



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Northumberland on 16 January 2014**

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, who died on 16 January 2014 at HMP Northumberland. He died from an enlarged heart and obstructive sleep apnoea. He was 47 years old. I offer my condolences to his family and friends.

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

In January 2009, he was sentenced to nine years in prison and moved to HMP Northumberland in October that year. He had suffered two heart attacks before his imprisonment and had a number of health issues including high blood pressure, obesity and sleep apnoea.

On 15 January, the man reported feeling unwell and remained in his cell throughout the day. Another prisoner saw him a number of times that day but, although a prison officer informed a nurse that the man was unwell, no member of healthcare staff went to see him. No officers checked his wellbeing again during the day or night. At about 8.10am on 16 January, an officer found him unresponsive in his cell, and it was apparent that he had been dead for some time. A prison GP certified his death at 8.40am.

I share the view of the clinical reviewer that not all aspects of the healthcare the man received were to the standard that he could have expected in the community. Although nurses regularly monitored and recorded his blood pressure, they did not refer him to a GP to review his consistently high blood pressure until September 2013. The man was not referred to a cardiologist after an irregular ECG and after a period of continued high blood pressure. A repeat prescription for paracetamol continued for four years without any review. I am also concerned that the officer who unlocked the man on the morning he was found dead, did not check on his welfare – a matter I have raised with the prison before.

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 2014

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SUMMARY

1. In January 2009, the man was sentenced to nine years in prison. He transferred to what was then HMP Acklington in October the same year.
2. His medical history included high blood pressure, sleep apnoea and obesity. He had a continuous positive airway pressure machine (CPAP) for sleep apnoea and received medication for high blood pressure and paracetamol (apparently for a painful knee and headaches) which he continued to take for some years without a review.
3. In June 2010, the man had an ECG (electrocardiogram) which highlighted an irregularity. There is no record that this was followed up, or that any further ECG tests were conducted. Nurses regularly monitored and recorded the man's blood pressure but, between July 2011 and February 2013, despite consistently high readings, he was not referred to a GP. In February 2013, his blood pressure was reviewed and a cardiac adjusted risk assessment showed nothing abnormal. In September 2013, a prison GP saw him because of his high blood pressure and prescribed another medication. He was reviewed again in January 2014 and further medication was prescribed.
4. On 15 January 2014, after morning unlock, the man told a fellow prisoner he felt unwell with sickness and diarrhoea. The prisoner reported this to an officer, who informed a nurse, but nothing was recorded. The man remained in his cell all day and another prisoner checked on him a number of times. There is no evidence that healthcare staff or officers checked on his wellbeing. No one informed night staff of the man's illness and therefore they did not check him during the night.
5. Just after 7.30am on 16 January, an officer unlocked the man's cell, but did not check his wellbeing. Another prisoner looked in on him and believed him to be asleep. He told staff that the man was still unwell and unable to collect his morning medication. A nurse did not go to see the man, but advised that he should rest in his cell for 72 hours.
6. At about 8.10am, an officer found the man unresponsive in his bed. Other officers and healthcare staff attended. Rigor mortis was present and, as it was clear that the man had been dead for some time, the staff did not attempt resuscitation. A prison GP certified his death at 8.40am.
7. We are concerned that a nurse or doctor did not check the man the day before he died. Despite high blood pressure readings for over 18 months, nurses did not refer the man to a GP for review until September 2013. An irregular ECG result was not followed up and there is no evidence that a long-standing prescription for paracetamol was reviewed. The officer who unlocked him on the morning he was found dead, did not check his welfare, as officers should do. We make seven recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and inviting anyone with relevant information to contact him. Two prisoners and one member of staff responded.
9. The investigator obtained copies of the man's prison medical records and extracts from his prison records. The investigator interviewed four members of staff and two prisoners on 14 and 15 February 2014 at HMP Northumberland. He gave the Director initial feedback about the preliminary findings of the investigation.
10. NHS England commissioned a nurse to review the man's clinical care at the prison.
11. We informed HM Coroner for Northumberland North of the investigation, who provided a copy of the post-mortem and toxicology reports. We have sent the Coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted the man's next of kin to explain the investigation process. We received no response.
13. The man's next of kin received a copy of the draft report. They did not make any comments. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report

