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 in January 2012, a prisoner at HMP Isle of Wight

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 report of an investigation into the death of the man at HMP Isle of Wight. He was 64 years old. The cause of death was coronary thrombosis (heart attack). I offer my condolences to his family and friends.

A review of the clinical care the man received at HMP Isle of Wight was conducted. I apologise for the delay in issuing this report.

The man had a number of serious medical conditions, including heart disease and epilepsy. In January 2012, at around 6.00pm, he had difficulty breathing and staff and prisoners thought he was having an epileptic fit. He stopped breathing and a senior officer and two prisoners attempted to resuscitate him. Paramedics later arrived and continued the resuscitation attempts, but he was pronounced dead at 6.58pm.

I agree with the clinical reviewer's conclusion that the man received a satisfactory level of clinical care at the prison. However, I am concerned that when he became unwell in January there was a delay in the emergency response and officers did not follow the prison's policy for obtaining emergency medical attention. While it might not have affected the outcome in his case, it is important that an ambulance is called immediately when there are serious concerns about a prisoner's health.

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 2013**

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SUMMARY

1. The man was remanded to HMP Winchester on 14 August 2007. On 6 December, he was sentenced to 13 years imprisonment and moved to what was then HMP Parkhurst on 17 December. He moved to Albany in 2010.

2. The man had several long term medical conditions, including asthma, diabetes, heart disease and epilepsy. He took many medications to help manage them and was under the care of healthcare staff and hospital consultants. On several occasions he was admitted to the inpatient healthcare unit for close observation, usually after suffering epileptic fits.

3. On 11 January 2012, the man was admitted to the inpatient unit as he was acting vaguely and did not recognise staff. The next week he was diagnosed with mild to moderate Alzheimer's disease. On 17 January, when he was back on his wing, he had an electrocardiogram (ECG) to test the electrical activity in his heart. The results of this test were not recorded in his medical record but healthcare staff said they did not show anything significant.

4. At around 6.00pm on the day of the incident, a prisoner reported that the man seemed to be having a fit in his cell. Officers went to the cell and one of them checked his pulse, which was very weak. He then telephoned to ask the orderly officer[1] to attend the wing immediately. An officer telephoned the inpatient unit to ask a nurse to come to the wing, but was told that the nurses were unable to leave patients in the unit at that time. It was suggested that they take him to the healthcare unit.

5. The man's condition deteriorated and he stopped breathing. A further call for assistance was made to the healthcare unit. A senior officer (SO) and two first–aid trained prisoners attempted cardiopulmonary resuscitation (CPR). The orderly officer arrived at 6.10pm and asked staff to bring a defibrillator[2] to the cell. An ambulance was called at 6.11pm. The Senior Officer attached a defibrillator to him and a shock was administered, as advised. CPR then continued. Paramedics arrived at 6.25pm, followed by a nurse two minutes later with emergency equipment. The paramedics continued CPR, but he was pronounced dead at 6.58pm.

6. The investigation found that although the man's health was generally managed well at HMP Isle of Wight, there were inadequacies in the emergency response. We make two recommendations about emergency procedures.

[1] The orderly officer is responsible for the oversight of activities within the prison such as discharging prisoners, dealing with incidents and leading on emergencies.
[2] A life-saving machine that gives the heart an electric shock in some cases of cardiac arrest

THE INVESTIGATION PROCESS

7. This office was informed of the man's death on 18 January 2012. The investigator issued notices to staff and prisoners at HMP Isle of Wight to inform them of the investigation process and ask anyone with relevant information to contact him. One prisoner responded, highlighting their concerns about emergency responses at night and staff training in resuscitation. Another investigator who was at HMP Isle of Wight on 19 January, obtained initial information about his death.

8. HM Coroner for Isle of Wight was informed of the investigation. A copy of the post-mortem report was received on 6 March 2012.

9. A review of the clinical care the man received at HMP Isle of Wight was conducted on behalf of the Primary Care Trust cluster.

