PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

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

**Investigation into the death of a man at HMP Pentonville in June 2014**

## *Our Vision*

*'To be a leading, independent investigatory body,*
*a model to others, that makes a significant contribution*
*to safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man from heart disease in June 2014 at HMP Pentonville. He was 67 years old. I offer my condolences to those who knew him.

A clinical review of the care the man received at HMP Pentonville was conducted. The prison cooperated fully with the investigation.

On 11 June 2014, after a short period on remand at HMP Belmarsh, the man was sentenced to six months in prison and went to HMP Pentonville. He was often homeless, had a long history of alcohol abuse and had served many previous short prison sentences. He had a history of asthma and had been investigated for tuberculosis a number of times, but had never complained of angina or any chest pain. On 16 June 2014, an officer found him unresponsive in his cell. Healthcare staff attempted to resuscitate him, but he did not respond. Shortly afterwards, a doctor confirmed that he had died.

Although the clinical reviewer was concerned about some aspects of the man's healthcare, these were not related to the cause of his death. Overall, she was satisfied that he received a standard of care in prison equivalent to that he could have expected to receive in the community. I agree that there was nothing the prison could have done to predict of prevent his sudden death. However, his case has shown up the lack of cardiovascular screening to identify those at risk of heart disease at both Belmarsh and Pentonville as well as deficiencies in the emergency response arrangements at Pentonville. Accordingly, recommendations for improvement are made regarding both these issues.

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** **November 2014**

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## SUMMARY

1. On 5 June 2014, the man was remanded to HMP Belmarsh, charged with assault. On 11 June, he was sentenced to six months in prison and sent to HMP Pentonville.

2. Records show that the man was often homeless, had been in prison numerous times and had alcohol misuse problems. He was blind in his left eye. He had previously received treatment for epilepsy and asthma and doctors had investigated the possibility of tuberculosis (TB). He continued with medication for his asthma.

3. One afternoon in June 2014, an officer saw the man go out onto the exercise yard for some time in the open air. No one saw him return to his cell, but an officer carried out a roll check between 5.30pm and 6.00pm and did not see anything to concern him.

4. At about 8.45pm, an officer unlocked the man's cell for him to collect his medication. He was lying on his bed and appeared to be asleep. The officer tried to rouse him but he did not respond. He described him as ashen grey and open-mouthed. The officer left the cell to get help, and returned almost immediately with a colleague who radioed an emergency medical code. The prison did not call an ambulance until five minutes after that.

5. At 8.51pm, a nurse arrived and began cardiopulmonary resuscitation. A prison doctor joined her approximately a minute later. Attempts to revive the man were unsuccessful and, at 9.00pm, the doctor confirmed that he had died.

6. The clinical reviewer was satisfied that the care the man received at Pentonville was equivalent to that he could have expected to receive in the community. However, she had some concerns about the quality of medical records and about some aspects of the management of his medical conditions, which the Head of Healthcare will need to address. Although it would not have made a difference to the outcome for him we consider that Belmarsh and Pentonville should offer cardiovascular screening in line with best NHS practice. Pentonville also need to ensure that emergency procedures are in line with national instructions. We make two recommendations.

## THE INVESTIGATION PROCESS

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

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. He visited the prison on 30 July and obtained the staff statements made after his death.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. We informed HM Coroner for Inner North London district of the investigation. We have sent the Coroner a copy of this investigation report.

11. The investigation was suspended until we received histology and toxicology results and a cause of death. The coroner's office sent the investigator the cause of death on 15 September, and we resumed the investigation. We received the clinical review on 30 September.

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

13. 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 PENTONVILLE

14. HMP Pentonville is a local prison serving the courts of North London and holds over 1,300 men.

15. Healthcare services are provided by Care UK in partnership with Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health Trust.

16. There is a large purpose built healthcare centre which has 22 inpatient beds and a day care facility for patients with mental health problems who are managed on the wings. There are a number of consulting rooms in the main prison and in the healthcare centre and a primary care facility on each of the wings

## HM Inspectorate of Prisons

17. The most recent inspection of Pentonville was in September 2013 when inspectors considered the prison was seriously overcrowded. The physical condition of the reception area and the first night centre was poor but mitigated by effective processes. Initial safety screening had improved and prisoners' immediate needs were identified and dealt with. Prisoners on A Wing received good information about how to access services and deal with prison life. Prisoners were dissatisfied with healthcare services. Inspectors found that waiting time for GP clinics were excessive and nurse led services needed development.

## Independent Monitoring Board

18. 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 March 2013, the IMB noted that the healthcare centre was invariably full with disproportionate numbers of mentally ill prisoners and prisoners with substance misuse problems. The IMB considered that the staff coped highly professionally with very challenging behaviour. The level of complaints to the IMB about healthcare was high and the IMB was concerned that the relationship between prison managers and the healthcare providers had deteriorated.

## Previous deaths at HMP Pentonville

19. The man's death was the third from natural causes at Pentonville since June 2012. There were no significant similarities between his and the other deaths.

