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 HMP Littlehey in 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 of a heart attack on 12 January 2014, at HMP Littlehey. He was 83 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Littlehey. The prison cooperated fully with the investigation.

The man had been in prison since June 2013 and at Littlehey since September 2013. He told staff he had been diagnosed with high blood pressure and high cholesterol in 1999 and was prescribed medication to manage these conditions. He said he did not have any heart problems. His medication continued while he was in prison. On 12 January 2014, the man collapsed while playing chess with a friend. Staff quickly began cardiopulmonary resuscitation and called an ambulance. Paramedics arrived and confirmed that the man had died.

I am satisfied that the man's death could not have been foreseen or prevented. I agree with the clinical reviewer that, in general, the man's long term conditions appear to have been well managed However, his community records, which would have shown his cardiac history, were not requested when he first came to prison to allow appropriate continuity of care. I am also concerned that the emergency response could have been improved by better access to defibrillators and better staff understanding of emergency codes. It is also disappointing that the man's son was informed of his death by telephone, rather than in person.

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**

CONTENTS

SUMMARY

1. On 21 June 2013, the man was sentenced to 24 months in prison for sexual offences and taken to HMP Chelmsford. At his reception health screen he said that he had been diagnosed with hypertension (high blood pressure) and high cholesterol in 1999. His community medical records were not requested.

2. On 19 September, the man transferred to HMP Littlehey. When he arrived he again reported hypertension and high cholesterol. A healthcare assistant noted that he had not been taking his medication properly as he had accumulated some. On 25 September, a prison GP reviewed the man and requested his community medical records. The man's blood pressure was slightly raised and the GP adjusted his medications. The man told the GP that he had a pain in his arm but refused any further investigation and said that he had never had any heart problems.

3. On 11 November, the GP reviewed the man. His community medical records had been received but were incomplete and she requested the full record. The man's blood pressure indicated that the adjustment in medication had been effective. The doctor noted, from the community records, that the man had been diagnosed with chronic kidney disease and angina in April 2011 and that he had previously been recorded as having raised cholesterol and excess triglycerides (fatty substances) in his blood, which can contribute to heart problems. The man continued to receive his medication and took it as prescribed.

4. On 12 January, the man was playing chess with his friends when he suddenly collapsed. Prisoners alerted staff and pressed the emergency alarm. Officers found that the man was bleeding from a head wound caused by the fall. An emergency code red (to indicate that a prisoner is bleeding) was called. This should automatically trigger the control room to call an ambulance but this was not done. An officer realised that the man appeared to have stopped breathing and staff began cardiopulmonary resuscitation. A custodial manager requested an ambulance. A nurse arrived and helped with the resuscitation attempt. The nurse requested a defibrillator, which took 13 minutes to arrive. Paramedics arrived quickly and took over the emergency treatment but the man did not regain consciousness and they pronounced the man dead.

5. The clinical reviewer says that the man's death could not have been predicted or prevented, and the standard of care he received in prison was generally good. However, the man's community records, which would have shown some cardiac history, should have been requested when he first arrived in prison to ensure continuity of care. During the emergency response, there was a delay in obtaining a defibrillator and we are also concerned that the emergency code procedure was not followed. We make four recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and inviting anyone with relevant information to contact her. One prisoner responded, but his information was not directly related to the investigation into the man's death.

7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. East Anglia Ambulance Service provided details of the contact they had with Littlehey on 12 January 2014.

8. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

9. Two investigators joined by the clinical reviewer, interviewed three members of staff and two prisoners at HMP Littlehey on 18 February. The investigator informed the Governor of the preliminary findings of the investigation.

10. We informed HM Coroner for South and West Cambridgeshire District of the investigation, who provided the post-mortem report. The inquest into the man's death was concluded on 23 January 2014.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. The man's family did not have any specific issues for the investigation to consider.

12. The man's next of kin was informed the draft report was available, but did not wish to make any comment. The prison have 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 LITTLEHEY

13. HMP and YOI Littlehey in Cambridge is a medium security prison holding approximately 1200 men over 21 and young adult men between 18 and 21 in adjoining sites.