10. The investigator reviewed the man's prison records. On 20 and 21 March 2012, he visited HMP Isle of Wight, where he interviewed six prison officers and three prisoners. He then gave written feedback to the Governor. We are sorry for the delay in issuing this report, which was caused by staffing changes during the course of the investigation and a backlog of cases in the office which we are striving to clear.

11. One of the Ombudsman's family liaison officers contacted the man's ex-wife, his nominated next of kin, shortly after his death and explained the purpose and scope of the investigation. His ex-wife did not have any specific issues she wished the investigation to cover.

HMP ISLE OF WIGHT

12. HMP Isle of Wight is an amalgamation of three prisons, Parkhurst, Camp Hill and Albany. From 2010, the man lived at the Albany site, which holds up to 567 sex offenders and vulnerable prisoners in five cell blocks.

13. Health services at HMP Isle of Wight are commissioned and provided by the Primary Care Trust (PCT). An inpatient unit was opened in October 2009 at the Albany site. It caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

Her Majesty's Inspectorate of Prisons (HMIP)

14. HMIP conducted an announced full follow-up inspection of HMP Isle of Wight in May 2012. They found that health services had improved considerably from their previous inspection, although there were some delays in accessing primary care services for prisoners at Albany. Inspectors also found that there were good care arrangements for men with palliative care needs.

15. The inspection found that prisoners with chronic (long term) diseases were reviewed regularly and there were suitable nurse-led clinics for prisoners with respiratory diseases.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for HMP Isle of Wight noted that the opening of the inpatient healthcare unit had reduced the number of prisoners staying as inpatients in outside hospital. They also noted that the ageing population at Albany led to increased waiting lists for some health services.

Previous deaths at HMP Isle of Wight

17. This office has investigated many previous deaths at the former HMP Albany, now part of HMP Isle of Wight. The majority of them were as a result of natural causes, reflecting Albany's relatively elderly population.

KEY EVENTS

18. The man was charged with serious sexual offences and remanded into custody on 14 August 2007. He was taken to HMP Winchester. On 6 December, he was sentenced to 13 years' imprisonment and moved to what was then HMP Parkhurst on 17 December 2007.

19. At a reception health screen, a nurse noted that he had been diagnosed with asthma, diabetes, heart disease, epilepsy, spondylosis (a condition that causes stiffening of the spine) and depression. He took many medications to help manage his conditions. His medical notes also showed that he had had a stroke three weeks before at HMP Winchester. He was referred to a consultant at hospital for follow-up appointments. Further test results from the hospital ruled out a stroke, but there were continuing references to a stroke in his medical records.

20. The man frequently had epileptic fits. He took anticonvulsants to help control them and his medication was adjusted to try to optimise the management of his epilepsy. Owing to the frequency of his fits, staff admitted him to the inpatient unit for observation on many occasions. He also experienced long-standing episodes of confusion and poor memory, which were thought to be due to a combination of his fits, cerebrovascular disease and lifelong learning difficulties.

21. In February 2009, a consultant physician reviewed the man's blood pressure. Tests showed a 50 per cent reduction in the flow in his right carotid artery. (Carotid arteries are in the neck and control the flow of blood to the brain.) The consultant planned to treat him by controlling his blood pressure with medication and helping him to stop smoking, thereby reducing the risk of a further stroke. His medical record shows that his blood pressure was within the normal range most of the time. Although he sometimes had high blood pressure, staff thought this was due to him not taking his medications regularly.

22. On 30 April 2010, the man was admitted to the inpatient unit for general observation. It was noted in his medical record that healthcare staff intended to monitor his medication compliance, his diet and fluid intake, any fits and incontinence. They would also record his weight weekly. He was discharged back to Parkhurst on 13 June. On 8 September, after spending a further six weeks in the inpatient unit after a fit, he transferred to a ground floor cell at the Albany site.

23. During 2011, the man had a number of epileptic fits, on one occasion fracturing his elbow. He also attended diabetic clinics and, towards the end of the year, he was admitted to the inpatient unit to review his care and medication.

24. On 10 January 2012, the man reported that he had been feeling sick and had had muscle spasms for 24 hours. A doctor diagnosed a minor upper respiratory tract (nose or throat) infection and advised him to take paracetamol.

