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 August 2011, while in the custody of HMP Wymott

October 2013

This is the report of an investigation into the death of a man, a prisoner at HMP Wymott who died in hospital in August 2011. He was 52 years old. The cause of his death was coronary heart disease and pneumonia. I offer my condolences to those affected by his death.

The local Primary Care Trust (PCT) commissioned a clinical reviewer to carry out a review of the man's clinical care. HMP Wymott fully cooperated with the investigation. I apologise for the delay in issuing this report.

The man was admitted to hospital as an emergency on 23 July 2011 after a heart attack in his cell and underwent surgery that day. He remained in hospital with a prison escort until his death. Throughout his sentence, he and healthcare staff were aware of his family history of heart disease. When he was diagnosed with a heart condition treatment was arranged promptly and he was well supported by both healthcare staff and prison officers. However, after his heart attack, there was some delay in calling an ambulance and the use of restraints, when he was in the Intensive Care Unit, was not justified by a properly considered risk assessment.

The clinical reviewer identifies some scope to improve the management of prisoners who require long term cardiac care but, overall, I am satisfied that the man received a good standard of care at Wymott and his death was not preventable.

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
Prisons and Probation Ombudsman **October 2013**

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SUMMARY

1. The man, a prisoner at HMP Wymott, died in August 2012 at hospital. He was 52 years old and serving a life sentence. He had a family history of heart disease and he had previously reported chest pain which had been investigated between 2002 and 2006. He had a heart attack in 2006 and after his discharge from hospital he was referred for tests which raised no further concerns. After further chest pain in 2008, he underwent tests and stable angina was confirmed.

2. On 15 July 2011, the man reported angina pain. The prison doctor referred him to a cardiologist for tests and adjusted one of his medicines. The doctor saw him again on 22 July and he reported that his chest pain had reduced. The next day, during the early afternoon an officer found him collapsed in his cell. The officer requested the help of healthcare staff and asked for an ambulance to be called. The control room refused to call one until healthcare had attended. The officer made a further request for an ambulance after nurses arrived.

3. Nine minutes after the emergency telephone call, a paramedic first responder arrived at the prison and, five minutes later, was joined by an emergency ambulance crew. They took over care of the man, diagnosed that he had suffered a heart attack and took him to hospital. Two prison officers accompanied him but he was not restrained.

4. The man had heart surgery and was admitted to the Intensive Care Unit. Once he became conscious, the escort officers applied restraints, in the form of handcuffs. The risk assessment was reviewed the next day and the handcuffs were removed. He remained in hospital until early August, when he died with his family at his bedside. A post-mortem examination concluded that the cause of death was coronary heart disease and pneumonia.

5. We are satisfied that the man's care was timely and appropriate. However, the clinical reviewer recommended some improvements in practice in the identification and management of those with heart conditions.

6. There are two additional areas of concern. Prison Service guidance makes it clear that when there are grave concerns about the immediate health of a prisoner, officers should not have to wait for healthcare staff to attend before an ambulance is called. Nor do we consider that the prison was justified in handcuffing the man in the Intensive Care Unit of the hospital, shortly after his operation.

INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners about the investigation inviting anyone who might have relevant information to contact the investigator. No one responded.

8. The investigator first visited HMP Wymott on 27 September 2011. He met the Governor and the investigation liaison officer, who gave him a full briefing about the circumstances of the man's death. He visited relevant areas of the prison, including C wing where he lived. He asked to meet representatives from the Independent Monitoring Board (IMB) and Prison Officers' Association, but no one was available.

9. One of the Ombudsman's family liaison officers wrote to the man's mother on 8 September 2011 to explain the purpose of the investigation. He later spoke to her by telephone. She did not identify any specific issues for the investigation to cover. The family received the draft report as part of the consultation process however had nothing further to add.

10. The investigator obtained copies of the man's prison and medical records. On 12 August 2011, a clinical reviewer was asked to commission an independent clinical review of his clinical care in prison. She commissioned the review on 7 September but the reviewer was then unable to complete it. On 12 October, another reviewer was asked to complete the review. Owing to circumstances beyond the control of this office, the clinical review was not received until 4 December 2012. I am sorry that this significant delay prevented us from issuing this report sooner.

11. The post-mortem report indicated the cause of the man's death was:

    1) Myocardial infarction (heart attack)
    2) Coronary heart disease
    3) Lobar pneumonia (affecting one or more lobes of the lung).

