Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in February 2014 while in the custody of HMP Elmley

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 in February 2014 while a prisoner at HMP Elmley. He died from bronchopneumonia. He was 65 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the clinical care the man received at HMP Elmley. The prison cooperated fully with the investigation.

The man had been released on licence from Elmley in April 2009, but was recalled to prison in April 2010 and sent back to Elmley. He had a number of chronic health conditions, including chronic obstructive pulmonary disease, (COPD) which healthcare staff managed throughout his time at Elmley.

On 2 February 2014, the man reported breathing difficulties. A prison GP prescribed some medication, but did not prescribe antibiotics in line with the national guidance for the treatment of COPD. On 3 February, his breathing difficulties got worse and he was taken to hospital. His condition continued to deteriorate and he remained in hospital until he died several days later.

The man did not attend numerous healthcare appointments, but the reasons were not followed up or recorded. He did not have timely blood tests to ensure his medication was at optimum level and the management of his COPD was not in line with national guidelines. Accordingly, the clinical reviewer found that the clinical care he received at Elmley was not equivalent to that he could have expected in the community.

I am also concerned that there appeared to be disagreement between healthcare staff and prison officers about the use of emergency medical codes, although the national and local instructions are clear. This appeared to result in some delay in the man receiving urgent medical assistance on 2 and 3 February. The Governor and Head of Healthcare need to overcome this. I am also concerned that, despite his very poor health and mobility, restraints were sometimes used without proper justification when he was taken to hospital.

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. The man was convicted of sexual offences in November 2005 and sent to HMP Elmley. He was released on licence in November 2006. In July 2007 he was convicted of further sexual offences and sent back to Elmley. He was released on licence again in April 2009. In April 2010, he was recalled to prison for breaching the conditions of his licence and, in February 2012, was convicted of further sexual offences and sentenced to 17 years in prison. He returned to HMP Elmley.

2. The man was in poor health for many years and had several long term medical conditions. His reception health screen in 2010 noted he was physically frail and suffered with chronic obstructive pulmonary disease (lung disease, including chronic bronchitis and emphysema), an enlarged prostate (for which he had a catheter), osteoarthritis and a duodenal ulcer

3. Healthcare staff monitored the man's medical conditions with blood tests, scans and X-rays. However, he often did not attend healthcare appointments and there was no follow up to record the reasons.

4. On 2 February 2014, a nurse responded to an emergency call when the man reported breathing difficulties but took ten minutes to attend. Although a code blue emergency had been called the control room did not request an ambulance. A prison GP reviewed him in healthcare and prescribed some medication but did not prescribe antibiotics in line with the national guidance for the treatment of COPD.

5. On 3 February, an officer was concerned about the man and sought healthcare assistance. He was taken to hospital by emergency ambulance after a nurse and a doctor assessed him. Two prison officers accompanied him and he was restrained by an escort chain.

6. The man remained in hospital and his condition continued to deteriorate. He died at 12.44am on 7 February. The post-mortem report recorded his cause of death as bronchopneumonia due to chronic obstructive pulmonary disease.

7. The clinical reviewer concluded that the care provided to the man by HMP Elmley was not equal to that he could have expected in the community. He was concerned that his frequent non-attendance at appointments was not followed up and that his COPD was not managed in line with national guidelines, in particular that he was not prescribed antibiotics on 2 February. We are concerned that a lack of agreement between healthcare staff and prison officers about the use of emergency codes delayed him receiving urgent care on two occasions. We are also concerned that he was restrained when taken to hospital, despite his very poor health, and without proper justification. We make four recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and inviting anyone with relevant information to contact him. One prisoner responded.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. He visited HMP Elmley on 21 February 2014 and saw the healthcare unit and the houseblock where he lived. He also spoke to prisoners, prison and healthcare staff. He interviewed 11 members of staff on 26 and 27 March at HMP Elmley. He gave the Governor's representative initial feedback on the investigation and followed this up in writing.

10. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.