25. The next day, 11 January, a nurse wrote in the man's records that he was "very vague" and "did not appear to recognise me". The nurse discussed this with a

doctor. They planned to review him the following day and admit him to the inpatient unit if necessary. Wing staff were asked to advise the inpatient unit of any change in his condition and he was admitted to the unit later that day.

26. On 12 January, a doctor noted the man had increased disorientation and memory loss and requested memory and blood tests. Nurses recorded that he had not shown any signs of confusion overnight and had taken his medication as prescribed. The next day, a doctor reviewed him and noted the comments made by the night staff. He noted "… Appears fit to return to wing, but would be observed over weekend if any doubts about ability to care for self. Review Monday".

27. The doctor reviewed the man on 16 January. A further memory test indicated that he had mild to moderate Alzheimer's disease. The doctor requested an electrocardiogram (ECG, to measure the electrical activity in the heart) and asked for him to be referred to the memory service. It is not clear when he was discharged from the inpatient unit, but a nurse noted that she had seen him on the wing later that day. She gave him his medication and noted that there were no problems or concerns.

28. On 17 January, the man had an ECG but there is no record of the results and the clinical reviewer was told they were missing. Healthcare staff said the ECG had not shown anything significant.

Events of the incident

29. At 4.29pm on the day of the incident a doctor examined the man, who engaged well with him, but said that he was confused by his medication regime and was feeling more depressed. There is no evidence that he reported chest pain or feeling unwell at this time.

30. The investigator interviewed a prisoner and the man's "buddy"[3]. The prisoner had assisted him during his fits but thought that he sometimes faked them to get attention from prisoners and staff. He said that at around 6.00pm, he was getting ready for cells to be locked for the evening. As he walked up the corridor of F1 wing, another prisoner told him that he was unwell. The prisoner went into the man's cell and saw him sitting in an upright chair. He believed he was having a genuine fit and described him as rigid. He considered the situation was serious and shouted for help.

31. At 6.02pm, Officer A was in the wing office when he heard raised voices and went to the man's cell. He saw him sitting in a chair, his head supported by the prisoner. He also believed he was having an epileptic fit.

32. Officer B followed Officer A into the cell. Officer B knew the man well and thought that the situation looked very serious. He checked and found a weak pulse. He then went to the wing office and telephoned the orderly officer, a

[3] Someone who is selected and paid by the prison to help and assist prisoners with mobility problems, such as with cleaning cells, getting meals and taking to groups and appointments.

Senior Officer (SO), to come to the wing immediately. It was around 6.05pm. No emergency code was used and the SO 1 thought she was attending a "normal incident". After the telephone call to the SO, Officer B rang the healthcare centre and asked Officer C for a nurse to attend F wing. He was told that nurses could not leave the inpatient unit in the evenings and overnight. A nurse suggested that officers should take the man to the unit in a wheelchair.

33. Officer A said that the man took a deep breath which made him think he was recovering from the fit. He then slumped into the chair and he decided to put him in the recovery position. The officer and the prisoner placed him onto his bed, as there was insufficient room in the cell to lay him on the floor. The officer patted him on his back and noted that he took a deep breath. He also found a weak pulse, so he left the cell to raise the emergency and get assistance. The prisoner described him as then going blue and he thought he had died.

34. Officer A met SO 2 in the corridor and took him to the cell. The SO found the man was not breathing very well. He then stopped breathing and the SO started cardiopulmonary resuscitation (CPR) assisted by two prisoners. Both were first aiders. The SO said that the man had a weak pulse, so he asked for a defibrillator to be brought to the cell.

35. SO 1 arrived on F wing at 6.10pm and saw SO 2 and two prisoners attempting to resuscitate the man. She left the cell to alert the duty governor, but was told that he had already been informed. The prison has three defibrillators - in the gym, healthcare department and in the main residential block of the prison. SO 1 asked an officer to bring a defibrillator from the residential block to F wing. The defibrillator in the healthcare centre was the nearest, but the centre was said to be closed.