HMP WYMOTT

12. HMP Wymott holds up to 1,174 adult male, sentenced prisoners. I wing, where the man lived, is a specialist unit for older prisoners who are given additional support to help them with their social care needs. Healthcare services at Wymott are commissioned and provided by the NHS. A private company provides general practitioner (GP) services and out of hours medical cover. Clinics are run every weekday morning and two afternoons each week. There are no inpatient beds, but nursing cover is provided 24 hours a day.

HM Inspectorate of Prisons

13. The most recent inspection of Wymott was a short follow-up inspection in November 2011. (The previous full inspection had taken place in October 2008.) In relation to healthcare, inspectors noted that staffing levels were sufficient, but that that prisoners waited too long to see the GP. None of the findings or recommendations in the inspection report related to issues relevant to the circumstances of the man's death.

Independent Monitoring Board (IMB)

14. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. In their annual report for the period June 2011 to May 2012, the Board reported that the healthcare department had significantly reduced the waiting time for routine general practitioner (GP) appointments from four to two weeks. The prison also provides screening for cardiovascular disease for men between the ages of 30 and 74.

Previous deaths at HMP Wymott

15. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, we have investigated a number of deaths at Wymott, of which the majority were due to natural causes. This is, in large part, due to its older population profile compared to most prisons. In a recent report, we made a recommendation about the need to justify the use of restraints by an appropriate risk assessment. We repeat that recommendation in this report.

KEY EVENTS

16. The man was born on 18 April 1959. In 1985, he was released from prison after serving a sentence for manslaughter. In 2000, he was convicted of a serious assault and for which he received a life sentence. He was held at several different prisons during his sentence. .

17. When he arrived at Manchester prison in February 2000, the man was in good health but reported that he had been told several years before, that he had a narrowing of his aorta (the largest artery in the body running from the heart down to the abdomen). (In 2004, after he reported chest pains, it was recorded that there was a family history of heart disease. His father had died when he was 49 and his mother had cardiac by-pass surgery when she was 66.)

18. In April 2002, the man complained of chest pains. Six months later, he was diagnosed with high blood cholesterol levels, which the clinical reviewer cites as "a significant risk factor in the development of cardiac disease". He was prescribed medication for this. Further symptoms between 2002 and 2006 were dealt with promptly, tests were conducted and he was sent to hospital when necessary.

19. After using the prison gym on 18 April 2006, the man complained of chest pain. He was admitted to a local hospital, where he remained until discharged on 25 April. His discharge summary said that he presented symptoms suggesting claudication (a condition of the blood vessels that leads to narrowing and hardening of the arteries that supply the lower limbs) for which he was referred to a vascular surgeon. He was advised to stop smoking and given drugs to treat angina, reduce his blood pressure and excess stomach acid and lower his cholesterol level. He was also prescribed a drug to lower the risk of blood clots. He was scheduled to return to the outpatient chest clinic six months later.

20. The man's conditions were continually monitored and advice given. He refused to attend some outpatient appointments in 2007, as he objected to being handcuffed. In June 2008, a nurse noted that his chest pain had got worse over the preceding few weeks. He told the nurse that his use of the GTN spray (to ease angina) had increased from once a month to about six or seven times a week. She completed a Rapid Access Chest Pain Clinic (RACPC) check list and referral form, which she faxed the following day to the hospital. He attended an appointment at the clinic where he was diagnosed with stable angina and advised that the prison doctor should follow up the cardiac pain. He declined to attend a follow up appointment at hospital in October 2008, but no reason was recorded.

21. In March 2009, the Parole Board recommended that the man progress to open prison conditions and he transferred to HMP Kirkham on 19 March. When he arrived her was referred to the coronary heart disease clinic because if his own and his family's history. While at Kirkham, his health was regularly monitored and he attended various hospital appointments. He went

on town and resettlement home visits, but after a breach of his temporary licence conditions, he returned to Wymott on 7 July 2010. On arrival at Wymott, his healthcare needs, medical condition and medication were again assessed.

22. On 15 July 2011, the man told a prison doctor that he had angina and used his GTN spray for relief. The doctor examined him and found no cause for concern at that time but referred him to a cardiologist for an exercise tolerance test and an angiogram (a specialised X-ray to examine arteries in the heart). In the meantime, the doctor adjusted his medication and advised him that, should any chest pain last more than 15 minutes or if he began sweating or vomiting, he should ask for medical help immediately. He saw the doctor again on 22 July and reported that, since his medication had been increased, he had experienced less chest pain.