HMP NORTHUMBERLAND

14. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. The prison can accommodate more than 1,300 men. Sodexo Justice Services has managed the prison since 1 December 2013. Care UK provide healthcare services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Northumberland was in June 2012. Inspectors found that the amalgamation of the two prisons had gone well. The Inspectorate assessed the healthcare provision as reasonable and the care of patients with lifelong conditions such as asthma, diabetes and heart disease was good. Clinical governance systems were robust and primary care provision was good. However, a significant number of NHS outpatient appointments were missed, mainly because of transportation problems.

Independent Monitoring Board

16. Each prison 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 report for year to December 2013, the IMB noted that, at a time of major change in the prison when the contract for health had been up for renewal over a prolonged period, there had been no increase in complaints about healthcare.

Previous deaths at HMP Northumberland

17. The man was the third person to die from natural causes at HMP Northumberland since January 2013. We repeat previous concerns in each of the other reports about checking prisoners when unlocking cells.

KEY EVENTS

18. On 25 January 2009, the man was convicted of sexual offences and sentenced to nine years in prison. He was sent to HMP Durham and transferred to HMP Acklington on 30 October 2009.
19. At his initial reception healthcare assessment staff noted he had a history of high blood pressure for which he received medication. He also had a history of substance misuse and had undergone alcohol detoxification at Durham. He said he had been treated in the past for mental health issues and had tried to kill himself in 2008. The man had sleep apnoea and his weight was considered in the obese range.
20. The man was under the care of the specialist pulmonary function team at the local hospital for his sleep apnoea. He had a Continuous Positive Airway Pressure (CPAP) unit to aid his breathing at night, which he managed himself. Residential officers and night staff on his house block were all aware of this.
21. The man's medical records show that he was first prescribed paracetamol in 2010. The records indicate this was likely to have been for a painful knee (following an operation) and intermittent headaches. He received 56 tablets which were re-ordered each month and which he kept in possession. There is no evidence that the prescription was ever reviewed and he continued to receive paracetamol each month until his death.
22. In June 2010, the man had an ECG (electrocardiogram) which indicated a potential left ventricular hypertrophy (thickening of the muscle in the left ventricle of the heart). There is no record that this was followed up or that he had any further ECGs.
23. A prison GP saw the man in June 2011, after a high blood pressure reading and prescribed further medication.
24. On 10 August 2011, the pulmonary function team saw the man at an outpatient appointment at Wansbeck General Hospital, but he did not take his CPAP unit for servicing and recalibration. The hospital advised that his unit should be tested through a titration study (sleep study used to calibrate CPAP therapy) to ensure it was appropriate for his needs and that prison healthcare staff should arrange this. The man did not attend every appointment he had in hospital, in relation to his sleep apnoea. It is recorded that he refused to attend one appointment but there are several others he did not attend because of security or escort issues in the prison. It is not clearly recorded on each occasion why they were cancelled or he did not attend, nor a note of specific follow-up arrangements by healthcare staff.
25. Between July 2011 and February 2013, nurses monitored the man's blood pressure every six months and recorded consistently high readings. Despite this, he was not referred to a GP and his condition was not reviewed.

26. In February 2013, records show the man had an annual review of his hypertension. A cardiac adjusted risk assessment was completed with no abnormal results recorded. It is not clear from the records who carried out the annual review or cardiac adjusted risk assessment.
27. In September 2013, a prison GP saw the man after a high blood pressure reading and prescribed further medication. In January 2014, he was reviewed again and as his blood pressure had still not settled he was prescribed a further medication.