36. The prison movement log[4] shows that an officer requested an ambulance at 6.11pm. The nurse who was on duty in the healthcare centre said that she also received a call at this time to say that the man had collapsed and was having problems breathing. She called the wing back two or three minutes later and was told that staff were performing CPR, so she went to the wing, taking oxygen and emergency equipment with her.

37. The log notes that at 6.18pm, paramedics arrived at the prison and were on their way to the wing. An officer brought the defibrillator at 6.23pm. SO 1 asked staff to clear the cell and place the man on the floor. She applied the defibrillator, which initially advised her to shock him, then advised no further action. The paramedics arrived at the wing at 6.25pm and the nurse two minutes later, at 6.27pm. SO 1 left the cell to allow the paramedics space to work on him.

38. At 6.43pm, a second paramedic team arrived at the prison gate. They were escorted to the wing and both paramedic teams attempted to resuscitate the man until 6.58pm, when he was pronounced dead.

[4] A log of prisoner movements throughout the prison during the day

Support for prisoners

39. Wing staff and the duty governor visited all prisoners on the wing individually and spoke to them about the man's death. Notices were displayed in the prison to let prisoners know of his death and the support that was available to them. All prisoners subject to suicide prevention monitoring were reviewed.

40. SO 1 said that the prisoners involved in the emergency response were able to talk to a Listener (prisoners trained by the Samaritans to offer support to fellow prisoners in distress). The prisoner confirmed that a Listener supported him that evening.

Support for staff

41. After serious incidents, such as the death of a prisoner, prison managers are expected to hold a "hot debrief" where staff involved in the incident can discuss how it was managed and be offered appropriate support. Although a debrief was not held, apparently because staff had finished their shift and wanted to go home, an SO and the duty governor had individual meetings with staff. SO 1 checked that staff were properly cared for and whether they wanted support from the prison's care team[5]. SO 1 told the investigator that she did not deploy the care team because "at the time every one said they were okay". Employee Support Officers visited the prison some weeks later to carry out a critical incident debrief, to enable staff to discuss the incident and the personal impact it might have had on them.

Family liaison

42. The prison's family liaison officer left the prison with the chaplain at 10.00pm to visit the man's ex-wife, his nominated next of kin and inform her of his death. The address given appeared not to exist and they eventually returned to the prison at 1.30am. The next day, staff checked his details using the Royal Mail website and found the correct address for his ex-wife. The FLO and an operational manager went to the address, arriving at 4.30pm, but were told by the householder that the man's ex-wife had moved two years before. The prison then asked Hampshire Police to find his ex-wife. At 5.50pm, the FLO was told that they had visited her and broken the news of her ex-husband's death. The FLO visited the man's ex-wife on 21 January.

43. The man was cremated on 2 February. The prison paid the funeral costs and three members of staff attended. A memorial service was held in the chapel at Albany on 6 February.

[5] The care team are officers trained in offering support to colleagues and prisoners involved in serious incidents in the prison.

Post-mortem report

44. The post-mortem report shows that the man's death was due to coronary thrombosis (a blockage in one of the arteries in his heart) and that all three coronary arteries in his heart were significantly narrowed.

ISSUES

Clinical care

45. The man had various longstanding medical conditions, before going into prison. Healthcare staff referred him to appropriate consultants at local hospitals and encouraged him to take the medications prescribed to help manage his conditions. The clinical reviewer says that his conditions could have been managed in a more proactive manner, as specified in the NHS care quality objectives. However, these lapses did not affect his overall care, which was equal to that which he could have expected to receive in the community.

46. We agree with the findings of the clinical review. Although the man's clinical care appears to have been generally satisfactory, the Head of Healthcare will need to consider the more detailed recommendations in the clinical review.

Emergency response

47. There are two nurses and two prison officers on duty in the inpatient unit in the evening and overnight. The nurses are not expected to attend wings routinely as this might mean leaving patients in the inpatient unit with insufficient professional supervision. The most recent prison policy for out of hours healthcare support states that nurses can attend medical emergencies if safe to do so without compromising the care of inpatients. The document also makes it clear that, in an emergency, staff should call for an ambulance in the first instance and that any expected attendance by inpatient unit staff must not delay an ambulance being called.