23. In the early afternoon of 23 July at around 2.50pm, two officers were unlocking cells after lunch, when a cell call bell sounded for cell C2-05. Officer A went to the cell immediately. The door was ajar as the cell had already been unlocked and he found the man lying on his bed on his back. He was conscious, his face was grey, his chest was heaving furiously and he was panting. The officer also said that he was grasping his chest with his hands and was clearly very unwell. He told the officer that he was having a heart attack and that he was dying. The officer immediately radioed the control room, asking for medical assistance for a "Code Blue" emergency on C wing. (Code Blue signifies that the patient is experiencing breathing difficulties or is not breathing.)

24. The communications officer noted in the daily log sheet that the call was made at 2.33pm and he immediately informed Nurse A, the duty governor and a Senior Officer (SO) - the orderly officer (uniformed officer in charge of the prison). He then shouted to Officer B, who went to the cell. Officer B noticed a GTN spray on the cupboard and asked the man if he had used it. He said he had used it twice, but it had not helped. Officer A then went to the cell door to guide the healthcare staff to the correct cell.

25. Nurse B received a telephone call informing her that the man had a chest pain and looked unwell. She knew his medical history and together with Nurse A walked quickly to C wing, arriving about five minutes later. The nurses collected the emergency bag from the wing treatment room and went upstairs to his cell. The bag contained blood monitoring equipment, a defibrillator (a machine that gives the heart an electric shock in some cases of cardiac arrest), airways, an oxygen cylinder and other equipment that might be needed in an emergency.

26. As the nurses went upstairs, Officer A again radioed the communications officer, and asked for an ambulance to be called. The communications officer replied that healthcare staff had to approve the request before they could do so. When she arrived at the cell shortly afterwards, Nurse B agreed that the man needed an ambulance. Officer A called the communications officer

again, and requested an ambulance explaining that it appeared to be a heart attack. The control room log shows that an ambulance was called at 2.41pm.

27. The nurses monitored the man's pulse, blood pressure, and blood oxygen saturation levels. Initially, Nurse B found no recordable blood pressure but a few minutes later obtained a very low reading. He had already used his GTN spray and she was reluctant to give him more, in case it further reduced his blood pressure. They continued monitoring his condition, elevated his legs and administered oxygen. The nurses considered giving him aspirin but decided against this as he was intermittently responsive. The defibrillator was prepared for use in case his condition worsened. They tried to reassure him and comfort him until the paramedics arrived.

28. A first response ambulance service paramedic arrived at the prison gate at 2.51pm and went to the cell, followed at 2.56pm by an ambulance with two crew members. The paramedics used their own emergency equipment and the nurses left the cell to allow them more room. After an electrocardiogram (ECG) test, the paramedics concluded it was a heart attack. The man was taken to the ambulance in an ambulance chair.

29. Before the man left the prison an escort risk assessment was completed which considered his risk to the public, risk of hostage taking, escape potential and risk to hospital staff. A short contribution from the healthcare department just indicated there was no medical objection to the use of restraints. He was assessed as low on all aspects except risk to the public, which was considered to be medium. The senior manager who authorised the risk assessment wrote, "…keep cuffed at all times, unless life-threatening…" However, the orderly officer decided that due to his condition, he should not be handcuffed. At 3.29pm, the ambulance left Wymott with two officers as escorts, arriving at the hospital's Accident and Emergency Department at 3.41pm.

30. At 3.53pm, the man was taken by ambulance to another hospital. Throughout, he was distressed and in pain. The escort officers and ambulance crew tried to comfort him. He became calmer as the effects of medication took effect but remained very frightened. At 4.17pm, staff at Wymott contacted his brother to inform him that he was unwell and was on his way to another hospital. They gave him the duty governor's contact details.

31. At 4.20pm, when they arrived at the hospital, the man was taken directly to the coronary care unit, where he was assessed and then taken to the operating theatre ten minutes later. A heart balloon pump (a mechanical device that increases blood flow and oxygen) was inserted. At 5.48pm, after the operation, Officer A spoke to the surgeon who told him that, given the condition of his heart, he would not normally have survived long enough to have the operation. Just after 6.00pm, he was moved to the Intensive Care Unit (ICU) where hospital staff expected him to remain for a minimum of two days. By this time, he was awake and sitting up in bed and, in line with the risk assessment instructions, the escort officers handcuffed him.

