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 Hewell on 6 May 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 6 May 2014, while a prisoner at HMP Hewell. He was 44 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.

The man was sentenced to 14 months in prison on 30 April 2014 and was sent to HMP Hewell. He had an initial reception health screening where his medications were noted. However, his community records were not requested. A doctor noted that the man had had a kidney transplant in 1996 and took medications on a daily basis to maintain effective kidney function. She re-prescribed his medication after discussion with a pharmacist, but did not see him. He did not see a doctor before he died.

At 11.59am on 6 May, the man's cell mate called for help because the man appeared to be fitting. Officers attended and called a code blue emergency. They commenced resuscitation and requested an ambulance. Healthcare staff arrived and continued resuscitation attempts. An ambulance attended and took the man to hospital where he died at 1.00pm.

I agree with the clinical reviewer that the care the man received was equivalent to that he could have expected to receive in the community. However, while it did not affect the outcome for him, it is important to ensure continuity of care for prisoners, especially those with chronic conditions. The man's community records should have been requested and his condition reviewed by a doctor or specialist nurse. I am also concerned that some officers did not have up to date first aid training and lacked confidence when dealing with the emergency and an ambulance was not requested automatically when the emergency code was called, as required.

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 **November 2014**

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SUMMARY

1. On 30 April 2014, the man was sentenced to 14 months in prison for a breach of his licence and further offences of burglary and was sent to HMP Hewell. He had received a kidney transplant in 1996 and arrived in prison with a letter from his doctor listing his medications. At his initial health screening, a nurse noted his various medications and that he had an outstanding medical appointment, but did not record when this was or what it was for. A doctor did not see him but, after discussion with the pharmacist, re-prescribed his medications. The man did not see a doctor during his time in prison and his community medical records were not requested.

2. On 6 May, the man refused to move from the induction block. As a result, an officer put him on report for refusing to move and placed him on basic regime. He was moved into the cell next door with another prisoner, also on basic regime, at about 11.45am.

3. At 11.59am, his cell mate pressed the cell bell as the man appeared to be having a fit while lying on the top bunk bed. An officer just outside the cell responded immediately. The officer could not find a pulse and radioed a code blue emergency. He began cardiopulmonary resuscitation (CPR) the man was on the top bunk bed. Another officer attended at 12.01pm, radioed for an ambulance and took over CPR.

4. At about 12.05pm, nurses arrived at the cell with emergency bags. A nurse tried to attach a defibrillator to him but it would not reach while he was on the top bunk bed. Other officers attended to assist in lifting the man on to the floor. CPR continued and the defibrillator advised a shock on three occasions. Paramedics arrived at 12.14pm and continued with CPR.

5. At about 12.15pm, the Governor contacted the man's partner, to inform her he was unwell and to arrange for her to attend the hospital. The man was taken to hospital at 12.46pm and hospital doctors pronounced him dead at 1.00pm.

6. Because of the distance between the man's partner's home and the prison, she arrived at the hospital at about 3.50pm. The decision was made not to inform her while she was travelling. The Governor, family liaison officer and a prison nurse met with her personally when she arrived to inform her of the man's death.

7. We agree with the clinical reviewer that the standard of care the man received at Hewell was equivalent to that he could have expected to receive in the community. However, his community medical records should have been requested and his chronic condition should have been reviewed. We are also concerned that some officers did not have up to date first aid training and lacked confidence when dealing with the emergency, also an ambulance was not called automatically as the emergency code protocol requires. We make four recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She visited the prison on 8 May and spoke to one prisoner. She interviewed four members of staff at Hewell on 4 June, and conducted three further telephone interviews. She gave the Governor initial feedback on the preliminary findings of the investigation in writing.

10. NHS England commissioned a doctor to review the man's clinical care at the prison. The clinical reviewer interviewed staff with the investigator on 4 June.

11. We informed HM Coroner for Worcestershire of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's partner, his nominated next of kin, to explain the investigation. His partner was concerned that he was being threatened by other prisoners and the stress of this caused his heart attack. She provided copies of letters he had written to her expressing his concerns. His partner also wanted clarification of where the man had died as she had been provided with conflicting accounts.