14. Cambridgeshire and Peterborough NHS Trust commissions healthcare services. The healthcare centre is open from 7.30am to 5.00pm Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services. A range of nurse-led clinics are run. Cambridgeshire and Peterborough NHS runs an out of hours service. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

15. The most recent inspection of Littlehey was in October 2011. The Inspectorate found the prison had made good progress in addressing the healthcare-related recommendations made after an inspection in 2007. Prisoners were generally happy about access to, and communication with, healthcare staff. Healthcare facilities were satisfactory.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its most recent report, for the year ending January 2013, the IMB did not report favourably on healthcare. They noted healthcare services provided by the Cambridgeshire and Peterborough PCT had suffered because of the length of time it had taken to change the contract for GP services. During this period 30 locum doctors had visited Littlehey and most were unfamiliar with prison. They concluded that healthcare was continually understaffed and that the recruitment process needed revising.

Previous Deaths at Littlehey

17. The man was the fourth prisoner to die from natural causes at Littlehey since 2012. We have raised the issue of emergency response before.

KEY EVENTS

18. On 21 June 2013, the man was sentenced to 24 months in prison for sexual offences and went to HMP Chelmsford. The man told a nurse at an initial health screen, that he had been diagnosed with high blood pressure and high cholesterol in 1999. He brought in a prescription for aspirin, bisoprolol (for heart problems, but also used to treat high blood pressure) and other medications to treat high blood pressure and high cholesterol. He said that he did not use illicit drugs and rarely drank alcohol. (It was later noted that the man was an ex-smoker who had not smoked cigarettes for approximately 15 years.) The man was assessed as suitable to keep his medication in his possession. His community GP medical records were not requested when he was at Chelmsford. He continued to receive aspirin and medication for hypertension, high cholesterol and also for indigestion.

19. The man moved to HMP Littlehey on 19 September. A healthcare assistant completed his initial health screen and recorded a history of hypertension and high cholesterol. The healthcare assistant noted that the man was confused and did not appear to have been taking his medication properly at HMP Chelmsford, as he had excess medication in possession. The healthcare assistant issued his medication and recorded that it should be reviewed when he saw a GP.

20. A prison GP saw the man on 25 September to review his condition and medications. She noted that his community medical records were not in his record and requested them. The man told her that he had been diagnosed with hypertension and high cholesterol in 1999. The man said that he had a pain in his left arm, but he would not let the doctor investigate. He said he did not have chest pain and that he had never had angina or a heart attack and did not require medication for a heart condition. The doctor recorded that his blood pressure was slightly raised and adjusted the man's blood pressure medication, including stopping bisoprolol.

21. On 11 November, the GP reviewed the man. She noted his community medical records had been received but were incomplete. The doctor requested the missing records, but it is not clear whether these were ever received. She noted, from what was available of the man's community record, that in April 2011 he had been diagnosed with chronic kidney disease and angina, (chest pain when the blood supply to the heart is restricted). The available records showed that the man had previously been identified as having high cholesterol and excess triglycerides (fatty substances) in his blood, which can lead to heart disease. The GP recorded the man's blood pressure as 150/90. She considered that this was within a healthy range for his age and the adjustment in medications had been effective.

22. Between 11 November 2013 and 12 January 2014, the man received his medication regularly and there does not appear to have been any further problem with him accumulating medication.

12 January 2014

23. At approximately 3.25pm on 12 January, the man was playing chess with another prisoner when he collapsed and fell onto the floor. Other prisoners attempted to rouse him and noticed his breathing was laboured. They described him as making a gurgling sound. The man's glasses cut his face when he fell. Prisoners pressed the emergency button and called for staff to help.

24. Senior Officer (SO) and two officers responded to the alarm. The SO told us that she arrived within seconds and immediately radioed a code red. She said that she used a code red because at this point the most obvious serious injury she could see was a head injury that was bleeding.

