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 Ranby in March 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 cardiac arrest on 1 March 2014 at HMP Ranby. He was 67 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 man's clinical care in custody. HMP Ranby cooperated fully with the investigation.

The man had been in prison since May 2010. Doctors were investigating the possibility of leukaemia before he went to prison and this was confirmed shortly afterwards. Although the prognosis was unclear, he understood the condition was life limiting from the outset. Over time, his condition fluctuated between feeling well and suffering from the side effects of his chemotherapy treatment. The man's health slowly deteriorated over the next three years. Hospital consultants frequently monitored him and prison healthcare staff saw him daily. Prison staff, particularly his personal officer, gave him good support.

On the afternoon of 1 March 2014, an officer found the man collapsed in his cell. Staff attempted to resuscitate him and called an ambulance. Paramedics attended but pronounced the man dead shortly afterwards.

The clinical reviewer identified some concerns, but concluded that the general care Ranby provided to the man was good. Although it would not have affected the outcome for the man, I am concerned that the prison did not call an ambulance immediately an emergency code was received, as national and local instructions require.

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 **August 2014**

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SUMMARY

1. On 28 May 2010, the man received an indeterminate sentence for public protection with a minimum period to serve of 30 months. Before his sentence, hospital doctors had told him that he might have leukaemia and they had taken blood tests. In August 2010, a consultant confirmed that he had leukaemia.

2. The man transferred to HMP Ranby on 8 September 2010. At his initial health screen he told the nurse about his diagnosis and that he suffered from depression and asthma. Healthcare staff continued his medication and requested his community and hospital records.

3. The man's condition slowly deteriorated and he started chemotherapy in January 2011. On 1 March, he reported chest tightness and a doctor prescribed aspirin. He had an ECG, but the results were not recorded. It does not appear that any further investigation of the cause of his chest problem was carried out, but there is no indication this was an ongoing issue. Throughout 2011 and 2012, healthcare staff saw the man every day. He attended many hospital appointments to manage and treat his leukaemia.

4. During February and March 2012, records show the man was pale and lethargic and staff had trouble taking blood for testing. On 16 March, a nurse reviewed the man and considered he was jaundiced and dehydrated. The nurse arranged for him to be taken to hospital where doctors diagnosed pneumonia. He remained in hospital for four days.

5. In December 2012, records show that the man was experiencing very high temperatures. He was taken to hospital twice as a result, but on other occasions no actions were recorded.

6. The man's treatment continued throughout 2013 and early 2014. Healthcare staff continued to see him daily and he attended hospital for treatment. At 4.56pm on 1 March 2014, an officer found the man collapsed and unresponsive in his cell. He radioed a code blue (a prisoner unresponsive or with breathing difficulties) and a nurse and healthcare support worker attended. The control room did not call an ambulance immediately the emergency code was received. A nurse began resuscitation and asked staff to call an ambulance. A paramedic attended and took over the resuscitation attempt. The man did not respond and the paramedic pronounced him dead at 5.27pm.

7. The clinical reviewer was concerned about how well the man's temperature was managed when he was undergoing chemotherapy, and the lack of follow up when he reported chest tightness in 2011. However, he was satisfied that the general care Ranby provided was good. We are concerned that an ambulance was not called as soon as an emergency code was called, contrary to the national instructions and the prison's own emergency response protocol. We make two recommendations.

THE INVESTIGATION PROCESS

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

9. The investigator obtained the man's prison medical records and relevant extracts from his prison record. The investigator interviewed six members of staff and two prisoners at Ranby. He informed the prison of the preliminary findings of the investigation.

10. NHS East Midlands commissioned a clinical reviewer to review the man's clinical care at the prison.

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

12. One of the Ombudsman's family liaison officers wrote to the man's' family to explain the investigation. The man's family had no specific issues for the investigation to consider.

13. The man's family received a copy of the draft report. There were no factual inaccuracies. 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 RANBY

14. HMP Ranby is a category C prison for prisoners who do not require a high level of security, but are not ready for open conditions. It holds over a thousand men. Nottinghamshire Healthcare Trust has provided primary healthcare services at Ranby since 1 April 2013.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of Ranby was in March 2014. The report of that inspection has yet to be published, but we understand that while inspectors had serious concerns about safety at the prison they found that the quality of health services had improved since their previous inspection in 2012 and they were confident that a new healthcare provider was addressing areas of deficiencies. Waiting times had improved and were reasonable for most services. There was no coordinated monitoring and support of prisoners with cardiac conditions. Inspectors were concerned that the supervision of medicine administration was inadequate and prisoners had nowhere to store medication safely. Mental health support was good. As at the previous inspection, concern remained about the lack of staff trained in first aid or resuscitation to cover times when there were no healthcare staff on duty. Hospital appointments were well managed and few were cancelled.

Independent Monitoring Board (IMB)

16. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The most recent IMB annual report for the year to March 2013 noted that the healthcare centre was well staffed, but an increase in the number of emergency code requests had risen which had increased the workload for nurses who were required to respond.