## KEY EVENTS

20. On 5 June 2014, the man was charged with assault and remanded to HMP Belmarsh. He had a history of epilepsy and asthma and was blind in one eye. He had previously been investigated for tuberculosis and had a longstanding problem of alcohol abuse.

21. The man was often homeless and had served a number of prison sentences, usually for short periods, from as far back as 1969. In prison he had often undergone alcohol detoxification, sometimes backed up by medication to reduce the possibility of seizures caused by alcohol withdrawal. However, he continued to drink heavily when he was out of prison. He was usually unable to give details of a community GP.

22. In 1998, the man developed asthma, for which doctors prescribed medication while he was in prison. In 2008, during another period in prison, he told staff he had asthma and epilepsy and had previously had pneumonia and tuberculosis (TB). Records show that doctors prescribed an anticonvulsant for seizures and investigated him for TB in 2008, but it is not clear what the results were. When he was in prison in September 2013, tests showed that he did not have TB. Doctors treated him for an infective exacerbation of asthma.

23. On 5 June 2014, when the man arrived at Belmarsh, he told a nurse, who carried out his initial health screen, that he had recently been treated for TB. A prison GP reviewed him, who said that he had recently received treatment for alcohol dependency, but continued to drink, despite warnings about the dangers. The GP referred him to the substance misuse team.

24. The man also told the GP that he had been treated for pulmonary TB, at hospital in December 2013. The GP organised consecutive day sputum testing and a chest X-ray. He prescribed antibiotics and referred him to the TB nurse. Healthcare staff checked with the hospital, but they had no record that they had treated him for TB.

25. The GP noted the man's asthma and prescribed salbutamol (a medication that opens the airways). His pulse rate was within the normal range, but his blood pressure was high. The doctor arranged for healthcare staff to review him daily.

26. On 6 June, a nurse examined the man. His blood pressure was lower than the day before and within the normal range. Healthcare staff reviewed him each day, for the next five days.

27. On 11 June, the man was sentenced to six months in prison and sent to Pentonville. A nurse completed his initial health assessment screen and noted that he had previously been suspected of TB, had asthma

and that he was dependent on alcohol. He told the nurse he did not suffer from chest pains. She noted his pulse and blood pressure were within the normal range.

28. A substance misuse nurse reviewed the man and recorded that he should continue with his alcohol detoxification programme. A prison GP saw him the same day and noted his previous chest infection and prescription of antibiotics. The doctor arranged for staff to collect sputum samples on consecutive days and prescribed additional asthma medication.

29. At 11.32am on 12 June, a nurse collected a sputum sample for examination. A prison psychiatrist saw him at 11.04am and noted that he did not need to move to the prison's detoxification wing.

30. There are no entries in the medical records to show that healthcare staff saw the man on 13, 14 or 15 June or collected any further sputum samples.

**Events leading up to the incident**

31. At about 2.00pm, an officer saw the man go into the showers on the second floor landing of A Wing and later saw him go back to his cell. At 2.45pm, he saw him go out onto the exercise yard. The exercise period ended between 3.45pm and 4.00pm, although no one remembered seeing him go back to his cell.

32. An officer did the evening roll check between 5.30pm and 6.00pm. The roll check is primarily a security procedure to check all prisoners are present and not a welfare check. In his statement, the officer said that the requirement was only to check that the prisoner was present and officers were not expected to get a response from prisoners. Pentonville's local instruction reflects this. He did not specifically remember seeing the man, but said he must have been in his cell at the time, as the roll check was correct.

33. At approximately 8.45pm, an officer went to A Wing to unlock prisoners who needed to collect night medication. He went to the man's cell first. He was lying on his bed and appeared to be asleep. When he unlocked the cell and called out to him, he did not respond.

34. The officer went into the cell, but could not rouse the man. He described him as 'ashen grey and open mouthed'. He went onto the landing and called for help. Another officer joined him immediately and they went back into the cell. A custodial manager followed them in. The officers could still not get a response from him. The officer said that he was cold to the touch. The custodial manager checked for a pulse, but could not feel one. At 8.47pm, an officer radioed a level one emergency medical code (to indicate a serious or life-threatening medical emergency).

35. A senior manager contacted the control room at 8.51pm to ask whether they had called an emergency ambulance. Despite the level one emergency code, they had not done so. The control room called an ambulance at 8.52pm.

36. The emergency response nurse arrived at the man's cell at 8.51pm. The staff lifted the man onto the floor and began cardiopulmonary resuscitation. A prison GP arrived less than a minute later. He examined him, who was not breathing, had no pulse or obvious heart activity and his pupils were not reacting. He described him as cold to the touch. He noted that he had a grey tinge to his skin and his neck was stiff. The doctor continued to attempt resuscitation, until 9.00pm, when he declared him dead.

37. Paramedics arrived at the cell at approximately 9.05pm. They examined him and found no heart activity.

**Support for staff and prisoners**

38. The prison issued notices to prisoners and staff to inform them of the man's death and gave details of the support available. All prisoners subject to suicide and self-harm prevention procedures were reviewed, in case they had been affected by the news of his death.

39. The prison held an informal debrief on the morning after the man's death. On 25 June, the senior manager held another debrief at which he reminded staff of the support services available.

