the same day. After this, he occasionally used a walking stick. Over the next two and a half years, the man continued to be monitored and prescribed medication for his cardiac condition and high blood pressure.
22. On 3 February 2013, the man had a mild stroke and was taken to hospital by ambulance. He returned to prison the same day with medication to help prevent further strokes. A prison GP referred him to the stroke clinic on 5 February. A stroke consultant, at University Hospital of North Stafford examined the man on 8 February and noted he had very mild right sided weakness, but all other tests were within normal range. The man's medication was revised and he had a 24 hour ECG (to measure the rhythms of the heart). He was discharged from the stroke clinic. The stroke consultant advised the man to stop smoking and said he would be contacted when the results of the ECG tests were available.
23. The man complained of acute chest pain on the morning of 9 February. His oxygen saturation levels were low at 89% and he had low blood pressure (115/60 and 106/66), so he was taken to hospital by ambulance. He had a chest X-ray and was diagnosed with a chest infection and prescribed antibiotics. He returned to the prison just after midnight.
24. On 24 April, a nurse saw the man on the wing and noted he had central chest pain and looked unwell. His GTN spray was not helping. An ECG was carried out which showed no evidence of a heart attack. He went to hospital, and was diagnosed with cholangitis (inflammation of the bile duct). He stayed in hospital until 30 April.
25. On 3 May, a nurse telephoned the hospital for advice because the man seemed very unwell and she was advised to send him to hospital. He was admitted and treated for jaundice and obstruction of the bile duct. He was discharged back to Stafford on 11 May.

26. On 23 June at 11.50am, the man's cell mate pressed his cell bell as the man appeared to be having a fit. He told staff that the man had collapsed from his chair and was foaming at the mouth. An officer telephoned the communications room and asked for the emergency response nurse to attend. An emergency code was not used. A nurse came and found the man unconscious and breathing with difficulty. She inserted an airway, and he began to regain consciousness. The man was taken hospital by ambulance and came back the same day. The hospital did not provide a discharge summary, although the accompanying prison staff requested one.
27. A nurse assessed the man when he got back from hospital and booked an appointment for him to see the GP the next morning. The nurse asked officers to call 999 if there were any concerns about his health. On 24 June a doctor reviewed the man and made an urgent neurology referral to investigate the reason for his seizure. A neurology appointment was received for 6 September at University Hospital North Stafford.
28. On 1 July, the man had an angina attack and spent the night in hospital. Healthcare staff at the prison monitored him when he returned as he continued to feel unwell. On 6 July, he woke up feeling unwell and confused. A nurse was concerned that he might have had a fit during the night and suggested that he should go to hospital, but the man declined. She monitored him all that day, and the doctor examined him on 7 July. The doctor asked officers to check the man at least hourly and instructed them to call 999 if he appeared to have a fit. Officers, nurses and doctors continued to check him and there is no record that he had any further fits until 19 July.
29. On 19 July, an officer unlocked the man at 8.14am for a cardiology appointment at the hospital. The man left his cell, walked a couple of steps then collapsed backwards onto the floor, hitting his head badly. Two officers were nearby and shouted for assistance as they went to help. Another officer ran to the wing office and informed another officer who telephoned the control room, said there was an emergency and asked for an ambulance. Records show the ambulance was called at 8.16am. He radioed the emergency response nurse but did not use an emergency code.
30. Three officers checked that the man had a pulse and placed him in the recovery position. A nurse attended and tried to make the man comfortable. He noted that his blood pressure was high (220/100), his pulse was in the normal range (65), but he described his breathing as slightly hyper. The man was not entirely conscious, but was very agitated and trying to get up. The nurse helped him into a chair, but he had a second seizure and bit his tongue, so they moved him back to the floor. The healthcare manager went to the cell and then brought a defibrillator as a precaution. The ambulance arrived at 8.39am and the paramedics took over his care. The man had a third fit before being stabilized by the paramedics. He was taken to hospital by ambulance just after 9.00am. Restraints were not used.
31. At 9.50am, the hospital asked for the man's next of kin to be contacted because they considered he was unlikely to live more than a couple of days.

The prison family liaison officer and a colleague went to inform the man's wife about what had happened.

32. The man remained unconscious and was considered unlikely to recover. He was released on temporary licence at 1.20pm, but an officer stayed with him at the hospital. The family liaison officer continued to update his wife by telephone.
33. On 5 August, the hospital began to discuss arrangements to discharge the man as no further active treatment was possible. He was paralysed, had a tracheotomy and his level of consciousness was very low, so he could not return to prison. The hospital liaised with social services and the prison to find suitable accommodation to meet his complex needs, but this was not resolved. From 7 August, an officer no longer stayed with the man at hospital, but a prison manager visited each day.
34. At the beginning of September, the prison considered applying to release the man on compassionate grounds. A multi-disciplinary meeting on 12 September recorded that the prison was waiting for a response from the hospital consultant with a specific prognosis. On 18 September, he became very poorly and at one time stopped breathing. His health continued to deteriorate and at that stage the hospital said that he could no longer be discharged.
35. The prison continued to prepare an application for release on compassionate grounds to release the man to a care home that could accommodate his needs. He was no longer independent, needed 24 hour care and it was unlikely he would recover from his brain injuries. The application to release him on compassionate grounds was submitted on 1 October.
36. On 1 October, the man became unwell and hospital staff started an end of life care pathway. He died at 4.10pm. As they had agreed, the family liaison officer phoned the man's wife at 4.45pm to inform her of his death and offer support and funeral expenses in line with national guidelines. A memorial service was held for the man in the chapel.