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

12. Despite extensive enquiries by the prison, police, coroner's officer and our office, it has not been possible to locate any of the man's relatives.

13. The prison received a copy of the report and has 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 ELMLEY

14. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves the courts in Kent and holds more than 1,200 men in five wings, with a mixture of single, double and triple cells

15. At the time of the man's death, NHS England, Kent and Medway commissioned Integrated Care 24 Ltd (IC24) to provide primary healthcare services at Elmley. The healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Elmley was in March 2012. The Inspectorate found that, overall, access to and quality of healthcare was generally good. Inspectors noted that GP clinics took place regularly and a high rate of non-attendance had recently reduced significantly. The Inspectorate found there was a good range of nurse and specialist led clinics and attendance at outside hospital appointments was well managed. Inspectors also noted that palliative care had been developed and used successfully with the cooperation of local services.

Independent Monitoring Board

17. 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 October 2013, the IMB noted that since the takeover of primary healthcare by South East Health (now known as IC 24) in February 2013, 45 new staff had been employed. There were plans to open clinical consulting rooms on all six houseblocks which it was hoped would relieve waiting times in outpatients and reduce 'did not attend' rates. Overall, healthcare was described as clean with staff doing an excellent job, being helpful, hardworking and cooperative.

Previous deaths at HMP Elmley

18. The man's death was one of two from natural causes at Elmley since the start of 2012. There have been two further deaths since he died. We have raised the issues of follow up of blood test results, non-attendance for medical appointments and emergency response before.

KEY EVENTS

19. The man was convicted of sexual offences in November 2005 and sent to HMP Elmley. He was released on licence on 8 November 2006. In July 2007, he was convicted of further sexual offences and went to Elmley again. He was released on licence on 9 April 2009. On 28 April 2010, he was recalled to prison for breaching the conditions of his licence and in February 2012, was convicted of further sexual offences and sentenced to 17 years in prison. He returned to HMP Elmley.

20. The man had suffered poor health for many years. At a health screen in April 2010, a nurse described him as physically frail and noted he suffered from chronic obstructive pulmonary disease (COPD), an enlarged prostate with indwelling catheter, osteoarthritis and a duodenal ulcer. He was prescribed theophylline (a medication to treat lung disease). He used a walking stick and a wheelchair to aid his mobility.

21. On 30 April 2010, a prison GP saw the man to review his medication. To help with his breathing difficulties, he gave him a nebulizer (which administers medication in the form of a mist inhaled into the lungs). Healthcare staff delivered his medication weekly and a prisoner carer helped with his day to day living.

22. For the remainder of 2010 and most of 2011, healthcare staff saw the man frequently in relation to the management of his catheter, his osteoarthritis and problems with an abscess on his ankle.

23. On 2 December 2011, a nurse referred the man to the doctor after he complained of coughing up sputum with blood. On 4 December, a doctor examined him and found his lungs had generalised crackles with poor air entry. He prescribed steroids and antibiotics and requested a chest X-ray. He did not attend the prison clinic for two X-rays arranged in December. The reasons were not recorded.

24. On 6 February 2012, the man stayed in the healthcare centre overnight for a mental health assessment after his conviction. No mental health concerns were identified. That night, he had an exacerbation of his COPD. On 7 February, a doctor prescribed antibiotics and he went back to the wing later that afternoon.

25. On 18 February, the man was admitted to the healthcare centre with breathing difficulties. He was given nebulised salbutamol (medication to help open airways and ease breathing) and the next day a doctor prescribed a course of steroids and antibiotics. On 20 February, he went back to the wing.

26. On 26 March, the man had a spirometry test (to assess how well the lungs are working). The test confirmed that salbutomol had eased his symptoms.

27. On 20 September, a prison GP requested routine blood tests together with an overdue check for theophylline levels. (Theophylline is a drug used to manage chronic lung disease, it is potentially toxic and the prescribed dose must be optimised). On 8 November, a doctor noted the theophylline levels had not been checked as he had requested in September and made a further request. However, the man did not attend the next four planned appointments for blood samples to be taken.

