A Report by the Prisons and Probation Ombudsman
Nigel Newcomen, CBE

Investigation into the death of a man at HMP Hewell in June 2013

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 at HMP Hewell in June 2013. A post-mortem examination found that he died of ischaemic heart disease. He was 41 years old. I offer my condolences to his family and friends.

A clinical review was commissioned of the clinical care provided to the man at Hewell. The prison cooperated fully with this investigation.

The man arrived at Hewell on 30 May after being sentenced to 12 weeks imprisonment. He was dependent on drugs and alcohol and began alcohol withdrawal treatment and a methadone maintenance programme. He did not report any other health problems in the following days and had little interaction with healthcare staff apart from collecting his medication daily.

In June, the man was found unresponsive in his bed after he had failed to collect his morning medication. An officer began to attempt resuscitation but stopped shortly afterwards when it became clear that he had been dead for some time.

The man apparently died some time during the night but this was not noticed at an early morning roll count or when his cell was unlocked at 9.00am, when a check should have been made on his wellbeing. Although it did not affect the outcome for him, an ambulance was not requested immediately an emergency code was called, as national instructions require. However, overall, I am satisfied that the standard of healthcare he received was equivalent to that he could have expected to receive in the community. His death was sudden and unavoidable and there was nothing that prison staff could have done to prevent it.

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 **December 2013**

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SUMMARY

1. The man suffered from chronic alcoholism and had been a drug user since the age 15. He had been released from a period on remand at HMP Hewell in March 2013 the same day he was convicted due to time already served.

2. On 30 May, the man was sentenced to 12 weeks imprisonment and was sent to Hewell. On arrival he began an alcohol detoxification and methadone maintenance programme. Apart from collecting his diazepam (for alcohol withdrawal) and methadone he had little other contact with healthcare staff.

3. One morning in June, an Operational Support Grade (OSG) completed a roll count on the man's wing and noted nothing untoward. At approximately 9.00am, an officer started to unlock the ground floor landing where he lived. When she opened his cell she said he appeared to be asleep, but she had no interaction with him.

4. After the man did not turn up to collect his methadone that morning, an officer went to his cell and found him lying in his bed unresponsive. He immediately called for assistance but an ambulance was not called until five minutes afterwards. A nurse who was close by attended and believed that he had already died, although he did not check for signs of life. Two officers who also came to the cell thought they saw signs of life, so one officer began to attempt resuscitation in the form of chest compressions. Another nurse attended and, although she was certain he had died, she advised the officer to continue as she did not believe she was legally able to confirm death. Shortly afterwards a senior nurse arrived and both nurses agreed that resuscitation should stop. The senior nurse found the man's jaw to be locked, no pulse and signs of rigor mortis. Paramedics arrived at 9.40am, and at 9.55am the senior nurse formally confirmed his death.

5. The post-mortem report indicated that the man died from ischaemic heart disease. The clinical reviewer found that his death was sudden and could not have been foreseen and prevented. We make recommendations about unlock and emergency procedures.

THE INVESTIGATION PROCESS

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

7. The local PCT commissioned a clinical reviewer to review the man's clinical care in prison.

8. The investigator visited Hewell on 12 June, where she met the Governor, prison liaison officer, family liaison officer, deputy healthcare manager and POA union representative. She obtained copies of the man's prison and prison healthcare records.

9. The investigator interviewed staff at Hewell on 2 and 4 September and conducted a further interview by telephone on 24 September.

10. HM Coroner for Worcester was informed of the investigation and provided a copy of the post-mortem report. The Coroner has been sent this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's partner and his mother to explain the purpose of the investigation and invite his family to raise any relevant matters for the investigation to consider. His partner said that she had been surprised at his death, but had no issues to raise and neither did his mother. As part of the consultation process the family received a copy of the draft report, they had no further comments or concerns.

HMP HEWELL

12. 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 1084 men in six houseblocks. Health services are provided by Worcestershire Health and Care NHS Trust.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons (HMIP) last inspected Hewell in November 2012. The Inspectorate found that, positive changes in the delivery of health care had been made since their last inspection in 2009, but commented that there were still some important developments to be completed, including staff recruitment and the control of infection in some areas. Prisoners waited a long time to see a GP, but the range of services available to them was good.

14. In relation to the management of substance misuse, the Inspectorate found that healthcare staff screened new arrivals, and when necessary prisoners received a comprehensive substance misuse assessment from a specialist nurse in reception. Appropriate first night prescribing of opiate substitute medication and alcohol detoxification was available.

Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published report the IMB said they were satisfied that outpatient care was staffed to ensure patients were seen and, if necessary, treated within a reasonable time.

Previous Deaths in Custody

16. This office has investigated five deaths from natural causes at Hewell since 2011. Three of these (including the man) were heart related.

