

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in June 2014,
while in the custody of HMP Moorland**

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 from heart disease of a man in June 2014, while a prisoner at HMP Moorland. He was 64 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Moorland was carried out. The prison cooperated fully with the investigation.

The man had been in prison since 8 November 2013 and moved to Moorland from HMP Nottingham on 25 February 2014. His initial health screen at Moorland indicated that he suffered from heart disease and had limited mobility. He was a heavy smoker, but did not want to give up. He had no significant health problems until May 2014, when he complained of a persistent cough. A prison GP suspected that he had lung disease and arranged a chest X-ray.

At the beginning of June, the man was feeling unwell and a nurse referred him immediately to a prison GP. The GP was concerned that his health had deteriorated and arranged for him to be admitted to hospital. The next day, he suffered two cardiac arrests in hospital and died that evening.

I agree with the clinical reviewer that, while she identified some areas for improvement, overall the man received a good standard of care at Moorland. I am pleased to note that the prison agreed to remove restraints when he had a cardiac arrest in hospital, but I question whether their use was fully justified and necessary before that.

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

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SUMMARY

1. On 8 November 2013, the man was sentenced to five years imprisonment and went to HMP Nottingham. He transferred to HMP Moorland on 25 February 2014. A reception nurse noted that his health was poor; he had limited mobility and had previously had a heart attack. He had suffered no chest pain for the previous twelve months, but had an inhaler in case of any pain and smoked cigarettes.
2. The man did not report any other significant health issues until early April 2014, when he complained of coughing and some breathlessness. A nurse referred him to the GP, but it took over one month to get an appointment. In May, the GP referred him to hospital for a chest X-ray, as he suspected he had lung disease.
3. At the beginning of June, the man reported that he was short of breath. A nurse noted his blood pressure was low, and referred him to a doctor who examined him within 30 minutes. The doctor carried out an ECG which showed some irregularities and sought advice from a hospital registrar, who agreed to admit him to hospital that day to try to stabilise his condition. Two officers escorted him and used handcuffs to restrain him.
4. The next morning, the man had a cardiac arrest. Officers removed the restraints and hospital staff successfully revived him. At 6.10pm, he had a further cardiac arrest and died shortly afterwards.
5. The clinical reviewer noted the need to ensure that abnormal blood pressure results were always followed up and that prisoners should not have excessive waits to see a GP, but overall found that the man received a good standard of care at Moorland. We agree with the clinical reviewer's assessment that his care was equivalent to that he could have expected to receive in the community. We welcome the fact that restraints were removed after he had a cardiac arrest, but we are not satisfied that their use before that, was based on a fully considered risk assessment. We make three recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of the man's relevant prison and medical records. NHS England commissioned a clinical reviewer to review his clinical care at the prison. The investigator and clinical reviewer jointly interviewed four healthcare staff and spoke to a prisoner at Moorland on 16 July 2014. They gave the Governor preliminary feedback about the initial findings of the investigation.
8. We informed HM Coroner for South Yorkshire of the investigation who provided the post-mortem results. We have sent the Coroner a copy of this investigation report.
9. One of the Ombudsman's family liaison officers contacted the man's daughter to explain the purpose of the investigation. She did not have any specific matters for the investigation to cover.
10. The man's family received a copy of the draft report and had no comments to make. The prison considered our draft report and recommendations, which they have accepted. The prison has also 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 MOORLAND

11. HMP & YOI Moorland is a Category C training prison in South Yorkshire. It holds up to 1000 men.
12. Nottinghamshire Healthcare NHS Trust runs healthcare services at the prison, including primary care, mental health and substance misuse provision. The prison does not have an inpatient facility or full time nursing cover.

HM Inspectorate of Prisons

13. The most recent inspection of Moorland, in December 2012, was published in April 2013 and found that the overall quality of health services had improved since the previous inspection. There was a wide range of clinics as part of a wing based service. Inspectors noted that an initiative with prisoner healthcare representatives on wings was working well and there was proactive support for older prisoners and those with disabilities.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In its latest annual report for the year to February 2014, the IMB noted that as well as general clinical services, there were specialist clinics for chronic diseases and secondary mental health. All house blocks had an allocated nurse for treatment and triage.

Previous deaths at HMP Moorland

15. There had been two other deaths at Moorland from natural causes in the two years before the man's death. There were no significant similarities with the other cases.