48. Prisoners we spoke to said they were worried about healthcare cover at night. They believed staff responses were slow, and because wing staff were not trained in CPR, they were concerned about delays in getting trained staff to an emergency on the wing.

49. Wing staff responded quickly to reports of the man being unwell in his cell at 6.02pm. An officer contacted the inpatient unit a few minutes later and asked for a nurse to attend as the wing staff believed he was having a fit. Although it was a serious medical emergency, the officer was told that nurses could not leave the inpatient unit and it was suggested that officers should take him to the unit in a wheelchair. His condition then declined and a senior prison officer and two prisoners started CPR. Wing staff again contacted the healthcare centre for assistance. An ambulance was not called until 6.11pm. Staff and prisoners continued CPR until paramedics arrived at 6.25pm, followed by a nurse from the inpatient unit at 6.27pm.

50. We are concerned that in a prison with 24 hour nurse cover, it took a nurse more than 20 minutes to attend after the man first collapsed and that an ambulance was not called immediately. Although operational prison staff made every effort to revive him, they did not have appropriate access to emergency life saving equipment (which is discussed later in this section). An ambulance should have been called at the same time that healthcare staff were alerted to his collapse. It

is not possible to say whether earlier intervention by healthcare professionals would have changed the outcome for him, and it does not appear likely, but it could make a significant difference in future medical emergencies.

The Governor and Head of Healthcare should ensure that all staff are aware of the policy for healthcare staff to attend medical emergencies and that an ambulance is called immediately.

Location of defibrillator

51. SO 1 arrived at the man's cell at 6.10pm. CPR had started by this time and she asked for a defibrillator to be brought to the cell immediately. She considered the nearest location of a defibrillator, the healthcare centre, to be "closed" so asked for one to be brought over from the main residential block. The SO was not able to give exact timings but thought it would take about two to three minutes to get the defibrillator to F wing from the main residential block. However, it took thirteen minutes after the SO's initial request. We consider this is too long in a serious medical emergency. We are reassured that the prison now has a defibrillator for F and G wing, where many of the prisoners are frail and elderly.

Use of radios and emergency codes

52. During the evening, after 5.00pm, two wing staff carry radios on F and G wing. All senior officers also carry radios. When the man collapsed, wing staff considered the situation to be a medical emergency. In spite of this, they did not use their radios or an emergency code[6] to alert other staff. If an emergency code had been used, the SOs on duty, who have been trained in CPR and defibrillator use, would have known to go to the cell immediately. In this case, one of the officers left his cell to telephone healthcare. Leaving an emergency to telephone staff can potentially lead to delay in staff and equipment arriving, and can also leave other staff on their own to deal with an incident. None of the officers interviewed explained why they did not use radios and an appropriate emergency code to alert others about the nature of the emergency. This means that SO 1 did not initially know about the seriousness of the situation. Had she been fully aware, she might have requested a defibrillator and an ambulance sooner.

The Governor should ensure that in an emergency staff radio an appropriate emergency code to alert others to the nature of the incident.

[6] A "Code Blue" is used to signify a life threatening emergency such as a prisoner who has collapsed or who is experiencing breathing difficulties. It also enables staff to determine what emergency equipment should be brought to the scene.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all staff are aware of the policy for healthcare staff to attend medical emergencies and that an ambulance is called immediately.

   The National Offender Management Service accepted the recommendation and responded:

   "Guidance for staff originally issued in February 2011 and last updated in February 2012. These make clear the expectations for both health and prison staff in relation to medical emergencies and the need to call 999 without delay. These will be revisited and refreshed as part of the transfer of healthcare services from the NHS Trust to a new provider from 1st April 2013. To be re-circulated to all prison staff."

2. The Governor should ensure that in an emergency staff radio an appropriate emergency code to alert others to the nature of the incident.

   The National Offender Management Service accepted the recommendation and responded:

   "National guidance has now been released (PSI 03/2013) Medical Emergency Response Codes.

   "Prior to this a notice to staff was issued outlining the processes for responding to medical emergencies (NTS 257 -2011) issued on 4/11/2011 and an Operational Instruction (OI 027-2012) issued 30/11/2012."