28. In January 2013, a blood sample was taken and a doctor noted very low levels of theophylline. She referred the man to another doctor, who saw him on 17 January to review his theophylline medication. No change was made.

29. On 7 February, a doctor reviewed the man and noted that minimal exertion caused him to become breathless. He relied on his carer to bring him meals. He was on maximum inhaler therapy, but he had not had a pulmonary rehabilitation or oxygen assessment and a doctor referred him to the community respiratory nursing team at hospital. On 7 March, a doctor was asked to re-refer him to the respiratory team because the original referral did not meet their criteria. He faxed the revised document the same day. There is no record that the respiratory team saw him or that the referral was followed up.

30. From March to June 2013, the doctor did not complain of any breathlessness. Healthcare staff saw him a number of times about other matters including problems with a non-healing ulcer on his ankle and the management of his catheter.

31. On 14 June, a nurse saw the man on the wing after he had become breathless while showering. She noted he was not breathless when talking and appeared well. She advised him to leave the window open to allow good ventilation. On 21 June, a nurse examined him who complained he had been breathless overnight and had not been able to find his nebuliser in the dark. His pulse and respiratory rates and oxygen saturation, were within normal limits. He was given a small torch to help him find his nebuliser at night.

32. Between June 2013 and February 2014, healthcare staff continued to see the man frequently about the management of his catheter and his ongoing ulcerated ankle.

Events on 2 February 2014

33. At 10.45am on 2 February 2014, an officer radioed a code blue (an emergency code which indicates a prisoner with breathing problems) as the man was having trouble breathing and reported having chest pains. At 10.55am, a nurse attended and spoke to him. He said his medication was out of date, he needed steroids and he felt unable to breathe properly. He complained of a chesty cough and green sputum. The nurse told the officer that in her opinion the code blue emergency call was unnecessary

and an overreaction. An ambulance was not called, however, she arranged for him to be taken to the healthcare centre.

34. The nurse examined the man and noted his pulse was elevated. He had a mild fever, low oxygen saturation and a raised respiratory rate. The nurse noted crackles in both lungs and that his blood pressure was slightly high.

35. At 11.33am, a doctor examined the man and noted he suffered from COPD, had limited lung function and had difficulty completing sentences because of breathlessness. He prescribed erdosteine (a medication which aids in the clearance of mucus from the airways) prednisolone (an oral steroid) and salbutamol nebulizer but did not prescribe any antibiotics. His condition stabilised and he returned to the wing in the early afternoon.

Events on 3 February 2014

36. On 3 February at about 2.00pm, a prisoner told an officer that the man had breathing difficulties. The officer went to see him, who was sitting on a chair in his cell. He noted that he looked pale and, though able to talk, his breathing was laboured.

37. The officer contacted a healthcare assistant, who said that she would take the man's medication to him. The officer returned to him and found him unchanged. He telephoned a nurse, who said that someone would attend. The officer went back to his cell intending to wait with him until a member of healthcare staff arrived.

38. However, the officer became very concerned about the man's condition and went to the healthcare centre to tell them he had breathing difficulties and needed urgent assistance. At 2.15pm, the nurse went to his cell with the officer, taking an emergency bag. They found he was still struggling to breathe and unable to complete a sentence. He was very pale and his hands were blue. The nurse administered nebulised salbutamol and oxygen.

39. The nurse returned to the healthcare centre to get a doctor. She also contacted the orderly officer to ask for an ambulance to be called. The control room called an ambulance at 2.54pm.

40. The nurse returned to the man's cell with a doctor and another nurse. His oxygen saturation levels were low, and his heart and respiratory rate were raised. The staff administered oxygen, intravenous hydrocortisone and oral prednisolone (both steroid medications).

41. Paramedics arrived just after 3.10pm and stabilised the man's condition. At 3.50pm he was taken to hospital. He was restrained with an escort chain and accompanied by two prison officers.