**Family liaison**

40. Despite extensive enquiries by the prison, police, coroner's office and this office, it has not been possible to locate any of the man's family. The local authority arranged and paid for his funeral, which was held on 5 August.

**Post-mortem**

41. The post-mortem report recorded the cause of death as due to atherosclerosis (hardening and narrowing) of the coronary artery.

## ISSUES

### Clinical Care

42. The clinical reviewer was satisfied that the overall level of care the man received at HMP Pentonville was equivalent to that which he might have expected to receive in the community. She made some recommendations about the quality of the medical records and the management of his medical conditions. As these were issues not directly related to his cause of death, we do not repeat them in this report, but the Heads of Healthcare at Pentonville and Belmarsh will need to address them.

43. The man died of atherosclerosis, a thickening of the arteries in his heart. The clinical reviewer noted that this does not usually produce symptoms until blood circulation becomes restricted or blocked, leading to cardiovascular disease. There is no evidence from his medical records to indicate that he ever reported symptoms such as angina or chest pain, which might reasonably have led to a suspicion or consideration of heart disease.

44. However, the clinical reviewer found that the focus of reception health screening at Belmarsh and Pentonville was predominantly to assess risk and to note existing health conditions. The screening template does not include a risk score for vascular disease. The clinical reviewer commented that the NHS Health Check includes vascular risk screening for people over 40, and believed that this should be done in prison. National Institute for Clinical Excellence (NICE) best practice guidelines, advise screening all patients who are at risk of heart disease. His lifestyle and alcohol consumption would have increased his risk. He had been at Pentonville only five days and it is unlikely that screening would have helped prevent his death. However, we consider that it is important that prisons identify prisoners with risk factors for cardio-vascular disease and monitor them in line with NHS best practice. We make the following recommendation:

    **The Heads of Healthcare at Belmarsh and Pentonville should introduce a routine review of cardiovascular risk factors for newly arrived prisoners and ensure that prisoners with identified risk factors receive appropriate treatment, monitoring and advice**.

### Emergency response

45. Prison Service Instruction (PSI) 03/2013, issued at the beginning of February 2013 required Governors to have a medical emergency response code protocol based on the instruction. 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.

46. The instruction makes it clear that it is essential that staff call an ambulance in all cases where there are serious concerns about the health of a prisoner. The instruction requires prisons to use a two level code system that differentiates between a blood injury and all other injuries.

47. Pentonville identifies medical emergencies using level 1 to identify all life threatening incidents and level 2 for those considered non-life threatening. The codes do not differentiate between the types of serious incident and are not in line with the national instruction.

48. At 8.47pm, an officer radioed a level 1 medical emergency, but the control room staff did not call an ambulance immediately, but waited until 8.52, after a manager requested one. This was five minutes after the officer called the emergency code.

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49. We are satisfied that the delay did not affect the outcome for the man, but in other circumstances, it could be crucial. We make the following recommendation:

**The Governor should ensure that the local emergency response protocol reflects the requirements of PSI 03/2013 and that the control room calls an ambulance immediately an emergency code is called.**

## RECOMMENDATIONS

1. The Heads of Healthcare at Belmarsh and Pentonville should introduce a routine review of cardiovascular risk factors for newly arrived prisoners and ensure that prisoners with identified risk factors receive appropriate treatment, monitoring and advice.

2. The Governor should ensure that the local emergency response protocol reflects the requirements of PSI 03/2013 and that the control room calls an ambulance immediately an emergency code is called.

**ACTION PLAN**

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible |
|---|---|---|---|---|
| 1 | The Heads of Healthcare at Belmarsh and Pentonville should introduce a routine review of cardiovascular risk factors for newly arrived prisoners and ensure that prisoners with identified risk factors receive appropriate treatment, monitoring and advice. | Accepted | In order to address the risks of cardio vascular disease HMP Belmarsh are introducing a cardiac clinic to be run within out-patients department to support offenders who come into prison with a pre-existing condition. The cardiac clinic will also monitor anyone with pre-existing cardiac conditions.<br><br>Changes will be made to the clinical records program (SystmOne) regarding screening for pre-existing conditions and questions regarding cardiovascular / cardiac conditions will be asked in the first night reception area.<br><br>By including these questions in the initial screening it is anticipated HMP Belmarsh will be able to identify offenders with pre-existing conditions and make the appropriate referrals for further health interventions.<br><br>The Healthcare team at HMP Pentonville are implementing a new initial screening process which should assist in identifying those with cardiovascular risks and the necessary following actions. | November 2014<br><br>Primary Care Clinical Lead and Team<br><br>December 2014.<br><br>Healthcare. |
| 2 | The Governor should ensure that the local emergency response protocol reflects the requirements of PSI 03/2013 and that the control room calls an | Accepted | A new Staff Information Notice to be sent to all staff clarifying the appropriate radio codes for medical situations - both emergency and non-emergency. Guidance will also be sent out that an ambulance should be called by the communications officer on hearing the identified emergency code confirmed by an orderly officer, duty governor or healthcare professional. | November 2014.<br><br>Safer Prisons Department. |

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| | ambulance immediately an emergency code is called. | | | |