13. The man's family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly. His partner also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. 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 HEWELL

14. HMP Hewell was formed in 2008 by amalgamating three separate prisons on the same site (Blakenhurst, Brockhill and Hewell Grange). It now comprises two separate sites – a closed category B prison for adult males (the former Blakenhurst) and an open prison, known as The Grange Resettlement Unit (formerly Hewell Grange), also for adult males. The closed site is a local prison and accepts prisoners from courts in the West Midlands, Warwickshire and Worcestershire. It holds up to 1074 men in six houseblocks. 24 hour health care is provided by the NHS. The man was located in the closed site.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Hewell was in November 2012. The Inspectorate noted that healthcare services were good and had improved since the previous inspection. There was adequate screening for prisoners on reception. Reception medical rooms were in need of refurbishment to help infection control. Those with lifelong conditions had access to specialist health care staff. Medication in possession risk assessments were not always included on SystmOne and lockable storage facilities for medications were not available in cells.

Independent Monitoring Board

16. 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 report for the year to November 2012, the IMB commented that all prisoners are seen by a member of healthcare staff on arrival at prison and healthcare is available equally to all prisoners. However, regime change had reduced clinic time and may have contributed to an overall reduction in appointments across the year.

Previous deaths at HMP Hewell

17. This is the second death from natural causes at Hewell since the beginning of 2012. We raised the issue of delays in calling an ambulance in our previous investigation.

KEY EVENTS

18. On 30 April 2014, the man was sentenced to 14 months in prison for a breach of licence and offences of burglary and was sent to HMP Hewell. He had been in prison before and his prison medical records from that time had been retained. During his initial health screening, a nurse noted the man had a pending hospital appointment, although he did not record any further information about this. He also listed seven different medications the man had been prescribed in the community, which were in a letter from his community GP, and referred him to see the doctor in reception. However, he did not record anything about the man's ongoing medical condition (kidney transplant). There is no evidence that the man's community medical records were requested.

19. That afternoon, a prison GP spoke to the prison pharmacist about the man's prescribed medications. However, she did not see him. The GP noted in the man's medical record that he was a kidney transplant patient and re-prescribed his regular medications; prednisolone (oral steroid), atenolol (for high blood pressure), aspirin, cellcept (to prevent organ rejection), omeprazole (to reduce stomach acid), cyclosporine (to prevent organ rejection) and atorvastatin (to reduce cholesterol). He was accommodated in the induction block.

20. A nurse carried out a second health screen for the man on 1 May. She noted that he had had an operation on his left shoulder in 1988 and a kidney transplant in 1996. The next day, the man was told not to use the gym until he had seen a doctor. He did not see a doctor before he died and there is no evidence that an appointment was made for him.

6 May 2014

21. On the morning of 6 May, an officer told the man to move to a residential wing from the induction block. The man refused to move. (He wrote to his partner stating he had refused to move the Friday before, but the PPO investigator saw no prison documentation to evidence this). He did not tell the officer his reasons, but had written a letter to his partner stating he would not move because he had a problem with gang members on the residential block and that he could not "fight them all". (We were told the prison were aware of the man's concerns and these were to be investigated as part of the adjudication process. He died before this was completed). The officer placed him on report for refusing a lawful order. While on report and waiting for adjudication, the man was placed on the basic level of the incentives and earned privileges scheme. (IEP - the scheme is intended to encourage good behaviour and challenge poor behaviour. The basic regime has the least privileges and can be imposed for a number of reasons, including a failure to comply with orders.)

22. At about 11.45am, when prisoners were coming back to their cells for lunch, the officer moved the man to a cell, sharing with another prisoner who was also on the basic regime. The man's previous cell mate said he played cards with him on the night of 5 May and spoke to him twice before he moved cells on 6 May, when he appeared to be fine.

23. Shortly after 11.45am, the man's cell mate pressed the cell bell alarm because it appeared that he was having a fit on the top bunk. It is not possible to know the exact time he pressed the cell bell as the system that records the timings for cell bells was not working. An officer was outside the door and went into the cell immediately the bell was pressed. He immediately called a code blue which was recorded at 11.59am. The officer could not detect a pulse and began cardiopulmonary resuscitation (CPR). As he was on his own and could not move the man safely, the officer stood half-way up the ladder and tried to perform CPR on the top bunk bed.

24. A senior officer arrived and immediately radioed for an ambulance at 12.01pm. He took over chest compressions while the man remained on the top bunk bed. A nursing sister and a healthcare assistant responded to the code blue and brought emergency equipment with them. They arrived shortly after the officers at approximately 12.05pm. The nurse stood on the chair in the cell to reach and assess the man, who she noted was unresponsive and grey in pallor. She lifted the automatic defibrillator onto the top bunk but could not reach to apply the pads to his chest.

