A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man, a prisoner at HMP Featherstone, in May 2013

Our Vision

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

This is the investigation report into the death of a man, a prisoner at HMP Featherstone, who died of a heart attack in May 2013. He was 42 years old. I offer my condolences to his family and friends.

A clinical review was conducted into the care the man received in custody. HMP Featherstone cooperated fully with the investigation.

The man had been at Featherstone since August 2012, shortly before he was convicted and sentenced. He had previously been on remand at other prisons. He had a history of drug misuse and mental health problems for which he was prescribed medication. He had no diagnosed serious physical health conditions. Although the post-mortem found liver disease, this did not contribute to his death. He had a family history of cardiovascular disease and a number of other risk factors. The prison conducted electrocardiogram tests to check his heart function but he did not have further screening for heart disease. He reported having chest pains on the morning of his death and his condition quickly deteriorated. Prison staff and paramedics attempted resuscitation and he was taken to hospital by emergency ambulance but sadly was found to be dead on arrival.

The investigation has identified a need for better screening for heart disease for prisoners at Featherstone with known risk factors, such as the man. While the clinical reviewer was satisfied with the efforts to try and resuscitate him, I am concerned that the initial response to the emergency was not as swift and as smooth as it should have been. The Governor needs to ensure that all staff are aware of their responsibilities in an emergency.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2013**

CONTENTS

Summary

The investigation process

HMP Featherstone

Key events

Issues

Recommendations

Prison service action plan

SUMMARY

1. The man arrived at HMP Featherstone on 17 August 2012. At his reception health screen, it was established that he suffered from depression and anxiety and had a long history of substance misuse. He admitted previously using illicit drugs in prison. He continued a methadone maintenance programme. At a secondary health screen, he disclosed a family history of heart disease and was referred to the GP who requested a routine electrocardiogram (ECG) test which helps detect problems with heart rate or rhythm. The subsequent test was normal.

2. Although the man had not been diagnosed with a heart condition, he had a number of risk factors for heart disease such as smoking and drug abuse, which were not assessed as national guidelines recommend. The clinical reviewer considered it was possible he had undiagnosed high cholesterol levels. He was prescribed olanzapine, an atypical antipsychotic, which usually requires additional cardiac monitoring. However, the clinical reviewer noted that the low dosage of olanzapine and the short time he had been prescribed it, meant that it was unlikely to have contributed to the condition that caused his death.

3. On 3 April 2013, the man had an urgent appointment with a nurse in the prison's healthcare department when he reported experiencing pains in the right side of his chest. The nurse examined him and conducted basic cardiovascular tests which did not indicate any concerns. She concluded it was muscular pain and told him to rest. He did not report any further chest pain at other healthcare appointments that month.

4. On 15 May at about 8.10am, the man told the officer who unlocked his cell that he had chest pains. The officer continued to unlock the remaining prisoners on the wing and went to inform the nurse at the wing treatment hatch, who said she would see him after she finished dispensing medication. His condition then deteriorated significantly. The officer did not immediately radio an emergency code blue to indicate a prisoner with chest pains and summon help, but went back to the medication hatch to get the nurse who immediately began emergency treatment. At that stage, the officer radioed for help and requested an ambulance. The nurse then radioed a code blue to indicate a prisoner with breathing difficulties.

5. It took about five minutes for an officer to bring emergency equipment. Additional healthcare staff to assist with the resuscitation did not arrive until between 10 and 15 minutes later. Paramedics arrived and continued the resuscitation attempts. They took the man to hospital, but he was certified dead on arrival.

6. The investigation found that, while the resuscitation attempt was well conducted, the appropriate procedures for responding to a medical emergency were not followed. A code blue emergency was not called immediately when the man reported severe chest pains. It took too long for additional healthcare staff to attend as the prison does not operate a first

responder system. The officer who found him was unaware of the location of the defibrillator. While it does not appear that these delays affected the outcome for him, as a nurse was in attendance and began treatment quickly, this was not a satisfactory emergency response and it was fortunate that the nurse was nearby.

7. We make three recommendations about monitoring for cardiovascular disease and emergency procedures.

THE INVESTIGATION PROCESS

8. Notices announcing the investigation were issued to staff and prisoners at Featherstone, inviting anyone with relevant information to contact the investigator. No one came forward.

9. The investigator visited Featherstone on 22 May 2013 and obtained copies of the man's prison and medical records. She interviewed members of staff at Featherstone on 1 July.

10. The local PCT commissioned a review of the clinical care the man received at Featherstone.

11. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report. This investigation report has been sent to the Coroner.