42. The man remained in hospital and his condition continued to deteriorate. He died several days later.

Support for staff and prisoners

43. Elmley issued notices to prisoners and staff to inform them of the man's death, giving details of support available. An officer personally informed other prisoners who lived on his landing.

44. On 9 February the chaplain offered prayers for the man at Sunday service and held a memorial service that afternoon attended by 13 prisoners.

Family liaison

45. On 4 February after the man was taken the hospital, the prison appointed the prison chaplain as the prison's family liaison officer. The man had originally given his cousin's details as his next of kin, but unfortunately she had since died. The prison was aware that he had a brother but the contact numbers for him were out of date. He had received no visits or contact from family or friends during his time at Elmley.

46. On 4 February, the man told the escort officers that he did not want anyone informed of his condition and did not give any contact details for his next of kin.

47. After the man's death, despite efforts by the prison, police and coroner's officer, including enquiries with his solicitor, it was not possible to locate any next of kin.

48. The prison arranged and paid for the man's funeral. The funeral was held on 26 March 2014 and attended by prison staff.

Post-mortem

49. The post-mortem report recorded the cause of death as bronchopneumonia due to, or as a consequence of chronic obstructive pulmonary disease.

ISSUES

Clinical Care

50. The clinical reviewer was not satisfied that the care the man received at HMP Elmley was equivalent to that he could have expected in the community. He made a number of recommendations for improvements in healthcare at the prison. Not all the recommendations are repeated in this report, but the Head of Healthcare will need to address them.

51. The man had a number of chronic conditions which were managed by healthcare staff. However, his attendance at appointments was poor. He did not attend sixteen appointments in the twelve months before his death and healthcare staff did not follow up any of these to find out the reason why he did not attend.

52. After a prisoner does not attend a healthcare appointment a member of the nursing team is expected to investigate and record the reason on SystmOne (the computerised medical record system). We found this was frequently overlooked and did not happen in the man's case. The Head of Healthcare told us that after three missed blood test appointments the prisoner concerned is taken off the list. After five missed medication appointments the doctor sees them to confirm the medication prescribed remains necessary and appropriate.

53. Prisoners have the right not to attend healthcare appointments and have some responsibility for their own health. However, we do not know whether the man failed to attend appointments because of administrative problems with the appointment systems or that officers failed to escort him to them. It is important that healthcare staff follow up the reasons for non-attendance and record this. We make the following recommendation:

    The Head of Healthcare should ensure that staff follow up and record the reasons for non attendance at healthcare appointments.

54. The man had long standing chronic obstructive pulmonary disease (COPD) for which he was prescribed theophylline. Theophylline is a potentially toxic drug and the prescribed dose needs to be optimised and managed through periodic blood tests. Records show that blood tests were overdue, not carried out (partly because he did not attend for the tests) or not repeated when requested. The clinical reviewer says that the medical record gives no assurance that the results would have been documented or acted upon, for example by stopping the medication or changing the dose prescribed.

55. The clinical reviewer was particularly critical of aspects of the man's medical care on 2 February. At 11.33am, a doctor examined him and recorded he suffered from COPD, had limited lung function and could only just complete a sentence in one breath. He prescribed some medication including steroids and salbutamol, but did not prescribe antibiotics. The National Institute for Health and Care Excellence (NICE) quality standard for the treatment of

COPD, states that there should be appropriate provision of antibiotics, among other medications. The clinical reviewer describes this as an opportunity missed and one which might have had an impact on the course of his final illness. The doctor told us that, in hindsight, he should have prescribed antibiotics and the omission was an error on his part. We make the following recommendation:

The Head of Healthcare should ensure that clinicians follow established national guidance for the treatment of COPD, and ensure that required blood tests are carried out, documented and acted upon.

Emergency Response

56. On 2 February 2014, the man had chest pain and difficulty breathing. The officer correctly called a code blue emergency as he considered there was a life threatening situation. A code blue should prompt the immediate attendance of the duty nurse and the immediate call for an emergency ambulance. However, the duty nurse telephoned to establish the situation before attending and an ambulance was not called. The nurse did not come for ten minutes. In interview, although she could not be specific, she explained that the only reason she could suggest for making the telephone call was because she was already seeing a patient whose needs were more urgent.