Events on 15 January 2014

28. On 15 January, an officer unlocked the man's cell as he was due to attend work but did not check on him. The man told another prisoner that he felt unwell with sickness and diarrhoea. The prisoner then told an officer, who asked another officer to report this to the duty nurse.
29. An officer saw the man, who explained he felt unwell and unable to leave his cell. The officer informed a nurse, who was issuing medication on the wing, about the man's condition. The nurse suggested that the man should remain in his cell for the day. There are no written notes of these events in his record or in the daily occurrence book or hand-over sheets.
30. The man remained in his cell all day and another prisoner said he visited him a number of times to check on him. There is no record of healthcare staff or officers checking him during the day. No one informed night staff when they came on duty that the man was unwell and they therefore did not check him. The other prisoner told us that the man had some minor discomfort, but had been in good spirits. He said he last spoke to him at about 7.10pm on 15 January when the man reported feeling better.

Events on 16 January

31. On 16 January, an officer began to unlock prisoners at about 7.30am. The man's cell, on the ground floor, was one of the first he opened. In a written statement, the officer explained that he would usually say good morning to each prisoner as he opened their door and wait for a response. However, on this occasion, he said he had been distracted by another prisoner who had an immediate request and he did not wait for a response from the man. He continued to unlock the rest of the landing.
32. The man's friend said that, at about 7.50am, he went into his cell to check on him. The man was lying in bed and appeared to be asleep so he left him. He told two officers that the man could not attend to collect his morning medication as he was still in bed and was unwell.
33. At about 8.00am, an officer escorted the prisoners collecting their medication and told a nurse that the man was too unwell to attend. The nurse did not check on him, but advised the officer that the man should rest in his cell for 72 hours and have clear fluids for 24 hours. If he did not improve or officers were

concerned about him she said that they should contact healthcare staff. The nurse explained that at the time she had no cause for concern and thought the man had a bug that was going around the wing.

34. An officer went back to the man's cell at around 8.10am. He saw the man lying in bed and called out to him, but did not get a response. He then shook his shoulder to try and wake him but the man did not respond. He had his CPAP face mask on and the machine appeared to be working. The officer called a code blue (indicating a prisoner who is unconscious or has breathing difficulties). A custodial manager, and officer and a nurse responded immediately and the control room called an ambulance.
35. The nurse examined the man. She noted his face was blue, he was cold to the touch and rigor mortis was present. As it was evident he had been dead for some time she did not attempt resuscitation. A prison GP attended and, at 8.40am, certified the man's death.

Post-mortem

36. Post-mortem and toxicology reports gave the man's cause of death as dilated cardiomyopathy (enlarged weakened heart that pumps blood less well) and obstructive sleep apnoea. The toxicology report revealed that he had recently ingested a high dose of paracetamol and that, given the condition of his heart, it was possible that this had impacted on his death, although this was not certain.

ISSUES

Clinical care

Hypertension

37. The man's blood pressure was consistently recorded as high, yet he was referred to a doctor only three times between January 2011 and January 2014. There is only one recorded annual review. The clinical reviewer commented that persistent high blood pressure is related to damage to the circulatory system and can contribute to the development of dilated cardiomyopathy.
38. We agree with the clinical reviewer that, while it was clear the man's condition was monitored, insufficient intervention in terms of treatment was provided and that the lack of regular reviews meant that his high blood pressure (hypertension) was not effectively managed for some time. Records show that, more recently, the situation appeared to improve and the man had an annual review in February 2013 and was referred to the GP in September 2013 and in January 2014. However, the lack of intervention and review before that is a concern. We make the following recommendation:

The Head of Healthcare should ensure that high blood pressure is promptly and appropriately investigated and treated in line with current clinical guidelines.