12. One of the Ombudsman's family liaison officers spoke to the man's partner and daughter about the investigation process. His family asked the following questions for the investigation to consider:

    - Did he have any illegal substances in his system?
    - Were there any injection marks on his body?

13. The man's family received a copy of the draft report. They did not make any comments. A copy of the prison service action plan has been attached to this report.

HMP FEATHERSTONE

14. HMP Featherstone is training prison in the West Midlands, for prisoners with more than 12 months of their sentence left to serve. It holds up to 687 prisoners in seven house units.

15. Healthcare services are provided by Staffordshire and Stoke on Trent Partnership NHS Trust. The healthcare department offers a wide range of primary care services, including health promotion and the management and treatment of long-term and acute medical conditions. There is no inpatient facility. Medication is dispensed to prisoners from the treatment rooms on each house unit.

HM Inspectorate of Prisons

16. The Inspectorate carried out a short follow-up inspection of Featherstone in November 2011. Inspectors noted that the prison had made significant progress since the previous inspection in October 2008. Healthcare services had improved, led by a senior manager. Almost all the healthcare-related recommendations made in the 2008 inspection report had been achieved.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their annual report for the period to November 2012, the Board reported that the performance of the healthcare department had generally been sound but the staffing situation had varied and vacancies and sickness absence had created problems. However, they considered that the healthcare manager and his deputy had responded well to these situations.

Previous Deaths

18. The man was the seventh prisoner to die at Featherstone since 2004, when the Ombudsman began investigating deaths in prison. There are no similarities between the previous deaths and that of his.

KEY EVENTS

19. The man was remanded into custody on 12 May 2011 for offences of burglary. He had been in prison before and had a history of heroin, cocaine and alcohol dependency. He later absconded and returned to custody in March 2012. He spent time at HMP Wandsworth and HMP Dovegate before transferring to HMP Featherstone on 17 August 2012.

20. At the man's initial reception health screen at Featherstone, the healthcare assistant noted that he was on a methadone maintenance programme, a diazepam detoxification scheme and was prescribed mirtazapine. He disclosed that he had 'self-medicated' and taken illicit substances at Dovegate. It was also noted that he had self-harmed and reported hearing voices while at Wandsworth and had been monitored as a risk of suicide and self-harm. He was referred to the drug treatment service and to the mental health in-reach team. On 20 August, one of the prison GPs prescribed mirtazapine (an antidepressant) and diazepam (used to treat anxiety disorders).

21. A nurse carried out a comprehensive health screen with the man on 21 August, during which he disclosed a family history of heart disease. A community psychiatric nurse (CPN) reviewed him on 29 August and referred him to the prison GP, who requested a routine ECG.

22. On 20 September 2012, a specialist registrar in psychiatry noted that the man had reported that he got out of breath climbing the stairs and that he was waiting for an ECG. An entry in his clinical record on 4 October 2012 shows that an ECG had taken place but the date of the test and the results were not recorded. On 4 December, the registrar recommended that he would benefit from regular ECG monitoring because of his frailty and the range of medication that had been prescribed. An ECG on 2 January 2013 was recorded as normal. (A doctor reviewed the ECG reports and was satisfied that these showed no signs of ischaemic heart disease.)

23. On 3 April, the man reported having pains in the right side of his chest, particularly when he coughed. A nurse conducted basic cardiovascular tests, including blood pressure and pulse measurements, which were normal (BP 120/68 and pulse 72). She noted he looked well and concluded it was muscular pain. The nurse advised him to rest and take pain relief (paracetamol and ibuprofen).

24. On 2 May, the man told wing staff and a nurse that he was suffering severe anxiety and stress due to bullying and harassment arising from a substantial drug debt. He reported fleeting suicidal thoughts. Staff began to monitor him under suicide and self-harm prevention procedures which continued until the time of his death. Between 9 May and 15 May, he spent most of his time in his cell. There is no record of any untoward incidents during this time and his only reported illness was a flu-like virus. Staff observed him at least once an hour during the night and the last entry, at 7.05am on 15 May noted 'appears asleep, movement noted'.

25. The next morning an officer began to unlock the cells. As she unlocked the man's door he called out to her. She went into his cell and found that he was dressed, but in a slumped position on his bed. He was conscious and able to speak and said that he had really bad chest pains which he did not think was indigestion. He had his hand on his chest and described it as very, very painful. She told him she would speak to the nurse who was issuing medication from the treatment hatch on the wing.

26. The officer told the investigator that, although she felt there was a sense of urgency about the man's situation, she nevertheless continued to unlock the remaining prisoners. She said this took her less than a minute. She then ran up the stairs to the treatment hatch, at about 8.15, where she told a nurse that he had bad chest pains and had described a tingling sensation and numbness in his arm.