KEY EVENTS

16. On 8 November 2013, the man was sentenced to five years imprisonment for sexual offences and was sent to HMP Nottingham. At an initial health screen at Nottingham, he told a nurse that he had asthma and angina (pains and discomfort in his chest) and had had a hernia operation in July 2013. Later the same day, a locum GP prescribed him medication, but it is not clear from his entry in the medical record whether he saw him in person. He had a secondary health check on 18 November, which recorded his basic clinical observations. There is no record that the reception process at Nottingham identified that he had very poor eyesight and a significant cardiac history, including heart attacks and the insertion of a stent.
17. On 25 February 2014, the man transferred to HMP Moorland. When he arrived, he told a nurse that he smoked cigarettes, but did not have alcohol or drug problems. She noted he should be considered as unfit for work due to his poor vision and limited mobility and that he would need a ground floor cell. She recorded that he had previously had heart attacks and had used a spray to relieve chest pain. She took his clinical observations and noted his blood pressure was very low. There is no record of any further action about this.
18. On 10 April, the man asked to see a nurse or doctor as he had a persistent cough. A nurse saw him on 14 April and referred him to the prison GP as she noted he had said he had the cough for three weeks. A prison GP prescribed two sprays to ease his angina, but did not see him. At an appointment on 13 May, the GP examined him and noted symptoms to indicate that he had chronic obstructive pulmonary disease (COPD, lung disease). He referred him to hospital for further tests, including an X-ray.
19. Two days later, officers were concerned about the man's breathing and took him to the treatment room on the wing. A nurse saw him, but was administering medicines through a locked gate at the time, so was unable to take any clinical observations. She told the investigator that he did not appear to be acutely unwell had a good colour, was able to walk unaided and could speak. She checked his medical notes and noted that the GP was investigating whether he had COPD. She told him that he should rest, use his inhaler and come back if he continued to feel unwell.
20. On 20 May, the man went to hospital for the X-ray the GP had requested. The results had not been received by the time his health deteriorated and he was taken to hospital on 6 June.
21. At 2.23pm on 6 June, a nurse examined the man in the healthcare unit as he was complaining of shortness of breath. She noted that he was pale, had swollen ankles and that his blood pressure was low. She referred him urgently to the prison GP.
22. At 2.51pm, a GP examined the man and noted that his breathing was irregular, his heart beat was fast and his blood pressure was low. The GP completed an ECG which showed a first degree heart block, when the electrical heart signal is slowed or disrupted causing occasional irregular beats. He consulted a medical registrar at a hospital, who advised that they should admit him to hospital for treatment.

23. The GP finalised the arrangements for the man's hospital admission and, at 4.40pm, officers took him to hospital as a non-emergency admission.
24. The prison had completed a risk assessment for the hospital admission. The medical section of the risk assessment was completed by a nurse. She said there were no medical objections to the use of restraints, his medical condition did not restrict his ability to escape unaided and the restraints should not be removed for treatment. The security assessment said he was a low risk of escape, outside assistance and hostage taking. He was assessed as medium risk to the public and hospital staff due to the nature of his offence. A prison manager decided that two escort officers should use a single handcuff to restrain him for the journey to the hospital, and an escort chain when he was admitted.
25. The man's condition deteriorated quickly in hospital. At 11.20am he had a cardiac arrest. At that point, another prison manager agreed the handcuffs should be removed. Hospital staff resuscitated him and moved him to the hospital's Coronary Care Unit. At 6.10pm, he had a second cardiac arrest. Hospital staff could not resuscitate him and pronounced him dead at 7.00pm.

Liaison with the man's family

26. The man had not given the prison any next of kin details and he did not have any visits or make any telephone calls while he was in prison. The prison contacted his offender manager, who knew he had a daughter and granddaughter, but neither she nor his solicitor had any contact details.
27. Four days after his death, South Yorkshire Police traced the man's daughter. The prison's family liaison officer contacted her and explained what had happened. His daughter had not seen him since she was a child, but agreed to act as his next of kin.
28. The prison arranged and paid for the funeral, which was held on 20 June.

Support for staff and prisoners

29. A Governor's notice informed staff and prisoners of the man's death and offered support to anyone affected. A prison manager held a hot debrief for prison staff who were with him when he died and offered them support (a hot debrief is a meeting immediately after an incident, designed to reassure staff and provide them with support). Staff reviewed prisoners at risk of suicide or self-harm in case they had been affected by his death.

Post-mortem

30. A post-mortem examination gave the cause of death as congestive cardiac failure, ischaemic heart disease and coronary artery atherosclerosis.

Issues

Clinical care

31. The clinical reviewer noted that reception health screens at Nottingham did not identify all clinical information sufficiently well. This did not affect the man's subsequent treatment, but she made a recommendation in her review which the Head of Healthcare at Nottingham will need to address.
32. The clinical reviewer found that the man had a thorough initial health screen when he arrived at Moorland, which ensured that he continued to receive his prescribed medication. She noted that the reception screening was a well-considered and patient centred approach. However, although the reception nurse recorded that his blood pressure was very low, there was no record of any follow up action. We make the following recommendation:

The Head of Healthcare should ensure that abnormal blood pressure readings are promptly and appropriately investigated and treated, in line with current clinical guidelines.

33. After a nurse referred the man to see a GP on 14 April, a GP did not see him until 13 May, over four weeks later. We have been unable to establish the reason for this delay. We agree with the clinical reviewer that this was too long and this aspect of his care at the prison did not reflect equivalence with provision in the community. We make the following recommendation:

The Head of Healthcare should ensure that prisoners have appropriate access to GPs for both routine and urgent appointments and should conduct regular audits of waiting times to ensure a satisfactory standard of service is maintained.

