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 on 6 January 2014 at HMP Dartmoor

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 from a ruptured aortic aneurysm on 6 January 2014, at HMP Dartmoor. He was 77 years old. I offer my condolences to the man's family and friends.

A clinical review was commission to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 1999. After spending time at HMP Brixton and HMP Albany, he was transferred to Dartmoor on 15 March 2013. He had suffered two heart attacks before his imprisonment and had been diagnosed with chronic heart disease. During his time in prison he was diagnosed with several chronic conditions including high blood pressure.

Just after 10.00pm on 6 January 2014, the man reported having severe back and kidney pain. He then collapsed, hit his head on his cell door and appeared to lose consciousness for a while. Prison staff called the on-call doctor who advised them to call an ambulance. Before the ambulance arrived, he lost consciousness again. Staff began to attempt resuscitation which paramedics took over when they arrived. The man did not respond and, at 11.35pm, a paramedic declared him dead.

I am concerned that there is no record that the man's blood pressure was monitored during his time at Dartmoor or that he had been informed of a screening test for aortic aneurysm. However, we do not know whether he would have decided to be screened and, if so, whether this would have altered the outcome. I am also concerned that, because Dartmoor did not have an emergency code protocol, as national instructions require, there was a delay in calling an emergency ambulance. In future emergencies such a delay could be crucial.

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 2014**

CONTENTS

SUMMARY

1. On 18 November 1999, the man was convicted of a serious sexual offence and sentenced to life imprisonment, with a minimum period to serve of seven years. He was sent to HMP Brixton where it was noted he had been diagnosed with chronic heart disease in 1985 and had suffered two heart attacks before his imprisonment. In 2004, he was transferred to HMP Albany (now part of HMP Isle of Wight).

2. While he was at Albany, the man was diagnosed with a number of health problems, including depression, chronic lung disease, high blood pressure, kidney failure, chronic kidney disease and vitamin B deficiency. Healthcare staff monitored and managed these conditions but noted that he did not always accept medical care or take his medication.

3. On 15 March 2013, the man transferred to HMP Dartmoor. When he arrived his previous long standing medical conditions were noted. He was prescribed medication for vitamin B deficiency and for raised cholesterol, but there is no record of any blood pressure readings throughout his time at Dartmoor. On 24 May, he had blood and liver function tests which were found to be normal

4. At 10.10pm on 6 January 2014, the man told a night officer that he was experiencing severe back and kidney pain. He collapsed and hit his head and appeared to lose consciousness. The night officer went to the wing office to telephone for help. He did not use an emergency code. When he got back to the man's cell, he found he had come to. An out of hours doctor advised staff to call an ambulance to take the man to hospital. Before the ambulance arrived, his condition deteriorated and he lost consciousness again. Prison staff attempted to resuscitate him and paramedics continued when they arrived. The efforts were unsuccessful and, at 11.35pm a paramedic pronounced the man's death.

5. We are concerned that, despite the man's history of high blood pressure, there is no record that this was monitored at Dartmoor. Nor does it appear that he was informed of a screening test for aortic aneurysm, which was available by self-referral from 2013 for men over 65. It is not possible to say whether screening and potential surgery as a result, would have altered the outcome for the man. We are also concerned that mandatory emergency procedures were not followed. We make three recommendations about these matters.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and inviting anyone who had relevant information to contact him. One prisoner responded.

7. The investigator obtained copies of the man's prison and relevant extracts of his prison medical records. He visited the prison on 14 January and saw the man's cell and spoke to his friends. He met the Governor, the liaison officer for this investigation and the prison's family liaison officer.

8. NHS England commissioned a doctor to review the man's clinical care at the prison.

9. We informed HM Coroner for Exeter and Greater Devon of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.

10. The man was not in contact with his family. Despite the efforts of both the prison and police, it has not been possible to trace any member of his family to inform them of his death and this investigation.

11. The prison 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 DARTMOOR

12. HMP Dartmoor is a category C secure training prison and holds up to 659 adult men. The healthcare provider is Dorset Healthcare University NHS Foundation Trust. Healthcare staff are on duty from 7.45am until 6.15pm Monday to Sunday. Overnight and weekend cover is provided by an out of hours service. There is no inpatient facility.

HM Inspectorate of Prisons

13. The most recent inspection of Dartmoor was in December 2013. The Inspectorate found the delivery of health services had improved with a new provider and more robust clinical governance arrangements. Access to services was good and clinical rooms were suited for their purpose. Emergency resuscitation equipment was located in the F wing treatment room and health centre. The equipment was well organised and appropriately stocked, but checking procedures were not adequate. Additional automated external defibrillators had been distributed around the prison and officers had been trained in their use.

Independent Monitoring Board

14. Each prison 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 September 2013, the IMB noted that the provision of healthcare was satisfactory. Transition to a new provider in April 2013 went well.

Previous deaths at HMP Dartmoor

15. The man was the third person to die from natural causes at HMP Dartmoor since 2009. There are no similarities between these cases.