27. The nurse was aware that the man had no relevant history of heart problems and noted that he had been able to speak to the officer to explain his symptoms. She did not consider the situation sounded urgent so she told the officer that she would go and see him as soon as she finished issuing medication. Ideally, she thought he should go to the healthcare department for an ECG. The officer went back immediately to the cell (she estimated this was about two minutes after she had first seen him), and found that his condition had deteriorated considerably. He was short of breath, making gargling noises and unresponsive when she called his name.

28. The officer went straight back to the treatment hatch to alert the nurse. The nurse closed the dispensary and they both ran to the cell, arriving at 8.19am. They found the man propped against the wall, struggling to breathe, so they laid him flat on the bed and loosened his clothing. The officer radioed to ask for emergency equipment and a defibrillator to be brought to the cell. (An automated external defibrillator analyses heart rhythm and delivers electric shocks to victims of cardiac arrest when it determines there is a rhythm that is likely to respond.) She also requested an ambulance and additional staff assistance.

29. The nurse said that the man was now barely conscious and his breathing subsided. She was unable to locate a pulse and began cardiopulmonary resuscitation (CPR), assisted by the officer. She also radioed for urgent assistance and called a code blue emergency code to indicate breathing difficulties. The control room called for an ambulance at 8.21am. Another officer collected the emergency equipment, including a defibrillator, which took around five minutes.

30. A Senior Officer (SO) and a Custodial Manager went to the cell and took over CPR from the nurse, so that she could use the defibrillator and other equipment. Additional healthcare staff did not arrive until about 10 to 15 minutes after the code blue was called. During the first two cycles of CPR, the defibrillator advised not to shock. They continued to administer CPR and later the defibrillator administered four shocks. Paramedics arrived at the

prison at 8.36am and arrived at the cell at 8.41am. They then moved the man onto the landing, where they had more room to manoeuvre and continued CPR.

31. The man was taken by ambulance to hospital. A written escort risk assessment for the journey indicated that he was assessed as low risk but should be handcuffed. One of the escort officers assured the investigator that despite the record, no restraints were used and resuscitation attempts continued throughout the journey. Sadly, he was certified dead on arrival at the hospital at 9.52am.

32. The man's family were informed that he had had a heart attack and prison managers met them at the hospital.

33. Prison managers offered support and assistance to staff involved in the emergency. A debrief was held quickly but the escort staff were unable to attend as they were still at the hospital. Support was also offered to prisoners on the man's wing.

34. The funeral took place on 30 May and the prison contributed to the funeral expenses. His family was invited to visit the prison, where a memorial service was held the following week.

35. The post-mortem found that the cause of death was coronary atherosclerosis and thrombosis. The man's family was concerned that he had taken illicit substances and asked if he had any recent injection marks. A toxicology screening was not conducted so we are unable to say whether he took any illegal drugs or medication he was not prescribed, but the post-mortem examination found no evidence of injection marks.

ISSUES

Clinical care

36. The clinical reviewer states that although the man had a significant and commendable level of treatment and support for his mental health conditions, he had little contact with GPs.

37. The man had a number of risk factors for cardiovascular disease, including smoking, cocaine and alcohol abuse and a family history. However, the prison did not offer some of the routine cardiovascular services expected in the community, such an assessment of his risk factors for heart disease, cardiovascular examinations and the measurement of blood lipids (fat). The clinical reviewer also notes that he was a prescribed olanzapine (an atypical antipsychotic) and guidelines recommend measurement of lipids for patients taking olanzapine every three months. Nevertheless, she does not believe that the small dose he took over a period of a few months had an effect on his heart condition. We share the clinical reviewer's concern about the absence of cardiovascular monitoring and make the following recommendations:

    The Head of Healthcare should ensure that secondary health screens include an assessment of risk factors for cardiovascular disease, particularly for prisoners most at risk, including those who have a history of smoking heavily and misuse of drugs and alcohol.

    The Head of Healthcare should ensure that national guidelines and best practice for monitoring prisoners prescribed atypical antipsychotics are followed.

Emergency response

38. We are concerned that the officer did not radio an emergency code blue when she found the man suffering from chest pains, particularly when she went back to his cell after speaking to the nurse and found him unresponsive. Prison Service national instructions require that, if a prisoner shows signs of chest pain or difficulty breathing, staff should not delay summoning emergency assistance.

39. While going to get the nurse after the officer who found that the man's condition had declined a second time was pragmatic and ensured that he had quick attention from a healthcare professional, at the very least radioing a code blue at the same time should have led automatically to mandatory emergency contingency responses. These are set out in Prison Service Instruction (PSI) 03/2013 – Medical Emergency Response Codes and include that the control room should automatically call an ambulance and a duty nurse (where available) should attend with the necessary equipment or other staff where there is no nurse cover. It was only when the officer went back to the cell third time, accompanied by the nurse, that she radioed for

assistance and an ambulance. She did not use an emergency code but shortly afterwards the nurse called a code blue.