Cardiology

39. The man's ECG in June 2010 showed potential left ventricular hypertrophy, yet this was not followed up or referred to again in the records. No further ECG's were performed to assess his cardiac health. The clinical reviewer comments that "it is good practice for patients who have experienced a protracted period of hypertension, to have an ECG to assess cardiac health." In addition, the man had sleep apnoea, and the clinical reviewer says that this along with an irregular ECG means a referral to cardiology specialists, could also have been beneficial. The clinical reviewer considers that this aspect of care was not equivalent to that the man could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that cardiac health in susceptible patients is assessed and that abnormal ECG results are followed up with referrals to specialist cardiology services where appropriate.

Sleep apnoea

40. The man was diagnosed with sleep apnoea and was under the care of the specialist pulmonary function team at a local hospital. He was given a Continuous Positive Airway Pressure (CPAP) unit to support his breathing at night which he managed himself.

41. The man was offered eight appointments between February 2011 and August 2012 with the specialist pulmonary function team. However he failed to attend, for various reasons, on all but one occasion. On 10 August 2011 he attended but did not take his CPAP machine with him for servicing and recalibration. Hospital staff recommended that he participate in a titration study (sleep study used to calibrate CPAP therapy) to be arranged by prison healthcare. There is no evidence that this was done. The clinical reviewer comments that such equipment should be maintained in line with Care Quality Commission (CQC) standards.
42. There are no clear records explaining why the man did not attend appointments, or why they were cancelled, or that staff made follow-up arrangements. There is also no record that healthcare staff acted on the recommendation for a titration study. The man's CPAP machine should have been serviced and recalibrated to ensure it was running at a therapeutic pressure for his needs. While there is no evidence that this impacted on his death, we make the following recommendations:

The Head of Healthcare should ensure that prisoners receiving care from specialist services have their care coordinated by a named member of the prison healthcare team and that missed appointments are followed up and the reasons recorded.

The Head of Healthcare should ensure that items of clinical equipment, such as CPAP machines, are maintained in accordance with CQC standards.

Paracetamol

43. The man had been prescribed paracetamol in 2010 and kept monthly supplies in his possession. Records are not clear, but indicate this was prescribed after an operation on his knee and because of intermittent headaches. There is no evidence that this prescription was ever reviewed.
44. The pathologist commented that the level of paracetamol in the man's blood was two to four times more than expected from a large therapeutic dose and potentially toxic. Given the condition of his heart, the pathologist concluded that the high level present might have contributed to his death, although this could not be proven. There is no evidence that the man had deliberately overdosed on paracetamol. We make the following recommendation:

The Head of Healthcare should ensure that regular medication reviews are carried out on long-standing prescriptions. The reasons for repeated prescribing should be recorded.

Response to the man's illness

45. We are concerned that when the man reported that he felt unwell with sickness and diarrhoea on the morning before his death, there is no record of

what was done. There is no evidence that a member of healthcare staff went to see him or that officers checked his wellbeing throughout the day and night.

46. The next day, when the man did not attend for his morning medication, a nurse was informed but, believing him to have a bug, did not check him and advised that he should remain in his cell for 72 hours. The clinical reviewer comments that the cause of the man's illness on 15 January was not confirmed, but it could have been an indication of his serious condition. It is important that healthcare staff check on a prisoner who has reported an illness and we make the following recommendation:

The Director and Head of Healthcare should ensure that healthcare staff see a prisoner who reports an illness, that care requirements are recorded and clearly communicated and that officers periodically check their wellbeing throughout the day and night.