25. Another nurse arrived very shortly afterwards, calling officers in from the wing landing to help get the man onto a blanket on the floor. It took five people to lift him off the bed. The healthcare manager arrived at approximately 12.06pm. An officer continued to carry out chest compressions and the healthcare manager provided breaths through a face mask. A nurse attached the defibrillator to the man. While doing this, three small packets of suspected drugs fell from the man's sock and were seized by staff. Nurses gave him three doses of naloxone (an antidote for opiates) in case his seizure was drug related. At 12.14pm, paramedics arrived and continued to work with healthcare staff to perform CPR. The man had three shocks from the defibrillator and several doses of adrenaline while the paramedics tried to stabilise him, before leaving in the ambulance at 12.46pm. The man was unrestrained.

26. At 12.15pm, a prison family liaison officer was appointed. The Governor contacted the man's partner and explained he was very ill and being taken to hospital. Hewell were willing to pay for a taxi. However, the man's partner made her own way to the hospital with a friend.

27. At 1.00pm, hospital doctors confirmed the man had died. As his partner had a long distance to travel, the family liaison officer decided to wait and inform her in person when she arrived at the hospital, which was around 3.50pm. The Governor, the family liaison officer and the healthcare manager met with the man's partner and delivered the news in person, explaining what had happened. His funeral was on 29 May and the prison offered to pay funeral expenses, in line with national guidelines.

Care for staff and prisoners

28. All staff said they felt supported after the incident and felt they had given the man the best emergency care they could. His first cell mate said he felt supported by staff. He was moved to a single cell and able to see Listeners (prisoners trained by the Samaritans). Despite several attempts, it was not

possible to contact the man's second cell mate. He had been released from prison on 7 May.

Post-mortem

29. The post-mortem states that the man died of acute cardiac failure, caused by ischaemic and hypertensive heart disease. The toxicology report shows drugs were not a factor in his death. The only injuries on his body were consistent with resuscitation attempts.

ISSUES

Clinical care

30. The clinical reviewer states the care the man received in prison was the equivalent to that he could have expected to receive in the community. His partner was concerned that he was being bullied and the stress of this caused his heart attack. The investigation found no evidence of bullying within the prison, but there is evidence he suffered some intimidation while in the community. The clinical reviewer found that there was no evidence that stress was the cause of his heart attack as the man was lying quietly on the top bunk bed at the time of the cardiac arrest. Statements from fellow prisoners say there was nothing unusual about his behaviour leading up to his death.

31. The man had received a reception health screening on 30 April when he arrived in prison. He brought in his own supply of prescribed medications and a letter from his community doctor, detailing the medications he needed. However, the letter was not a complete account of his recent medical treatment. The man also said he had an outstanding hospital appointment which was noted, but there was no detail and it was not followed up.

32. Prison Service Order, PSO 3050, states that for continuity of healthcare 'efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with'. Although the prison had access to the man's previous prison medical history dating back to 2006, there is no evidence his most recent community medical records were requested. Healthcare staff told us that records are usually requested within 48 hours. However, this does not appear to have happened.

33. The clinical reviewer states that the quick summary (the information about the man's medical conditions printed and given to the paramedics to take to hospital) on 6 May, was incomplete and incorrect. For example, the dates for his kidney transplant were incorrect. Such information could have been verified from his community records. Also, it is clear from his community records (which the clinical reviewer has seen) that he was having six monthly reviews in relation to his kidney transplant. Although this had been happening in the community, prison healthcare staff were unaware that it needed to continue. The man was in prison a very short time and the clinical reviewer states that, although it did not affect his care and was not the cause of his death, the consequences could have been significant. Community records should always be requested, especially for prisoners with chronic conditions. We make the following recommendation:

    The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested to ensure continuity of healthcare in line with PSO 3050.

34. Although a nurse referred the man to the doctor on 30 April, a doctor did not see him, but re-prescribed the medication he needed after a discussion with the pharmacist. The doctor was the duty doctor and did not get to reception until near the end of her working day. No further referral for the man to see a

doctor was made in the second health screening or in the days that followed. The doctor stated that the man would have been flagged in the healthcare ledgers as suffering from a chronic disease and a member of healthcare would have referred him to the doctor, probably within six weeks of reception. She said healthcare staff were alert to monitoring prisoners and would have seen him frequently when he collected his medications.

35. The National Institute of Health and Care Excellence (NICE) guidelines suggest regular follow ups for transplant patients and notes that they are more at risk of other illnesses and heart attacks. The clinical reviewer states that, as it was not immediately apparent to reception staff that the man had received ongoing care while in the community, it would have been sensible to review his chronic conditions fully. This should have been in an in-house chronic disease clinic or by a GP. Although healthcare staff at Hewell are aware of prisoners with chronic conditions through the healthcare ledgers, there is no specific clinic for the management of chronic conditions. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with chronic diseases are appropriately assessed and monitored by GPs or by trained nurses in regular chronic disease management clinics.

