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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP North  
Sea Camp in July 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, from heart disease, of a man, at HMP North Sea Camp on 2 July 2014. He was 73 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at North Sea Camp. The prison cooperated fully with the investigation.

The man was sentenced to two years and eight months in prison in August 2013 and arrived at North Sea Camp in October. He received treatment for chronic lung disease and had infrequent contact with healthcare services.

On 27 June 2014, a nurse reviewed the man after he complained of being short of breath. The nurse diagnosed a chest infection and a prison GP prescribed antibiotics, but did not examine the man. Another nurse reviewed the man the next day. He was still unwell, and the nurse asked the GP to prescribe medication to help clear his chest. Again the GP did not see the man. The following evening, staff recorded that the man was feeling better.

On the morning of 2 July, another prisoner found the man unresponsive in his room. The prisoner told an officer, who radioed for an emergency ambulance. Nurses arrived and attempted to resuscitate the man. Shortly afterwards, paramedics attended and pronounced the man dead.

The clinical reviewer was concerned that the man's illness in the lead up to his death was managed without sufficient input from a doctor. For that reason, he concluded that the man's standard of healthcare in prison was not equivalent to that which he could have expected to receive in the community. Overall, however, I do not consider that the prison could have foreseen the man's death.

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**

**February 2015**

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## SUMMARY

1. In August 2013, the man was sentenced to two years and eight months in prison. His medical history included chronic obstructive pulmonary disease (COPD - lung disease) and depression. He had smoked heavily in the past, and had a history of alcohol abuse.
2. The man first went to HMP Nottingham before moving to HMP North Sea Camp in October. He received treatment for COPD, and had occasional contact with healthcare staff. Apart from a urinary infection in December 2013, staff recorded no concerns.
3. On 27 June 2014, a nurse reviewed the man after he complained of being short of breath. The nurse diagnosed a chest infection, and a prison GP prescribed antibiotics, but did not see the man. Another nurse reviewed the man the next day. He was still unwell, and the nurse asked the GP to prescribe medication to help clear his chest. Again the GP did not examine the man. The following evening, staff recorded that the man was feeling better.
4. On the morning of 2 July, another prisoner found the man unresponsive in his room. An officer attended but could not find any signs of life. The officer radioed an emergency medical code which led to an ambulance being called. Healthcare staff arrived shortly afterwards and attempted to resuscitate the man. Paramedics arrived around 10 minutes later, and pronounced him dead.
5. The clinical reviewer concluded that the standard of healthcare the man received at North Sea Camp was not equivalent to that which he could have expected to receive in the community. Although the actions of staff on 2 July were appropriate, the clinical reviewer was concerned that a doctor did not review the man during his final illness. We make one recommendation.

## THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP North Sea Camp informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
7. NHS England commissioned the clinical reviewer to review the man's clinical care in prison.
8. The clinical reviewer obtained copies of the man's medical records and relevant extracts from his prison record. He interviewed staff from North Sea Camp on 10 and 23 September, and gave the Governor initial feedback about the preliminary findings of the investigation.
9. We informed HM Coroner for South Lincolnshire of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
10. One of the Ombudsman's family liaison officers contacted the man's son, his nominated next of kin, to explain the investigation. The man's son did not have any specific issues for the investigation to consider.
11. The man's family received a copy of the draft report. They were very concerned at the standard of medical care that the man received before 2 July. The prison also received a copy of the draft report. Their response to our recommendations and action plan is included at the end of this report.

## **HMP NORTH SEA CAMP**

12. North Sea Camp is an open prison near Boston in Lincolnshire. (Open prisons are for the lowest security category of prisoners who can be reasonably trusted not to escape.) The prison holds over 400 sentenced men in six units. Prisoners who are assessed as suitable are able to work in the community.
13. Lincolnshire Partnerships NHS Foundation Trust provided health services at North Sea Camp at the time of The man' death (Nottinghamshire Healthcare NHS Trust is now the provider). The healthcare centre is open from 7.30am to 6.00pm Monday to Friday, and 7.30am to 12.15pm at weekends. There are four GP sessions a week and a number of clinics for life long conditions, including a clinic for prisoners with chronic respiratory conditions.

## **HM Inspectorate of Prisons**

14. In its most recently published report of an inspection in April 2012, the Inspectorate found that there had been some improvements in the standard of health services. However, they reported that there were no care plans for prisoners who needed them. Despite a previous Inspectorate recommendation, there was still no older prisoner policy. All nurses had up to date resuscitation and defibrillation training to intermediate life support standard, but some officers were not up to date with their first-aid or emergency life support training.

## **Independent Monitoring Board**

15. 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 annual report for the year to 28 February 2014, the IMB was concerned about the ongoing care of older and seriously ill prisoners in the absence of a dedicated residential unit or 24 hour healthcare cover.

## **Previous deaths at HMP North Sea Camp**

16. The man was the second prisoner to die at North Sea Camp since 2013. Both deaths were from natural causes but there were no other similarities.