40. We are concerned that some initial delay occurred while the officer went to the treatment hatch twice. During that time the man was left alone, in considerable pain. While there is no evidence that this impacted on the outcome, it is essential that prisoners have immediate access to emergency assistance in the event of serious and potentially life-threatening symptoms, in line with Prison Service instructions.

41. We are also concerned by the apparent lack of prompt action and healthcare backup once the nurse made the code blue call. The nurse told the investigator that in an emergency, it was the responsibility of officers to take a defibrillator to the incident. The officer who initially assisted the nurse said that at the time of the emergency she did not know where defibrillators were kept.

42. Although there were several nurses on duty, they were dispersed in various house units. It therefore took a considerable time, (between 10 to 15 minutes) for them to attend the emergency call to assist the nurse. This was somewhat mitigated by the attendance of a SO, who had been trained in first aid. All healthcare staff, except the doctor, are expected to respond to an emergency incident but the prison did not have an identified nurse first responder to attend serious medical emergencies.

43. PSI 03/2013 was issued at the beginning of February 2013 and governors were required to have a medical emergency response code based on the instruction by 28 February 2013. Featherstone has local protocols for the use of emergency codes and calling an ambulance in emergencies but it is apparent from the response to this emergency incident that the staff were either unaware of them or unclear about what should happen and their respective roles. There is evidently a need for Featherstone to tighten up and practice its emergency procedures. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including:

- **Efficiently communicating the nature of a medical emergency;**
- **Bringing the relevant equipment to the scene; and**
- **Ensuring there are no delays in calling, directing or discharging ambulances.**

RECOMMENDATIONS

1. The Head of Healthcare should ensure that secondary health screens include an assessment of risk factors for cardiovascular disease, particularly for prisoners most at risk, including those who have a history of smoking heavily and misuse of drugs and alcohol.

2. The Head of Healthcare should ensure that national guidelines and best practice for monitoring prisoners prescribed atypical antipsychotics are followed.

3. The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including:

    - Efficiently communicating the nature of a medical emergency;
    - Bringing the relevant equipment to the scene; and
    - Ensuring there are no delays in calling, directing or discharging ambulances.

ACTION PLAN: The Man – HMP Featherstone

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that secondary health screens include an assessment of risk factors for cardiovascular disease, particularly for prisoners most at risk, including those who have a history of smoking heavily and misuse of drugs and alcohol.	Accepted	The secondary reception health screen is a national standardised screening tool. Staffordshire and Stoke on Trent Partnership Trust (SSOTP) and the Head of Healthcare have raised this recommendation with the commissioner of Offender Health care (NHS England) for them to make the decision if the tool should just be amended locally or nationally to include this recommendation. The matter has been raised with the commissioner on a number of occasions since October 2013. The issue has been added as an Agenda item at the next Quality and Performance meeting between SSOTP and NHS England on the 19.2.15 so a formal decision can be made.	Target date for completion: February 2015	
2	The Head of Healthcare should ensure that national guidelines and best practice for monitoring prisoners prescribed atypical antipsychotics are	Accepted	Staffordshire and Stoke on Trent Partnership Trust (SSOTP) have accepted this recommendation. A standard operating procedure was developed. This has now been signed off by the Trust and by the Offender Health Quality Operational Group on the 20.6.14. It was amended following comments received by the Trusts Medicines Management	Target date of completion: March 2016	

	followed.		Committee and Secondary Mental Health Services. The standard operating procedure was re- issued to all Health Care managers on the 10.10.14 for implementation. Compliance with the Standard Operating Procedure will be Audited during 2015/2016 by the Head of Healthcare.		
3	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including: • Efficiently communicating the nature of a medical emergency; • Bringing the relevant equipment to the scene; and • Ensuring there are no delays in calling, directing or discharging		This recommendation was accepted by the prison and has been completed. At HMP Featherstone, Emergency medical response codes blue and red are announced over the radio net. This ensures that all staff, including Healthcare, are aware of the nature of the medical emergency, and know what relevant equipment to bring to the scene. When an emergency code is called, an ambulance is called immediately by the control room to ensure there is no delay in calling an ambulance. A Governor's Operational Order to all staff was published to this effect on 10/12/13 and was republished on 24/10/14. There are also notices prominently displayed in the control room to reiterate these procedures.	Completed 10/12/13 Head of Safer Custody	.

	ambulances.				