32. Prison managers visited the man daily and kept the risk assessment under review. The duty governor reviewed the assessment the next day, 24 July, and decided that restraints were not needed. Officers removed the handcuffs at 4.40pm and they were not used again. His mother visited him early that evening. His mother and brother kept in contact with him by telephone and visited him at the hospital frequently. He remained in the ICU and healthcare staff at Wymott maintained contact with hospital staff to monitor his progress.

33. On 28 July, the man's doctor told him that he had a hole in his heart which could not be repaired. Initially, medication would be tried and, if that was unsuccessful, a mechanical aid would be used to support his heart. There was the possibility that a heart transplant would be needed. He was shocked at the news and asked them to inform his mother. A nurse telephoned his mother and the escort staff informed the prison. Prison healthcare staff were told that doctors planned to remove his balloon pump.

34. On 29 July, hospital staff told Wymott healthcare staff that they had not removed the balloon pump. That evening, the man was agitated and confused and the hospital decided to use medical restraints consisting of a pair of mitts loosely strapped to the bed so that he was not able to remove his oxygen mask. Because he frequently bent his leg and twisted the pump line leading from his stomach to his left leg, the nurse used a strap on his leg, secured to the bed. The restraints were used only in the periods when he became agitated and impeded the effective use of his oxygen mask or pump line.

35. The man's condition deteriorated and he was taken to surgery in the early hours of 31 July, to have a temporary pacemaker inserted. He returned to the ICU and subsequently moved to the coronary care unit in the late morning of 3 August. The prison reviewed his risk assessment on 4 August, and concluded there was no reason for any change. He remained in a poor condition and needed the support of oxygen, infection control and pain relief.

36. On 10 August, hospital staff noticed that the man's infection was not responding to medication, which meant he would not be able to have a heart transplant. During the early evening, the hospital consultant explained the situation to him. She said that she would discontinue some of the treatments the following day, including the removal of his heart balloon pump, which could result in his death. He asked not to be resuscitated if there was a serious deterioration and the consultant agreed. He also asked that his mother be informed of the situation and his decision. Hospital staff spoke to his mother and she arranged to visit him the next day.

37. At 9.15pm, the man asked his consultant to remove the balloon pump and this was completed at 9.40pm. The consultant telephoned his mother and advised her to visit her son. At 10.10pm, his mother arrived and remained with him. A priest requested by his mother attended five minutes later and left at 10.30pm. During the night, he was given pain relief and sedatives and he died peacefully at 5.01am, with his mother at his bedside. His death from heart failure was certified by a doctor at the hospital and the escort staff

informed the prison at 5.05am. At 5.20am, the duty governor contacted the escort staff for a briefing.

38. The duty governor was also one of Wymott's family liaison officers (FLO) and he contacted the man's mother in the morning and arranged to visit her at home with another FLO that afternoon. They explained the procedures following a death in custody and offered financial assistance with the funeral costs. She requested that her son's clothing be donated to charity and his remaining personal effects be returned to her. His mother also asked the prison to make the funeral arrangements with a local funeral director, which the FLOs did. On 12 August, the Governor wrote a letter of condolence to her, and outlined the support available. The duty governor visited her on 17 August to return his property. At his mother's request no prison staff attended the funeral.

39. A post-mortem examination concluded that the man died as a result of a heart attack, coronary disease and pneumonia.

ISSUES

Clinical care

40. The man was diagnosed with angina in June 2006. In June 2008, his chest pains became more frequent and he increased the use of his GTN spray. He was referred to the Rapid Access Chest Pain Clinic, where staff confirmed a diagnosis of stable angina. In mid-July 2011, his medication was increased and a prison doctor referred him to a cardiologist. One week later he reported feeling better, but the following day, 23 July, he had a heart attack and died in hospital in August.

41. The man's family and personal history gave warning signals that he might have heart disease. Prison healthcare staff were aware of this and, when necessary, promptly referred him to specialists for treatment. The clinical reviewer believes that he received good clinical care and we agree. In particular, he was promptly assessed and care plans were drawn up and followed. However, the clinical reviewer found that formal care plans and pathways for long-term conditions were not formalised after the reception health screen as would be expected by the NHS Quality Outcomes Framework. In his case this meant that although his cardiac condition was documented, he did not enter a formal care pathway, although he received many of the elements of such a pathway. We are satisfied that this did not impact on his care but as the clinical reviewer has identified scope for improvement we make the following recommendation:

    The Head of Healthcare should introduce a pathway for the care of long-term cardiac problems to include patients identified with a cardiac history at the reception health screen.