## KEY EVENTS

17. On 16 August 2013, the man was sentenced to two years and eight months in prison for causing death by dangerous driving. He was 72 years old and this was his first time in prison. The man went first to HMP Nottingham. His medical history included COPD and depression. The man had smoked cigarettes heavily in the past but had given up about three years earlier. He had a history of alcohol abuse, but had stopped drinking eight months before his sentence.
18. At the man's initial health screens, nurses noted his medical conditions and a prison GP prescribed his regular medication. The man's blood pressure was normal and the nurses recorded no concerns.
19. On 22 August, a nurse assessed the man's physical and mental health after the man's solicitor was concerned about him. The man said he felt mentally well and safe at Nottingham. On 27 August, another nurse assessed the man's mental health again. The nurse concluded that the man was stable. A full set of blood tests on 30 August were normal.
20. A prison GP reviewed the man on 10 September. He recorded that the man had some shortness of breath, but his COPD was well-controlled. The GP concluded that the man was fit enough to exercise, and agreed that he could keep his medication in his cell.
21. On 16 October, the man transferred to North Sea Camp. At an initial health screen the next day, the nurse recorded that the man appeared frail and used a stick to help him walk. Medical observations showed his blood pressure was normal but he had reduced oxygen saturation (the concentration of oxygen in the blood which affects breathing). The nurse recorded that the man needed a GP review. A prison GP prescribed the man's regular medication, but there is no evidence that he reviewed the man in person.
22. The man lived on North Unit, in a single room close to a disabled bathroom with easy access. Another prisoner helped him with day to day living. Although frail, the man was usually able to walk to the healthcare unit across the prison to collect his medication.
23. On 28 November, the prison's respiratory lead nurse reviewed the man. The man told the nurse that he had smoked from the age of 18 but had stopped three years previously. The nurse recorded that the man suffered from a productive cough twice a day and shortness of breath. A breathing test showed that the man's had very severe COPD. The nurse recommended a COPD review every six months, and asked a GP to adjust the man's medication. The GP updated the man's medication the next day, but he did not review him in person.
24. The nurse reviewed the man on 10 December and performed an electrocardiogram (a test to show heart activity). The nurse scanned the

results onto his medical record and noted that a prison GP would review this. There is no record that this happened.

25. On 13 December, the GP reviewed the man's medication after he told staff he wanted to stop his medication for depression. The man told the GP that he had settled in prison and no longer felt depressed. The GP agreed to reduce the man's prescription gradually. Healthcare staff noted no further concerns about the man's mental health during his time at the prison.
26. On 19 December, the nurse reviewed the man as he was suffering from a urinary infection. She noted that he had low oxygen saturation, and referred him for pulmonary rehabilitation, a support programme to improve the symptoms of COPD. There is no further mention of this in the records.
27. Over the following months, the man had infrequent contact with healthcare services, apart from collecting his usual medication. On 5 June, the man had an abdominal aortic screening (a test to detect swelling in the main blood vessel from the heart) which is routine for men over 65. The results were normal.
28. On 19 June, another prison GP reviewed the man's COPD (The man had asked for a review as he had not had one since the nurse's advice in November 2013). The GP examined the man's chest and recorded that it was clear, he did not record any other observations. On 23 June, the GP wrote to the respiratory consultant at Lincoln County Hospital requesting an assessment. He noted that the man was worried that his COPD was getting worse. The man did not have an assessment before his death.
29. On 27 June, officers on North Unit asked healthcare staff to review the man as he was complaining of being short of breath. The nurse examined the man and recorded that he was able to speak without running out of breath and looked well. However, his oxygen saturation was poor, and his temperature, blood pressure and pulse were high. The nurse gave the man a subutamol nebuliser (a spray to help breathing), which improved his oxygen levels. He diagnosed a possible chest infection, and asked a GP to prescribe antibiotics, steroids and a nebuliser for the man to keep in his room. The GP updated the man's medication, but did not examine him in person.
30. On 30 June, the nurse examined the man's chest and found fluid in his lower lungs. She recorded that he was struggling to cough up thick mucus, and was not eating well. The nurse asked officers to give the man extra pillows to help him sit up in bed, and a GP to prescribe medication to help clear his chest. The GP prescribed this medication without seeing the man.
31. The nurse reviewed the man again the next morning. She advised him to rest in his room because of his chest problems. At around 6.00pm, the nurse went to give the man his medication on North Unit. The man told the nurse that he felt slightly better, and that the extra pillows had helped him during the night. The nurse recorded that the man looked well and had no concerns. At around

8.00pm, the man's friend helped the man take his medication. He told us that the man appeared well.