Unlock procedures

47. An officer unlocked prisoners' cells just after 7.30am, but did not wait to get a response from the man. For their own safety, officers are supposed to look through the observation hatch before unlocking a cell door. When unlocking cells, they should also take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

"Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

48. HMP Northumberland's Local Security Strategy specifies that staff should interact with prisoners when unlocking cells. However, it was at least another half an hour after unlocking the cell before the man was found. Although this did not affect the outcome for him, in other circumstances poor unlock procedures could lead to a delay in treating a seriously ill prisoner. We have made previous recommendations to HMP Northumberland about this matter. We repeat our recommendation:

The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that high blood pressure is promptly and appropriately investigated and treated in line with current clinical guidelines.
2. The Head of Healthcare should ensure that cardiac health in susceptible patients is assessed and that abnormal ECG results are followed up with referrals to specialist cardiology services where appropriate.
3. The Head of Healthcare should ensure that prisoners receiving care from specialist services have their care coordinated by a named member of the prison healthcare team and that missed appointments are followed up and the reasons recorded.
4. The Head of Healthcare should ensure that items of clinical equipment, such as CPAP machines, are maintained in accordance with CQC standards.
5. The Head of Healthcare should ensure that regular medication reviews are carried out on long-standing prescriptions. The reasons for repeated prescribing should be recorded.
6. The Director and Head of Healthcare should ensure that healthcare staff see a prisoner who reports an illness, that care requirements are recorded and clearly communicated and that officers periodically check their wellbeing throughout the day and night.
7. The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

ACTION PLAN: THE MAN – HMP NORTHUMBERLAND

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that high blood pressure is promptly and appropriately investigated and treated in line with current clinical guidelines.	Accepted	There is a system now in place for GPs to review patients' blood pressure readings and make decisions regarding medication and monitoring. Following this, Nurses arrange care and recalls in line clinical guidelines.	Completed Head of Healthcare Care UK – HMP Northumberland
2	The Head of Healthcare should ensure that cardiac health in susceptible patients is assessed and that abnormal ECG results are followed up with referrals to specialist cardiology services where appropriate.	Accepted	Doctors carry out cardiac assessments and will make referrals to a cardiac specialist if any abnormal results are identified.	Completed Head of Healthcare Care UK – HMP Northumberland
3	The Head of Healthcare should ensure that prisoners receiving care from specialist services have their care coordinated by a named member of the prison healthcare team and that missed appointments are followed up and the reasons recorded.	Accepted	A named clinician will be appointed to any complex condition requiring continuity of care or specialist monitoring. This has already been set up within palliative care, with adopted key workers appointed for each patient. HMP Northumberland is in the process of developing a complex case register. A named nurse will be appointed to each person on the register, who will ensure that missed appointments are followed up accordingly.	September 2014 Head of Healthcare Care UK – HMP Northumberland

4	The Head of Healthcare should ensure that items of clinical equipment, such as CPAP machines, are maintained in accordance with CQC standards.	Accepted	HMP Northumberland is looking to develop an equipment log which will monitor service history, the date of the last recalibration and details of any repairs. This log will be reviewed by a Senior Nurse on a monthly basis.	September 2014 Head of Healthcare Care UK – HMP Northumberland
5	The Head of Healthcare should ensure that regular medication reviews are carried out on long-standing prescriptions. The reasons for repeated prescribing should be recorded.	Accepted	The GP and Pharmacist routinely review all long-term medications on a regular basis using a system which flags up repeat prescription requests for review.	Completed Head of Healthcare Care UK – HMP Northumberland
6	The Director and Head of Healthcare should ensure that healthcare staff see a prisoner who reports an illness, that care requirements are recorded and clearly communicated and that officers periodically check their wellbeing throughout the day and night.	Accepted	A system is in place where requests for healthcare are processed and appointments are arranged, with the care that is being provided recorded on System One. Any special instructions are then provided to wing staff and recorded in the wing observation book. From 1 June 2014, a new out-of-hours process has been introduced. All Doctors now have remote access to System One and are able to check each patient's history and record any advice that is given. The patient is then added to a ledger so it is visible the next day for staff to read and action.	Completed Director and Head of Healthcare Care UK – HMP Northumberland

7	The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	A Notice to Staff will be issued to reinforce the instructions within the Local Security Strategy and Residential Services/Safer Custody guidelines about the requirement for checks to take place on each prisoner's wellbeing when roll checks are conducted.	September 2014 Head of Safer Custody & Head of Residence
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