### **Post-mortem report**

37. The post-mortem examination concluded that the man died of bronchopneumonia, damaged lungs and a severe traumatic brain injury. The post-mortem states that he had developed a ventilator acquired pneumonia while in the intensive care unit, which was treated with antibiotics.
38. The report also states that bronchopneumonia developed through loss of mobility and the inability to expel pulmonary secretions.

## ISSUES

### Clinical care

39. The clinical reviewer considered that the man's general medical care while at Stafford was excellent and that this care was equivalent to that which he could have expected to receive in the community.
40. However, the clinical reviewer notes that throughout the last three months of the man's life there were increasingly frequent entries that indicated his deteriorating health. He states that there is little doubt the man developed epilepsy, which might have started as a result of ischaemic brain changes, as evidenced by his mild stroke in February 2013. It is therefore unfortunate that following the urgent referral for a neurology review in June 2013, University Hospital of North Stafford could not offer an appointment until 6 September 2013, by which time the man was already seriously ill in hospital.
41. The clinical reviewer noted that an earlier appointment might have been available at another hospital. The neurological assessment was to confirm the diagnosis of epilepsy and initiate any treatment which might have prevented the man having further fits. However, he was admitted to University Hospital of North Stafford on 19 July, therefore any delay in obtaining a neurology assessment was superseded. It is unlikely that a neurology appointment could have been obtained earlier than July at another hospital, so ultimately did not affect the care he received.

### Emergency Response

42. Prison Service Instruction (PSI) 03/2013 requires Governors to have a medical emergency response code protocol in place by 28 February 2013. The instruction gives clear guidance on how staff must communicate the nature of a medical emergency, using agreed emergency codes, and to ensure an ambulance is automatically requested by the control room as soon as an emergency code is called.
43. Stafford implemented a local protocol on 28 March 2013, which complies with the PSI. Although when interviewed officers and healthcare staff were aware of the protocol and emergency codes, these were not always used correctly or consistently. On both 23 June and 19 July, the local protocol was not followed and an ambulance was not called automatically, but had to be requested separately. While it is unlikely to have made a difference to the outcome for the man, any delay in a future emergency could be crucial, and we make the following recommendation:

**The Governor should ensure that all prison and healthcare staff are made aware of and understand the local protocol and PSI 03/2013 and their responsibilities during medical emergencies, so that:**

- **Staff efficiently communicate the nature of the medical emergency**
- **Relevant emergency equipment is brought; and**

- **There are no delays in calling, directing or discharging ambulances**

### **Compassionate release**

44. Release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).
45. The application for compassionate release was sent to the PPCS 1 October, the day the man died. The Healthcare Deputy Manager said that there was a delay in getting the man's consultant to write his section of the application. He was reluctant to write the report because it required him to state whether or not the man could commit another offence. Eventually, he completed the form saying this was unlikely. While the application for compassionate release was delayed because of the concerns of the consultant, communication between the hospital and prison was ongoing and well-documented. We are satisfied that the prison actively managed the application and the delay was not within its control. In any event, the application was predicated on release to a nursing home which was no longer an option.

### **The man's location**

46. The man's needs were met in hospital and the difficulties in arranging funding for a transfer to a care home had no adverse affect. However, there was ongoing confusion about who was responsible for funding his care should he move to a care home. There is evidence that the prison worked with the hospital and social services about this, but this was not resolved by September, after which his condition was too poor to allow him to be discharged from hospital.

## **RECOMMENDATION**

The Governor should ensure that all prison and healthcare staff are made aware of and understand the local protocol and PSI 03/2013 and their responsibilities during medical emergencies, so that:

- Staff efficiently communicate the nature of the medical emergency
- Relevant emergency equipment is brought; and
- There are no delays in calling, directing or discharging ambulances

## ACTION PLAN: The man – HMP Stafford

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that all prison and healthcare staff are made aware of and understand the local protocol and PSI 03/2013 and their responsibilities during medical emergencies, so that:</p> <ul style="list-style-type: none"> <li>• Staff efficiently communicate the nature of the medical emergency</li> <li>• Relevant emergency equipment is brought; and</li> <li>• There are no delays in calling, directing or discharging ambulances</li> </ul>	Accepted	<p>The Governor has now issued a staff information notice on the intranet which advises all staff of the outcome of this investigation including the failure to follow correct procedures and advises them that they must follow the policy in PSI 03/2013 - Response to Medical Emergencies as previously advised in a notice to staff issued on 18 February 2014.</p>	<p>Completed Deputy Governor</p>	