Previous deaths at Ranby

17. The man was the second prisoner at Ranby to die from natural causes since the start of 2013. We made a recommendation about the correct use of emergency codes in that investigation.

KEY EVENTS

18. On 28 May 2010, the man was convicted of arson and sentenced to an indeterminate sentence for public protection, with a minimum term of 30 months before he could be considered for release. He was sent to HMP Doncaster. Before going to prison, the man had undergone several blood tests at Doncaster Royal Infirmary and doctors had told him he might have chronic lymphocytic leukaemia (a slow growing, low grade blood cell cancer).

19. On 11 August, a consultant haematologist saw the man and confirmed a diagnosis of chronic lymphocytic leukaemia. The consultant told him it was likely to be incurable but at that time did not require treatment. He told the man that his condition would be monitored every three to four months.

20. On 8 September, the man transferred to HMP Ranby. A nurse carried out his initial health screen. The man told her about his diagnosis of leukemia and that he suffered from depression and asthma, for which he was prescribed medication and inhalers. The nurse requested his community and hospital health records.

21. Soon after his arrival at Ranby, an officer became the man's personal officer. (A personal officer is the prisoner's first point of contact if they have questions, complaints or need help or advice). The man's personal officer and the man developed a good working relationship. The man's personal officer took a close interest in his wellbeing and often arranged to be one of the escorting officers when he went to hospital appointments, including on days she would not normally be working.

22. Over the next three months, the man's condition deteriorated slowly. Staff were concerned about him being depressed and a mental health nurse saw him regularly as part of his care plan.

23. The man's condition deteriorated further and he started chemotherapy in late January 2011. A prison GP saw him on 1 March as he had complained of tightness in his chest. The GP prescribed aspirin. The man had an ECG, but the results are not noted in his record. (There is no evidence that a problem was detected.) His prescription for aspirin continued for one year but no further investigation was made to establish the reason for the chest tightness. There is no record that the man complained of this again.

24. Throughout 2011 and 2012, healthcare staff saw the man daily and he attended frequent hospital appointments to manage and treat his leukaemia, including more chemotherapy. The man was also prescribed steroid medication. A member of healthcare staff attended all his appointments with him, to make sure he understood and that there was clarity about his ongoing treatment.

25. During February and March 2012, the man became progressively weaker. Records show he was pale and lethargic. On 27 February, a

healthcare support worker noted that it was not possible to take blood and it was decided to wait until the man's next scheduled appointment for the hospital to take blood tests. On 16 March, a prison practice nurse reviewed him and considered he was jaundiced and dehydrated. She arranged for him to be taken to hospital. At hospital, doctors diagnosed pneumonia and he remained in hospital until 20 March. Through most of 2012, healthcare staff continued to see the man daily and he attended hospital appointments for chemotherapy.

26. In December 2012, the man's temperature was often high and healthcare staff monitored it. On 8 December, the man's temperature was recorded as 38.1C and noted to be "a little high". Healthcare staff gave him paracetamol and planned to see him again that afternoon. There is no record that this happened. By 10 December, the man's temperature had reached 39.3C and he was then sent to hospital as an emergency. It is not clear what treatment he received in hospital, but he returned to Ranby the next day. On 21 December, the man's temperature was 39.6C and he was sent to hospital again. He returned to the prison the day after.

27. Through 2013, the man's treatment continued and healthcare staff still saw him every day. Records show that staff monitored his temperature, but the results were not always recorded. Sometimes it was recorded as high but there was no record of what action was taken.

28. On 2 December 2013, the haematologist started an alternative treatment for the man's leukaemia and nurses at Ranby implemented a new care plan.

29. At lunchtime on 16 January 2014 a nurse practitioner recorded a slight rise in temperature, 37.3C, for which he was given paracetamol. At about 3.00pm, a prison modern matron went to see the man. She found him lying on his bed. He was awake but did not respond to instructions. His glucose level was high and his abdomen was distended. The matron arranged for the hospital to review him the next day. The hospital diagnosed steroid induced diabetes and prescribed metformin (diabetic medication). His glucose levels improved and his temperature continued to be checked daily.

30. On 3 February, the hospital consultant reviewed the man, and reduced the steroid medication because his blood count had improved. The man's temperature was taken daily throughout February, but the results were not always recorded in his medical record. On 26 February, the man said he felt tired and weak. On the mornings of 27, 28 February and 1 March, his temperature was normal each time it was checked.

1 March 2014

31. At 4.56pm on 1 March, an officer found the man face down and unresponsive in his cell. He radioed a code blue. The control room did

not call an ambulance automatically when they received the emergency call. A nurse and a healthcare support worker responded and arrived at his cell a few minutes later, around 5.00pm. At first they found no apparent signs of life. An operational manager and the duty governor, also attended. The nurse asked for an ambulance to be called. The record shows this was requested at 5.03pm.