25. Another officer also attended. The three officers moved the man into the recovery position. One officer told us that she noticed he had not made any noise and that she had not seen him breathe. The officer initially found a weak pulse, but said that it became rapid and then stopped. The three officers immediately began cardiopulmonary resuscitation (CPR).

26. A custodial manager attended and quickly realised the situation was serious. He radioed the control room to call an ambulance. The East of England Ambulance Service records show that they received this call at 3.35pm.

27. A nurse responded to the code red call and arrived within two minutes. She checked for signs of life, and recorded that the man was unresponsive and his pain response was zero. She began to assist with CPR. The nurse had brought the emergency bag for a code red (which contains equipment to treat and stop bleeding), so she asked an officer to collect the resuscitation bag. The nurse also asked someone to bring a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The defibrillator was on another wing and records show it took 13 minutes to arrive.

28. At 3.45 paramedics arrived. The paramedics attached their defibrillator and administered adrenalin. They ventilated the man and continued CPR. At 4.03pm the paramedics stopped the resuscitation attempt and confirmed that the man had died.

Liaison with the man's Family

29. Soon after the man died, an operational manager telephoned his son and informed him of his father's death.

30. A prison family liaison officer subsequently telephoned the man's son and visited him later that day to offer support. In line with national policy, the prison contributed towards the cost of the man's funeral which took place on 4 February. A service was held in the prison on the same day.

Support for Staff and Prisoners

31. Staff and prisoners were informed of the man's death by a Governor's notice which offered support to anyone affected. Prisoners identified as at risk of suicide and self-harm were reviewed in case they had been adversely affected by the news of the man's death. The duty governor held a debrief for prison and healthcare staff who were with the man when he died. Staff interviewed during the investigation spoke positively about the support they had been offered. Prisoners who were involved in the incident told investigators that staff had offered them support after the man's death.

Post-mortem

32. A post-mortem examination concluded that the man died from ischaemic heart disease (a medical condition defined by interrupted or restricted blood flow through arteries in the heart muscle) and hypertension (high blood pressure).

ISSUES

Clinical Care

33. The clinical reviewer concluded that the man's healthcare needs were managed well at Littlehey and his care was generally equivalent to that he could have expected in the community. The clinical reviewer identified some areas for improvement in aspects of healthcare, not all of which we repeat, but are identified in the review annexed to this report and which the head of healthcare will need to address.

Medical records

34. The man's community medical records showed he had a cardiac history and hypertension. However, his community records were not requested when he arrived at HMP Chelmsford in June 2013 and, therefore, were not available when he transferred to HMP Littlehey. The man told healthcare staff he had hypertension and high cholesterol, but said he did not have any heart problems. His community records were not requested until a GP saw him on 25 September. Because the historical records were not available at the time, the GP was not aware that he had previously suffered from angina. Partial community records were available to the GP in November, and she noted his angina and raised triglycerides. The clinical reviewer states good medical practice requires that medical records are requested at the time of the patient's registration. Prison Service Order (PSO) 3050, continuity of healthcare, states that efforts should be made to retrieve any information required from the prisoner's community GP or other relevant service when they arrive in prison.

35. The clinical reviewer considers that the management of the man's medication for his hypertension was appropriate, including the decision to stop bisoprolol. However, he says that there was lack of clarity even when the partial notes were obtained about the man's cardiac condition. It would therefore have been appropriate to have made further cardiac investigations, such as an ECG. We make the following recommendations:

The Head of Healthcare at Chelmsford should ensure that GP records are requested for newly arrived prisoners, particularly those with ongoing health conditions.

The Head of Healthcare at Littlehey should ensure that where there is uncertainty or concern about a prisoner's medical history or condition, relevant investigations are carried out to clarify the situation.