## 2 July

32. The man's friend looked into the man's room twice during the early hours of 2 July. He told us that the man was lying on his right side and appeared to be sleeping. Just before 7.30am, the man's friend went into the man's room to help him get up. The man's friend called out to the man, but he did not respond. He touched his hand, which was cold, and could not see any signs of life.
33. The man's friend ran to the wing office and told an Officer that the man was unresponsive. The Officer went to the room with the man's friend and checked the man's neck and wrist, but could not find a pulse. She radioed a code blue emergency call (which indicates when a prisoner is unconscious or has respiratory problems) and asked healthcare staff to come quickly. Control room staff called an ambulance immediately.
34. A few seconds later, more officers arrived after hearing the emergency radio call. A custodial manager laid the man flat on his bed and continued to check for signs of life. He told us that he thought he was dead. The Officer left the room to clear the corridor of prisoners and check that the man's friend was okay.
35. Two nurses arrived at the man's room with emergency equipment shortly after the prison staff. A nurse told us they heard the emergency radio call and drove from the healthcare unit to North Unit. The nurses checked for signs of life with a defibrillator (which analyses heart rhythm and delivers electric shocks to restart the heart). The machine did not detect a shockable rhythm and the nurses began cardiopulmonary resuscitation.
36. At around 7.40am, a paramedic arrived and helped the nurses continue the resuscitation attempt. The paramedic tried to clear the man's airway, but his jaw was stiff. The paramedic could not find any signs of activity in the man's heart, and pronounced him dead at 7.47am.
37. The Governor and the duty governor debriefed some of the staff involved in the emergency response before they left the prison and ensured they were offered support. The staff offered prisoners on North Unit support. The man's friend received help from mental health services.
38. Prison managers asked the officer to act as the prison's family liaison officer. At around 12.10pm, the officer and the Deputy Governor visited the man's family to inform them of his death.
39. The officer continued to support the man's family after his death. In line with national guidance, the prison contributed to the funeral costs. The prison held a memorial service for the man.

## **Post-mortem**

40. After a post-mortem examination, the Coroner gave the cause of death as ischaemic heart disease, and coronary artery atheroma (fatty deposits which build up on the walls of the coronary arteries).

## ISSUES

### Clinical care

41. The clinical reviewer found that healthcare staff assessed the man appropriately when he arrived at North Sea Camp. He received appropriate treatment for his chronic COPD. However, he was concerned that prison GPs had little input into the man care, particularly during his final illness. In that respect, the clinical reviewer concluded that the care the man received at the prison was not equivalent to that which he could have expected to receive in the community.
42. When the nurse took the man's medical observations on 27 June, the results were abnormal and suggested that he was unwell. The nurse discussed the results with the GP who prescribed antibiotics, steroids and a nebuliser without seeing the man. There was no further review until three days later, and no plan to monitor the man during this period. The nurse took the man's pulse on 30 June, but did not repeat any other observations. The GP prescribed medication to clear the man's chest, but again did not examine him in person.
43. The clinical reviewer was concerned that the man did not receive an appropriate clinical assessment by a doctor during his final illness. The nurses who took medical observations on 27 and 30 June did not have minor illness training, and the reviewer would have expected a doctor to see the man or for him to be sent to hospital. The GP prescribed medication without physically assessing him. The GP considered that a hospital admission during the man's final illness might possibly have led to a different outcome. However, he noted that the man was at risk of sudden death because of his heavy smoking and drinking in the past, and his respiratory problems.
44. We agree with the clinical reviewer's assessment of the man's clinical care at North Sea Camp. There were a number of occasions when prison GPs prescribed medication without directly reviewing the man. An appropriately trained clinician should have assessed the man when he was unwell in June. The clinical reviewer considers that the GP should have reviewed the man, and nurses should have considered sending him to hospital for assessment if a prison GP was not available. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners who are unwell are reviewed by an appropriately trained clinician, and sent to hospital when this is not possible.**

45. While there was little evidence of heart disease screening at North Sea Camp, the clinical reviewer found no indication that would have helped healthcare staff identify that the man had an underlying condition. Although he had some risk factors such as COPD and a history of smoking and alcohol misuse, the clinical reviewer found that the man's blood test results were acceptable. His blood pressure was usually normal and the abdominal aortic screening in June 2014 was negative.

## **Emergency response**

46. Prison Service Instruction (PSI) 03/2013 says that a code blue emergency call should be used in a medical emergency, including when a prisoner has chest pain, has difficulty breathing or is unconscious. It directs that when a medical emergency is called over the radio network, staff should call an ambulance immediately.
47. When Officer Newstead assessed the man on 2 July, she could not find any signs of life. She immediately radioed a code blue and the control room staff called an ambulance straight away. We are satisfied that the officer acted appropriately and that North Sea Camp has a suitable emergency protocol reflecting current Prison Service requirements. The clinical reviewer concluded that emergency treatment was appropriate.

## **RECOMMENDATION**

The Head of Healthcare should ensure that prisoners who are unwell are reviewed by an appropriately trained clinician, and sent to hospital when this is not possible.

## ACTION PLAN

<b>No</b>	<b>Recommendation</b>	<b>Accepted/Not accepted</b>	<b>Response</b>	<b>Target date for completion and Function Responsible</b>
1	The Head of Healthcare should ensure that prisoners who are unwell are reviewed by an appropriately trained clinician, and sent to hospital when this is not possible.	Accepted	Whenever prisoners are unwell they will be seen by an appropriately trained clinician or sent to hospital if this is not possible.	Complete  Head of Healthcare