32. The nurse found a faint pulse and gave the man oxygen, but his pulse became undetectable. The nurses began cardiopulmonary resuscitation and continued until a paramedic arrived at 5.22pm and took over. The man did not respond and the paramedic pronounced him dead at 5.27pm.

Liaison with the man's family

33. At 8.10pm, two prison family liaison officers went to the man's brother's home and informed him of his death. The man's family later visited the prison and spoke to one of his friends. The family liaison officer arranged the funeral, at the request of the man's family. The funeral took place on 1 April and the Governor and other members of prison staff attended. The prison met the cost of the funeral in line with national guidance.

Support for staff and prisoners

34. A Governor's notice informed staff and prisoners of the man's death and 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. A debrief was held for the staff who had been involved in the man's care.

Post-mortem

35. A post-mortem examination showed that the man died from cardiac arrest, leukaemia, type 2 diabetes and asthma.

ISSUES

Clinical care

36. The clinical reviewer concludes that, from when the man first arrived at the prison, input from healthcare staff was considerable and, on the whole, appropriate. The man required regular scheduled hospital outpatient's visits, which he was able to attend without difficulty. There was good communication between primary and secondary care. In the last 12 months of his life, 243 appointments were documented on SystmOne (the computerised medical records system). After October 2013, no restraints were use and he was released on temporary licence to attend hospital appointments, accompanied by a nurse. Healthcare staff saw him daily for medication and temperature checks. The clinical reviewer comments that this high level of input encouraged compliance with his chemotherapy regime and reduced the risk of complications resulting from chemotherapy.

37. Healthcare staff at Ranby were aware of the complexities of the man's treatment and the clinical reviewer says that healthcare staff accompanying him to outpatient appointments was good practice and ensured there was no confusion relating to instructions from the haematology department.

38. Pain relief was not an issue during the man's illness; his main problems were fatigue and chronic diarrhoea which were as a result of his condition and medications. His temperature was recorded most days once he began steroid treatment and chemotherapy. Daily temperature monitoring and recording in the clinical record were part of the nursing care plans. However, there were some days when no temperature was recorded.

39. The clinical reviewer was concerned, that there were some documented entries of high temperatures which do not appear to have been followed up. On 8 December 2012, the man's temperature was recorded as 38.1C. The nurse noted this as 'a little high' and prescribed paracetamol. The clinical reviewer says this was in fact dangerously high, yet this was not followed up or taken again later in the day. The man was undergoing chemotherapy and the effective monitoring of his temperature was critical, as a high temperature could have indicated serious complications.

40. Although the man died from a cardiac arrest, there was nothing in his medical record that indicated he had any heart disease. In March 2011, the man complained of chest tightness and the doctor prescribed aspirin. An ECG was carried out but the results were not recorded. There is no other evidence that his chest tightness was followed up or any further investigations were made. However, it does not appear that the man reported any further problem with chest pain.

41. The clinical reviewer also notes that in the weeks leading up to 16 March when the man was admitted to hospital with jaundice and low haemoglobin levels he had been unwell and becoming progressively more anemic, yet nurses did not refer him to a doctor. The clinical reviewer's says that at this time the man could easily have died from acute heart failure or sepsis.

42. The clinical reviewer found that most of the man's care was good but there were episodes in 2012 where the man's clinical care fell short of expected standards and noted that the effective management of temperature in patients undergoing chemotherapy is critical. We recognise that the healthcare provider at Ranby changed in 2013, but because of the clinical reviewer's concern we make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are fully aware of the critical nature of effective temperature monitoring and follow up when a patient is undergoing chemotherapy.

Emergency protocol

43. 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.

44. HMP Ranby issued a Staff Information Notice on medical emergency response Codes on 18 February 2013 which gives clear instruction in line with PSI 03/2013 that an ambulance should be called automatically as soon as an emergency code is called. This was not done. It is important that an ambulance is called immediately in a life threatening situation. We make the following recommendation:

The Governor should ensure that all prison 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 and that an ambulance is requested as soon as an emergency medical code is called.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff are fully aware of the critical nature of effective temperature monitoring and follow up when a patient is undergoing chemotherapy.

2. The Governor should ensure that all prison 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 and that an ambulance is requested as soon as an emergency medical code is called.

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ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that healthcare staff are fully aware of the critical nature of effective temperature monitoring and follow up when a patient is undergoing chemotherapy.	Accepted	The Head of Healthcare will ensure that all healthcare staff are fully aware of the critical nature of effective temperature monitoring and staff requiring further training will be identified. Staff will also be reminded of the requirement to follow up temperature checks when a patient is undergoing chemotherapy.	Head of Healthcare 31 October 2014
2	The Governor should ensure that all prison 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 and that an ambulance is requested as soon as an emergency medical code is called.	Accepted	A Notice to Staff will be re-issued to remind them of the requirements of PSI 03/2013. In addition, an "Emergency Response Guide" will be attached to staff wage slips which states when a code blue or red should be called and the action that should be taken. All control room staff will receive further guidance about their responsibilities, which will include information about when the emergency services should be called.	Head of Safer Custody 31 October 2014