34. The clinical reviewer was satisfied that these matters did not affect the eventual outcome for the man and that overall the clinical care he received at Moorland was equivalent to that he could have expected to receive in the community. She noted some areas of good practice and that the nurse's assessment on 6 June, when his health deteriorated, was competent, thorough and well documented. This resulted in an appropriate referral to the GP. The GP's subsequent examination and assessment was also thorough and effective liaison with the hospital led to an efficient transfer.

Restraints and escorts

35. 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 into account 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.

36. A risk assessment was completed on 6 June, when the man went to hospital, but we have some concerns about its accuracy. A nurse noted that his medical condition did not restrict his ability to escape unaided and the restraints should not be removed for treatment. In February, the same nurse had noted that he had very poor vision and limited mobility, but this was not mentioned. On 6 June, his condition had deteriorated significantly and needed hospital treatment. He had been able to walk to the healthcare centre, but he was short of breath. The GP had diagnosed acute decompensated heart failure – a worsening of symptoms, typically shortness of breath, oedema and fatigue, in a patient with existing heart disease.
37. The security assessment said the man was a low risk of escape, outside assistance and hostage taking but noted he was a medium risk to the public and hospital staff due to the nature of his offence. Despite the low risk of escape, a prison manager decided that two escort officers should use a single handcuff to restrain him. The manager explained that, as he was convicted of a sexual offence against children, he was considered a risk to the public. However, he said that there was nothing specific in his records to indicate a risk to healthcare staff. He said he was content that the risk should be assessed as medium when prisoners convicted of sex offences attend hospital appointments. He said this highlighted to escort staff that they should be more vigilant when supervising prisoners.
38. It is possible that a properly considered risk assessment would still have reached the conclusion that the man needed to be restrained, but he was an older prisoner with limited mobility who was seriously ill at the time. The manager's comments suggested that he took a blanket approach to assessing risk for prisoners convicted of sexual offences. The man's risk of escape had been assessed as low and he could only have been a risk to the public if he had escaped from two escorting officers. The purpose of restraints is to prevent escape, not to highlight to escorting officers the potential risk should the prisoner escape. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances and actual risk at the time.
39. We welcome the fact that after the man had a cardiac arrest the officers removed restraints and they were not used again. However, there is a need for all those involved in making decisions to ensure that they take a prisoner's health and mobility fully into account in risk assessments and that staff follow the guidance in the 2007 High Court judgment. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities when assessing how health and mobility impacts on the risk of escape. We make the following recommendation:

The Governor and Head and Healthcare should ensure that risk assessments for prisoners attending 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 abnormal blood pressure readings are promptly and appropriately investigated and treated, in line with current clinical guidelines.**
- 2. The Head of Healthcare should ensure that prisoners have appropriate access to GPs for both routine and urgent appointments and should conduct regular audits of waiting times to ensure a satisfactory standard of service is maintained.**
- 3. The Governor and Head of Healthcare should ensure that risk assessments for prisoners attending 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 abnormal blood pressure readings are promptly and appropriately investigated and treated, in line with current clinical guidelines.	Accepted	The Head of Healthcare will review NICE blood pressure guidance and ensure the appropriate process is implemented in order to assess, treat and monitor patients with hypertension and hypotension	31 December 2014 Head of Healthcare
2	The Head of Healthcare should ensure that prisoners have appropriate access to GPs for both routine and urgent appointments and should conduct regular audits of waiting times to ensure a satisfactory standard of service is maintained.	Accepted	The Head of Healthcare will review the GP waiting list on a fortnightly basis. The review will include the following aspects: <ul style="list-style-type: none"> • Audit of current waiting times • Review GP appointment allocations and implement any changes identified • GP waiting times will be a set agenda item for discussion during the monthly GP meeting and minutes retained as evidence • Escalate any GP waiting time issues to the Trust Clinical Director. 	31 December 2014 Head of Healthcare
3	The Governor and Head of	Accepted	Following discussion with the Head of Healthcare and	31 December

	<p>Healthcare should ensure that risk assessments for prisoners attending hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.</p>		<p>the Head of Security, a review of the risk assessment document will be undertaken and amended as appropriate. The risk assessments will be amended to take into account the dynamic risks presented, known security risks and individual circumstances based on the actual risk the prisoner presents at the time of the escort. In relation to the application of restraints, the risk assessment will also include the following four elements for consideration:</p> <ul style="list-style-type: none"> • No Restraints - close supervision by the escorting officers has been considered to be sufficient to maintain security for the prisoner/patient. • Escort Chain - the escort chain is sufficient and will allow the prisoner/patient a degree of privacy during medical consultation/treatment • Single Cuff – the prisoner/patient is presenting a risk to the public, security, or to the safety of escorting or hospital staff • Double Cuff – the prisoner/patient is presenting a significant risk to the public, security, or to the safety of escorting or hospital staff. 	<p>2014 Governor HMP/YOI Moorland, Head of Security and Head of Healthcare</p>
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