KEY EVENTS

17. The man suffered from chronic alcoholism and had been a drug user since he was 15 years old. He had served several prison sentences. On 9 October 2012 he had been remanded to HMP Hewell, during which time he was treated for alcohol withdrawal and drug dependency. It was noted that he had hepatitis C (a virus that can infect and damage the liver). He received some anticoagulant treatment for reported deep vein thrombosis and tramadol for neck pain, although his community GP records did not fully support these prescriptions. On 18 March 2013, he was sentenced to five month imprisonment. He was released from custody the same day as he had already served the time on remand.

18. On 31 May the man was sentenced to 12 weeks imprisonment and went to Hewell the same day. At a reception health screen, it was noted that he appeared to be withdrawing from drugs and alcohol. He tested positive for benzodiazepine (used to treat anxiety and often available illicitly, known as ‘benzos’) and opiates. He told a nurse that his alcohol intake for the week before his arrest had been about 210 units. (The NHS recommends that a man should not drink more than three to four units of alcohol a day regularly.) A doctor prescribed alcohol detoxification treatment and a methadone maintenance programme.

19. On 1 June, the man asked a nurse if he could be prescribed pregabalin for his neck pain. He presented an empty pregabalin box with his name on explaining that it had been prescribed in the community. A letter was faxed to his community GP asking for details of his current prescriptions and a summary of key healthcare problems. A reply received on 4 June confirmed a recent prescription of pregabalin, but it was not clear what this was for. This was re-prescribed by the prison GP.

20. Apart from collecting diazepam (for alcohol withdrawal) and methadone the man had little contact with healthcare staff and did not report any further health concerns.

21. An Operational Support Grade (OSG) was on night shift on 8 June on houseblock four (where the man lived) and arrived there at 9.00pm. The OSG told our investigator that prisoners had been locked in their cells since 7.30pm that evening, and at handover no concerns were raised about the wellbeing of any of the prisoners on the wing.

22. At 5.00am the next morning, the OSG started a roll check (a physical count of prisoners for security purposes) for houseblock four. She said that during the roll count all prisoners were either awake or lying on their beds and she noted nothing untoward. She said that ordinarily he shared a cell and slept on the top bunk but his cellmate had been taken to hospital a few days earlier so he was alone in the cell. She could not recall what he was doing when she checked his cell that morning.

23. At 7.30am, an officer (officer A) took over from the night OSG . Officer A said that no concerns were raised during the handover. At approximately 9.00am, prisoners needing morning medication were unlocked. Officer B was opening the cells on the man's landing and his cell was the last to be opened. His cell was next to the medication hatch where prisoners were queuing. Officer B said she opened the viewing panel to his cell and saw he was in his bed and apparently asleep. She said that, as she was unlocking the door, she was distracted by another prisoner who wanted to talk to her and she did not check on his wellbeing. She then went to assist with the medication queue.

24. The man did not attend to collect his methadone, so at 9.26am Officer C went to his cell. He found him lying on his right hand side. He called his name and, when he did not reply, he shook his shoulder and found that he was cold and unresponsive. The officer immediately called a code blue emergency (indicating that a person has breathing/respiratory problems) and asked healthcare staff to attend. He left the cell and said he asked Nurse A, who had been helping with the methadone prescriptions in the clinical room next door, to assist.

25. Nurse A told the investigator that when he went into the cell he saw the man lying on his bed. He noted that he was extremely pale and still and that there was pooling of blood in his lower limbs. The nurse said it was obvious to him that he was dead and he did not check for signs of life. Officer A and Nurse B, who was part of the emergency response team that day, then came into the cell and Nurse A left.

26. At 9.28am, as Nurse B arrived, Officers A and B said they thought they heard a bubbling sound coming from the man, so Officer A tried to begin cardiopulmonary resuscitation (CPR) by giving chest compressions. Nurse B told the investigator that it was obvious to her that he had died but, when Officer A asked if he should continue CPR, she was not sure if she was legally allowed to say he was dead. Although she was certain that resuscitation would not be possible she said that the officer should continue. A senior nurse then arrived and he and Nurse B indicated to the officer that he should stop as the man was clearly dead. The senior nurse said that he believed that CPR had barely begun. He examined him and found his jaw to be locked, no pulse and signs of rigor mortis. Records show that an ambulance was called at 9.31am and paramedics arrived at the cell at 9.40am. He was confirmed dead by the senior nurse at 9.55am.

27. At 1.30pm, the Governor and the prison's family liaison officers visited the man's partner and informed her of his death. At his partner's request, they then visited and informed his mother. In line with national policy the prison contributed towards the cost of the funeral.