KEY EVENTS

16. The man had been diagnosed with chronic heart disease in 1985 and had suffered two heart attacks, in 1995 and 1997. On 18 November 1999, he was convicted of sex offences and sentenced to life imprisonment with a minimum period to serve of seven years before he could be considered for release. He was sent to HMP Brixton and his reception health screen noted his previous heart attacks and that he occasionally suffered from angina. He took aspirin daily and used a mouth spray to treat his angina. The man had smoked cigarettes for a long time and was given advice about giving up. Although he had cut down, he continued to smoke until his death.

17. The man transferred to the then HMP Albany on 5 April 2004 (now part of HMP Isle of Wight.) At his reception health screen, staff noted his medical conditions and medication. He continued to take aspirin daily and was again advised about giving up smoking. In 2006, he was diagnosed and treated for depression and chronic lung disease.

18. In December 2009, the man was diagnosed with hypertension (high blood pressure) and was prescribed medication. In March 2011, he was diagnosed with kidney failure and chronic kidney disease. Records show that he suffered with Vitamin B deficiency in 2011 and 2012 and he received replacement vitamin B therapy.

19. The man did not always accept the treatment he was offered. Records indicate that he did not attend for flu vaccinations, missed appointments with the dentist and rejected other medical care when it was offered. He had not used his inhaler for many years as he did not think he had a problem with his breathing and stopped taking medication for high blood pressure in 2012 because of the side affects. However, he attended regular health checks, which included coronary heart disease monitoring and regular blood pressure readings at HMP Albany.

20. The man refused to participate in any sentence planning or treatment, or to engage with the Parole Board so made no progress towards release. He transferred to HMP Dartmoor on 15 March 2013.

21. When he arrived at Dartmoor, staff noted his medical history and the medication he was prescribed. On 24 May, the man had blood and liver function tests, which were normal. He continued with replacement vitamin B therapy and simvastatin, to control his cholesterol levels. There is no record of any blood pressure monitoring during his time at Dartmoor.

Events on 6 January 2014

22. At 10.10pm on 6 January, an operational support grade responded to the man ringing his cell bell. The man told him that he had severe pain in his right kidney and back. He then collapsed and hit his head against the cell door. The operational support grade could not get a response from the

man. Instead of using the radio, he ran to the wing office and telephoned the night orderly officer and the relief night orderly officer.

23. When the operational support grade returned to the man's cell, he had regained consciousness and was lying with his back against the cell door. The two night orderly officers came to the cell. The man said that his lower back and right kidney area were painful, but he managed to move away from the door to allow the officers to get in.

24. The two night orderly officers helped the man to his feet and then to his bed. One officer who was first-aid trained, checked for head injuries but found no marks or bumps. The man said he felt hot and graded his pain level as high, at level 10. A night orderly officer asked the communications room to contact the out of hours doctor at 10.38pm. She spoke to a doctor by telephone at 10.39pm, who advised that as she was an hour away she should call an ambulance to take him to hospital. The officer asked the control room to call an emergency ambulance, which was done at 10.45pm.

25. The man said he felt sick. The staff turned him onto his side, but then he wanted to sit up. He started to look a little better and staff assisted him to lie back on his bed. At first, he seemed to relax, but his breathing suddenly deteriorated and he became unconscious. Neither of the night orderly officers were able to find a pulse so, at 10.51pm, an officer contacted the communications room to request an emergency ambulance again, although one had already been called.

26. The operational support grade had collected a defibrillator which was attached to the man, but found no shockable heart rhythm. A night orderly officer and the operational support grade began cardiopulmonary resuscitation (CPR). Paramedics arrived at the prison at 11.10pm and reached the man two minutes later. The paramedics continued with CPR, but he could not be revived. At 11.35pm, a paramedic pronounced the man's death.

Support for staff and prisoners

27. A debrief was held for all staff involved in the emergency response and appropriate support was offered.

28. Staff and prisoners were informed of the man's death by a Governor's notice and support was offered. The wellbeing of prisoners on suicide and self-harm monitoring was checked in case they had been adversely affected by his death.

Family liaison

29. The man was not in contact with his family. He had no active telephone or mail contact with anyone in the community, other than his offender manager (probation officer). A retired probation officer was recorded as

his next of kin, but could not be contacted. The man's current probation officer was informed of his death and was not aware of any of his family members. The police tried to find a next of kin, but were unsuccessful.

30. The prison arranged and paid for the man's funeral, which was held on 5 March 2014.

Post-mortem examination

31. A post-mortem examination found that the man died as a result of a ruptured atherosclerotic abdominal aortic aneurysm, which had resulted in extensive bleeding into the soft tissues of the abdomen. The examination also identified pre-existing heart disease, lung disease and changes in the kidney, in keeping with hypertension

ISSUES

Clinical care

Blood Pressure Monitoring

32. The man had been at Dartmoor for only just over eight months at the time of this death. The clinical reviewer found that his reception health screen was generally good except that his blood pressure reading was not recorded, despite his history of hypertension (high blood pressure.) The clinical reviewer found no blood pressure readings noted in the man's medical record any time after his arrival at Dartmoor. While it is possible that readings were taken, but not recorded, the clinical reviewer noted that without records it is not possible to reach any conclusions about the adequacy of the man's blood pressure control. The National Institute for Health and Clinical Excellence (NICE) guidelines on the management of hypertension indicate the importance of regular monitoring and recording of blood pressure in hypertensive patients. We make the following recommendation:

The Head of Healthcare should ensure that staff appropriately monitor and record blood pressure readings for prisoners with hypertension in line with national guidelines.