Emergency response

36. Officers and nursing staff performed CPR on the man while he was lying on the top bunk bed in his cell. CPR is best carried out on a hard surface. However, officers did not immediately move him off the top bunk bed because they did not feel it was safe to do so, and they were concerned that moving him without the proper support could cause him further injury, so it should be a clinical decision. A nurse stated that he was surprised the man was still on the bunk bed when he arrived in the cell but did say that it was difficult to get him off the bed even with five taller officers helping. A nurse was unable to attach the defibrillator to the man until he was on the floor.

37. It became apparent during interviews that one officer was first aid trained and although another officer had been first aid trained, this was out-of-date. We consider that moving someone from a bunk bed to the floor should not require a clinical decision. Although it is unlikely to have changed the outcome for the man, a delay in effective CPR could be crucial in other circumstances. We agree with the clinical reviewer, that more up to date training for all officers who are likely to be first to respond to any emergency incident, would increase their confidence in making such decisions, without waiting for healthcare staff. We make the following recommendation:

    The Governor should ensure prison staff have up to date first aid training to give confidence in decision making when dealing with an emergency.

38. An officer called a code blue at 11.59am, but the control room staff did not call an ambulance until an officer requested one at 12.01pm. In line with PSI 03/2013 on emergency medical response codes, Hewell's service instruction states the control room should call an ambulance automatically as soon as a code blue (prisoner unconscious or not breathing) or code red (a severe injury

with a potentially life threatening loss of blood) is radioed. It is apparent from our interviews during this investigation, that when an emergency code is radioed at Hewell, the control room does not automatically call an ambulance. We found that staff often use code blue or red to obtain healthcare assistance, not always in an emergency situation, which is not what the codes are designed for.

39. Although the minor delay in calling an ambulance would not have changed the outcome for the man, in other circumstances it could make a significant difference. We make the following recommendation:

The Governor should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that:

- **staff efficiently communicate the nature of a medical emergency;**
- **relevant emergency equipment is brought; and**
- **that there are no delays in calling, directing or discharging ambulances**

RECOMMENDATIONS

1. The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested to ensure continuity of healthcare in line with PSO 3050.

2. The Head of Healthcare should ensure that prisoners with chronic diseases are appropriately assessed and monitored by GPs or by trained nurses in regular chronic disease management clinics.

3. The Governor should ensure prison staff have up to date first aid training to give confidence in decision making when dealing with an emergency.

4. The Governor should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that:

    - staff efficiently communicate the nature of a medical emergency;
    - relevant emergency equipment is brought; and
    - that there are no delays in calling, directing or discharging ambulances

ACTION PLAN: The man – HMP Hewell

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested to ensure continuity of healthcare in line with PSO 3050.	Accepted	System one records are now routinely updated to add community GP details and other relevant records to ensure compliance	Completed Head of Healthcare	
2	The Head of Healthcare should ensure that prisoners with chronic diseases are appropriately assessed and monitored by GPs or by trained nurses in regular chronic disease management clinics.	Accepted	There is now a weekly Multi-Disciplinary Team Meeting including the GP's, the Lead Primary Care Nurse, the Nurse Practitioner responsible for Chronic Diseases and the Deputy Head of Healthcare to discuss and update all the men identified as having any chronic on going illnesses including transplants.	Completed Head of Healthcare	
3	The Governor should ensure prison staff have up to date first aid training to give confidence in decision making when dealing with an emergency.	Accepted	In line with the national policy, HMP Hewell ensure that sufficient numbers of staff at the prison receive first aid training. HMP Hewell will ensure that such designated first aiders receive the required three yearly requalification training and will support them to additionally attend refresher training annually. A notice will be issued to remind first aid trained staff of the need to complete refresher training within the agreed time period.	31 October 2014 The Governor & Head of Safety	
4	The Governor should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical	Accepted	The Governor and Head of Safety will remind staff of their responsibilities during medical emergencies by way of a notice to staff. The Medical Response Protocol will be reviewed to ensure it covers all the elements listed and re-	31 October 2014 The Governor & Head of Safety	

	emergencies as outlined in the local Medical Emergency Response Code Protocol so that: • staff efficiently communicate the nature of a medical emergency; • relevant emergency equipment is brought; and • that there are no delays in calling, directing or discharging ambulances		published to all staff, who will aim to ensure that all of the elements of the protocol are met wherever possible.		