28. Staff and prisoners were informed of the man's death through a Governor's notice and were offered support. All prisoners at risk of self-harm or suicide were checked to ensure their wellbeing in case they had been adversely affected by the news of his death. A debrief for all the staff involved in the emergency response was held the same day.

29. The post-mortem indicated that the cause of death was ischaemic heart disease.

ISSUES

Medical Care

30. The man had no previous history of heart disease and did not show any symptoms leading up to his death. The clinical reviewer says his death would have been sudden and could not have been prevented. Toxicology showed that he had therapeutic levels of prescribed medication in his body. There were also several drugs present that had not been prescribed and therefore had been taken illicitly, however none of these were at levels that would have contributed to his death. Neither the post-mortem nor clinical reviewer suggests that the combined effects of these drugs had any bearing on his death.

31. The clinical reviewer considered that the man's detoxification from alcohol, and methadone maintenance were handled appropriately and did not have any direct bearing on his heart condition or his death.

32. The clinical reviewer examined the man's clinical care at the prison during two previous stays as well as the sentence he was serving at the time of his death. He identified some issues, particularly about medication, which the head of healthcare will wish to consider but are not covered in this report as they were not directly related to the circumstances of his death. Overall, the clinical reviewer found that the medical care he received was good and comparable with that of a normal GP Practice. His immediate care needs were dealt with appropriately, as was the management of his chronic health problems.

Unlock procedures

33. The OSG said that during the early morning roll count at 5.00am she normally opens every viewing panel and shines a torch in, to ensure the correct numbers of prisoners are present and not in any evident distress.

34. Hewell has a local instruction 'Management and Security of Nights' issued on 24 November 2012, which states that "it is expected that the wellbeing of the prisoner is checked. Night patrols should satisfy themselves that breathing or movement is noted". This instruction was further reinforced on 30 January 2013 when local operational order 003/2013 was published to remind prison staff that, when conducting a roll count, "the wellbeing of each prisoner must be assessed". At interview the OSG said that she was not aware of these instructions.

35. Officer B told the investigator that she routinely greets prisoners when she unlocks their cells to check on their wellbeing before moving on to the next cell. However, because she was interrupted by another prisoner when unlocking the man's cell door, she omitted to do this. She had noted that he appeared to be asleep.

36. It is apparent that the man had died some time during the night but there was no check on his wellbeing either at the 5.00am roll check or when his cell was unlocked at 9.00am. Officers said that they did not always follow the correct unlock procedures and at weekends officers would not disturb prisoners to check on them when they unlocked them. On weekdays officers said there was often not sufficient time to do more than just a quick visual check.

37. After the man's death, the Deputy Governor issued a notice to all OSGs to remind them of the correct roll count procedures. The Governor has also instigated an investigation into the early morning roll check and unlock for 9 June. While we understand that staff will not necessarily want to wake prisoners early in the morning, we consider that they should be satisfied that a prisoner is actually alive and take some action if there is no sign that the prisoner is breathing. At unlock they should make take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "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". We make the following recommendation:

The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

38. Officers and nurses responded promptly when the man was found. While there was some initial confusion and uncertainty about whether to start resuscitation, the first officer on the scene acted appropriately when he thought there were signs of life. It was then quickly recognised that the presence of rigor mortis and other indicators meant that he had been dead some time and a decision was made to stop. We are satisfied that the staff involved acted properly.

39. While it would not have made a difference in the man's case, we are concerned that an emergency ambulance was not called immediately a code blue emergency was called. PSI 03/2013 which came into effect in February 2013, some months before his death, makes it clear that when an emergency code is called, an ambulance should be requested immediately by the control room and that a local protocol should be in place that reflects this. Officer C called a code blue at 9.26am, but records show that an ambulance was not called until 9.31am. We make the following recommendation:

The Governor should ensure that there is a Medical Emergency Response Code protocol in line with PSI 03/2013, and that an ambulance is requested immediately an emergency code is called.

RECOMMENDATIONS

1. The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

2. The Governor should ensure that there is a Medical Emergency Response Code protocol in line with PSI 03/2013, and that an ambulance is requested immediately an emergency code is called.

ACTION PLAN: The Man – HMP Hewell

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that all prison staff are aware of the correct procedures at roll checks and that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	A Notice to Staff will be re-issued regarding the wellbeing of prisoners at unlock. An operational order was issued in 2013 to all operational staff at HMP Hewell. This will be included in team briefings across the prison.	30/11/2013	
2	The Governor should ensure that there is a Medical Emergency Response Code protocol in line with PSI 03/2013, and that an ambulance is requested immediately an emergency code is called.	Accepted	A Medical Emergency Response Code protocol is in place. A Notice to Staff will be issued as a reminder of the correct emergency codes and the requirement to request an ambulance immediately when one is used.	30/11/12013	