Access to national screening

33. The National Abdominal Aortic Aneurysm Screening Programme began in 2009, and fully rolled out nationally in 2013. All men who turn 65 after 1 April 2013 should automatically be invited for screening. Men over 65 who have not previously been screened can self-refer for screening.

34. When screening identifies men with aortas measuring 5.5cm or wider they are referred to surgeons to discuss treatment options. The post-mortem revealed that the man's aneurysm was eight centimetres. Had he been screened, it is likely that he would have been eligible for surgery. Although he did not fit into the category that would have been offered screening automatically, we consider that he should have been informed of the possibility, as part of good health promotion.

35. While we do not know whether the man would have taken the opportunity for aortic aneurysm screening or whether this would have affected the outcome, it is not apparent that he was aware of the possibility. There is no record in his medical notes that he was told about screening for this condition or other screening programmes such as for bowel cancer, aimed at men between 60 and 69, but also available to older men on request. We make the following recommendation:

The Head of Healthcare should ensure that information on national screening programmes is available for eligible prisoners as part of good health promotion in the prison

Emergency response

36. We are concerned that the operational support grade did not call an emergency code when he found the man suffering from kidney and back pains, particularly when he became unresponsive after he fell and hit his head. This meant that the officers responding were not aware of the nature of the emergency, did not collect any emergency equipment and an ambulance was not automatically called. An emergency ambulance was requested after staff consulted the out of hours doctor. When the man's breathing began to deteriorate and he became unresponsive again, a night orderly officer asked the communications room again to call an emergency ambulance. This meant that paramedics did not arrive until an hour after the man was first found to be ill. We cannot say whether earlier treatment from the paramedics would have altered the outcome for the man.

37. 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 requires a two level code system that differentiates between a blood injury and all other injuries. The instruction explicitly states that all prison staff must be made aware of and understand the instruction and their responsibilities during medical emergencies.

38. Dartmoor was unable to provide us with a local emergency response protocol or instruction and we are concerned that, by January 2014, the prison had still not complied with the requirement to have such a protocol which was expected to be in place almost a year earlier. It is worrying that staff told the investigation that it is usual for a nurse or doctor to assess a patient before an ambulance is called. This is directly contrary to the national instruction which makes it clear there should be no delay in calling an ambulance in a medical emergency, which can always be cancelled if ultimately not required. 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 and that Dartmoor has a medical emergency response code protocol based on the PSI which:

- **Provides guidance to staff on efficiently communicating the nature of an emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff appropriately monitor and record blood pressure readings for prisoners with hypertension in line with national guidelines.

2. The Head of Healthcare should ensure that information on national screening programmes is available for eligible prisoners as part of good health promotion in the prison

3. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Dartmoor has a medical emergency response code protocol based on the PSI which:

    - Provides guidance to staff on efficiently communicating the nature of an emergency;
    - Ensures staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances.

ACTION PLAN: The man – HMP Dartmoor

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and **function responsible**
1	The Head of Healthcare should ensure that staff appropriately monitor and record blood pressure readings for prisoners with hypertension in line with national guidelines.	Accepted	National guidelines (NICE) are in place. Healthcare staff at HMP Dartmoor have been reminded of these and an audit of compliance will be undertaken in July 2014. The procedure for monitoring patients who refuse interventions will also be reviewed through the Clinical Governance Framework.	Head of Healthcare July 2014
2.	The Head of Healthcare should ensure that information on national screening programmes is available for eligible prisoners as part of good health promotion in the prison.	Accepted	All eligible patients are invited for screening as per national guidance and are sent a letter by the NHS Abdominal Aortic Aneurysm (AAA) Screening Programme. All patients over the age of 65 are also invited to self refer for AAA screening if they wish. AAA screening is actively promoted in the prison, and screening programmes will be built into the monthly health promotion timetable. New Health Promotion posters regarding national screening programmes will also be produced and displayed widely around the prison.	Head of Healthcare August 2014

3.	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Dartmoor has a medical emergency response code protocol based on the PSI which: • Provides guidance to staff on efficiently communicating the nature of an emergency; • Ensures staff called to the scene bring the relevant equipment; and • Ensures there are no delays in calling, directing or discharging ambulances	Accepted	The national policy for calling emergency codes via the communication system was published at HMP Dartmoor as a Governor's Order in December 2013. The Governor will re-issue the policy to remind staff of their responsibilities and to give greater assurance.	Governor July 2014