57. There was clearly some disagreement between the nurse and the officer about the need to call a code blue on this occasion. We identified some friction between prison officers and healthcare staff about this. Officers interviewed said they would always be cautious and call a medical emergency in any case of doubt. Healthcare staff were concerned about the time they spent responding to medical calls that were not emergencies.

58. On 3 February the man again reported shortness of breath. An officer was very concerned about him but was aware of the issues with healthcare staff the previous day, so did not call a code blue. This resulted in a significant delay in him receiving medical care.

59. Prison Service Instruction (PSI) 03/2013 was issued at the beginning of February 2013 and 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 is very clear about the circumstances when codes should be used and says that local procedures must ensure that staff understand they should not delay summoning emergency assistance and that it is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner. It emphasises that it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required.

60. Elmley has a local protocol based on PSI 03/2013 which reinforces national guidelines. Despite the requirement in both the PSI and the local instruction to request an ambulance as soon as a medical emergency is called, we found staff at Elmley still delay until the need for an ambulance is confirmed by medical staff. We make the following recommendation.

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand the prisons protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies including appropriate use of emergency codes.

Restraints, security and escorts.

61. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarding as inhumane unless justified by other relevant considerations.

62. On 3 February, the man was taken to hospital accompanied by two prison officers and retrained with an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). A senior manager agreed the level of restraint and was aware of his breathing difficulties. His level of risk was assessed as low overall. Healthcare staff were not asked to contribute to the risk assessment, including whether his medical condition impacted on his risk of escape. Both a nurse and a doctor told us that in their opinion it was not necessary to restrain him.

63. At 10.45am on 4 February, a senior manager visited the man in hospital and reviewed the need for restraints. He noted that hospital staff said that he was very ill, unable to walk or get out of bed and as a result the escort chain was removed, but two escort officers remained.

64. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We are concerned that despite the man's frail condition and lack of mobility, his medical condition was not appropriately considered, particularly in relation to the impact his

condition had on his risk of escape. We are not satisfied that the decisions taken were justified by fully considered risk assessments that complied with the 2007 High Court Judgement. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners transferred to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff follow up and record the reasons for non attendance at healthcare appointments.

2. The Head of Healthcare should ensure that clinicians follow established national guidance for the treatment of COPD, and ensure that required blood tests are carried out, documented and acted upon.

3. The Governor and Head of Healthcare should ensure that all staff are made aware of and understand the prisons protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies including appropriate use of emergency codes.

4. The Governor should ensure that risk assessments for prisoners transferred to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.

ACTION PLAN:

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that staff follow up and record the reasons for non attendance at healthcare appointments.	Accepted	A member of staff is allocated each day to monitor and record every incident of non-attendance at health care appointments. Reasons for non-attendance are clearly recorded in the medical information system.	Completed Head of Healthcare
2	The Head of Healthcare should ensure that clinicians follow established national guidance for the treatment of COPD, and ensure that required blood tests are carried out, documented and acted upon.	Accepted	A policy and protocol on the management of COPD has been reviewed and published which is in line with NICE guidance. This has been ratified by the Quality Governance Board.	Completed Head of Healthcare
3	The Governor and Head of Healthcare should ensure that all staff are made aware of and understand the prisons protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies including appropriate use of emergency codes.	Accepted	The medical response codes for emergencies have been reviewed and published in line with PSI 03/13. A management of medical emergencies protocol is in place and has been ratified by the Quality Governance Board.	Completed Governor and Head of Healthcare
4	The Governor should ensure that risk assessments for prisoners transferred to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.	Accepted	The Deputy Governor/Security Governor and Duty Governors review risk assessments for all prisoners attending hospital. Individual circumstances are reviewed at this point and individual cases are considered in respect of illness, security category and risk to ensure that any use of restraints or other escort arrangements are appropriate.	Completed and ongoing DDC and Governor