Emergency response on 23 July

42. On the afternoon of 23 July, a prison officer responded to the man's cell call bell, realised he was very unwell and radioed the control room at 2.33pm. When nurses arrived on the wing about seven minutes later, the officer asked the control room to call an emergency ambulance, but was told that healthcare staff would have to approve this before an ambulance could be called. Just after that, the nurses arrived and asked for an ambulance. The emergency ambulance was called at 2.41pm and an ambulance service paramedic arrived nine minutes later. We recognise that the short delay between the first and second request for an ambulance made no difference to his immediate treatment or his eventual death but in different circumstances such a delay might have been more significant, with very serious consequences.

43. A letter from the Department of Health and the National Offender Management Service to Prison Service Governors, NHS Primary Care Trust Offender Health Leads and Prison Healthcare Managers, dated 17 February 2011 titled "Emergency access to establishments for ambulance services" notes that:

> "It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the prison healthcare team to attend the scene before emergency services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Health Care Team arrives and after assessment of the patient deems that an emergency ambulance response is not required. The most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner."

We consider that an ambulance should have been requested at the same time that healthcare staff were called. It is a particular concern that control room staff declined to call an ambulance when asked by an officer on the ground faced with an emergency situation.

The Governor should ensure that all staff are instructed to call an ambulance whenever there are serious concerns about a prisoner's immediate health.

Use of Restraints

44. 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.

45. A High Court judgement in 2007 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 restraining by handcuffs of 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.

46. When the man left Wymott on 23 July, staff completed a security risk assessment which specified that he should be handcuffed. However, the Orderly Officer decided that due to his condition, it was unnecessary to do so during the journey to hospital. After his operation that afternoon, while he was in the Intensive Care Unit, handcuffs were applied. In the late afternoon of the day after, a prison manager reviewed the risk assessment and as a result the handcuffs were removed.

47. The man was assessed as a medium risk to the public, but in all other areas he was considered to be low risk. There is no clear indication why staff thought that his risk to the public was higher than the other factors and the intelligence information taken into account dated back to 2009. Whether or not his risk to the public was assessed correctly this risk would apply only if he escaped which, in the light of the other risk assessments and his medical condition, seems highly improbable. Despite the overall low level of risk, as well as his serious medical condition in the ICU, prison staff handcuffed him shortly after he came round from his heart operation and restraints remained in place overnight and until late afternoon the next day.

48. In view of the level of perceived risk, the man's state of health and his lack of mobility owing to a serious life-threatening condition, we do not consider that the use of restraints was justified or appropriately balanced security with humanity. We recognise that after a day the restraints were removed and not used again. We consider this was an appropriate decision, but 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.

RECOMMENDATIONS

1. The Head of Healthcare should introduce a pathway for the care of long-term cardiac problems to include patients identified with a cardiac history at the reception health screen.

   Accepted

   Healthcare at HMP Wymott have now implemented a pathway for all known Long Term Conditions identified in reception, the pathway also includes any newly diagnosed during other nurse led or GP clinics. The pathway supports all staff with the next steps to management and refers to NICE guidance; the pathway also highlights the lead nurses responsible for that Long Term Condition.

2. The Governor should ensure that all staff are instructed to call an ambulance whenever there are serious concerns about a prisoner's immediate health.

   Accepted

   The Protocol for calling an Emergency ambulance was issued on notice to staff 88/2012, (27th November 2012). If a member of staff finds an individual in a life threatening situation it is their responsibility to request an ambulance.

3. 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.

   Accepted

   The Head of Healthcare has undertaken an audit of 10 further risk assessments and PER forms. Following the audit, the Head of Healthcare in consultation with the Head of Security has formulated an action plan which includes raising awareness of healthcare staff via team briefings, the development of examples of completed risk assessments for healthcare staff to refer to for guidance and the reception nurse delivering further training to all nursing staff involved in completing risk assessments.

   Sample checks of completed risk assessments and PER forms will be conducted on an on-going basis to ensure continued compliance and consistency.

   Decisions to apply restraints are made taking full account of the information contained in the healthcare risk assessment, security information and any dynamic factors that need to be considered at the time.