Emergency Response

36. The clinical reviewer says that the initial response to the man's collapse from prisoners, officers and healthcare staff was appropriate and timely. However, a defibrillator was not readily available and had to be collected from another wing. This took 13 minutes which is too long in such an emergency. Such a

delay on another occasion of cardiac arrest could be crucial. We make the following recommendation:

The Governor should ensure that there are sufficient defibrillators which are readily available in the prison and taken to emergency incidents when needed.

37. Prison Service Instruction (PSI) 03/2013, which was issued at the beginning of February 2013 required governors to have a medical emergency response code protocol based on the instruction by 28 February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called. The instruction explicitly states that all prison staff must be made aware of and understand the instruction and their responsibilities during medical emergencies.

38. HMP Littlehey has a protocol based on this instruction; however it is clear that staff were not sufficiently aware of their responsibilities in line with PSI 03/2013 and did not follow it. Staff told us that they used these codes to summon healthcare assistance for minor incidents and the control room did not call an ambulance automatically when a code was called. In the man's case, an ambulance was not requested until 3.35pm, eight minutes after the emergency code was called. It would not have changed the outcome in this case, it is important that an ambulance is called immediately in a life threatening situation. After our initial feedback, the Governor informed us that a revised protocol reflecting the PSI had been put in place and, in all future cases, a code red or code blue will immediately prompt the control room to call an ambulance. We therefore do not make a recommendation.

Informing the man's next of kin

39. An operational manager telephoned the man's son and informed him of his death rather than arranging for someone to go and see him and tell him in person.

40. 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"

41. The operational manager told us that he was aware of the correct procedure, but he could not explain why he did not follow it. The man's son did not live a great distance from the prison and it is difficult to understand why a phone call rather than a personal visit, was necessary. The prison's family liaison officer, told us that it is usual for the family liaison officer to visit the next of kin and inform them in person unless there are exceptional circumstances to prevent them from doing so. We make the following recommendation:

The Governor should ensure that in the event of a death, the prisoner's next of kin is informed quickly and in person by a member of Prison Service staff in line with national guidance.

RECOMMENDATIONS

1. The Head of Healthcare at Chelmsford should ensure that GP records are requested for newly arrived prisoners, particularly those with ongoing health conditions.

2. The Head of Healthcare at Littlehey should ensure that where there is uncertainty or concern about a prisoner's medical history or condition, relevant investigations are carried out to clarify the situation.

3. The Governor should ensure that there are sufficient defibrillators which are readily available in the prison and taken to emergency incidents when needed.

4. The Governor should ensure that in the event of a death, the prisoner's next of kin is informed quickly and in person by a member of Prison Service staff in line with national guidance.

PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare at Chelmsford should ensure that GP records are requested for newly arrived prisoners, particularly those with ongoing health conditions.	Accepted	On completion of reception screening prisoners are asked to sign an information to share document that allows the prison to gain any information required from outside agencies, including GPs. The form is faxed to the appropriate outside agency the following morning, and when necessary the GP's surgery advised of the imminent fax and to check they are still registered with the GP. Non responses are chased within 24 hours. All received information is passed to the duty GP to view and action. Once signed, this is scanned and entered in the prisoner's clinical notes.	Completed Head of Healthcare
2	The Head of Healthcare at Littlehey should ensure that where there is uncertainty or concern about a prisoner's medical history or condition, relevant investigations are carried out to clarify the situation.	Accepted	Healthcare to introduce a process to identify concerns and ensure that the GP obtains required information.	31 October 2014 Head of Healthcare

3	The Governor should ensure that there are sufficient defibrillators which are readily available in the prison and taken to emergency incidents when needed.	Accepted	There are currently 11 defibrillators in the establishment. A additional defibrillators will be ordered to ensure that there is one on each residential unit.	31 October 2014 Head of Healthcare/ Head of Safer Custody and Equalities
4	The Governor should ensure that in the event of a death, the prisoner's next of kin is informed quickly and in person by a member of Prison Service staff in line with national guidance.	Accepted	The Death in Custody contingency plan has been amended to make it very clear that the next of kin must be informed by a Family Liaison Officer. All managers have also been reminded of this.	Completed Head of Security