



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in July 2014,
while in the custody of HMP Hewell**

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 bronchopneumonia and congestive cardiac failure of a man in July 2014, while a prisoner at HMP Hewell. He was 69 years old. I offer my condolences to all who knew him.

A clinical review of the care the man received in prison was conducted. The prison co-operated with the investigation.

The man was sentenced to life imprisonment in 1996. He developed ischaemic heart disease and had cardiac surgery. In 2011 he was diagnosed with severe heart failure in the left side of his heart. He transferred to HMP Hewell in 2013. Prison healthcare staff managed his condition and he spent time as an inpatient in the prison healthcare centre and in hospital.

On 3 July 2014, a prison doctor referred the man to hospital for a further assessment of his heart and a chest infection. He was diagnosed with end stage heart failure and pneumonia. On 7 July, his condition became very serious and the hospital began end of life palliative care.

The investigation found some weaknesses in the management of the man's chronic condition about which I make recommendations. Nevertheless, the clinical reviewer concluded that Hewell's healthcare team had helped to prolong his life and his care was equivalent to that which he could have expected to receive in the community. I am therefore satisfied that he received an appropriate standard of care at Hewell. However, I am concerned that the use of restraints when he went to hospital in July was not justified by fully considered risk assessments, a matter which I have raised with the prison before.

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. The man was sentenced to life imprisonment for murder in October 1996. In prison, doctors diagnosed him with ischaemic heart disease and he had major heart surgery, including two coronary artery bypass grafts in April 2001, an aortic valve replacement in September 2008 and a pacemaker fitted in April 2009. Doctors diagnosed severe left-sided heart failure in September 2011.
2. The man transferred to HMP Hewell from HMP Swaleside on 16 May 2013. He received medication for his heart problems and other medical conditions, including warfarin, to thin his blood, which required frequent blood tests to establish the correct dose. Prison healthcare staff, hospital consultants and specialists managed his care.
3. In December 2013, a prison GP referred the man to a cardiologist and neurologist as he had reported dizzy spells, shortness of breath, palpitations and his blood pressure was low. Tests showed that the left side of his heart had become enlarged and weakened, which indicated he had life-limiting congestive heart failure.
4. The man's oxygen levels and blood pressure remained low and he continued to experience dizziness and breathlessness. Healthcare staff at the prison monitored him frequently, and he attended outpatient appointments and spent periods as an inpatient in the prison's healthcare centre and in hospital. On 3 July 2014, his oxygen levels remained low and he was short of breath, so a prison GP arranged for him to be admitted to hospital for assessment.
5. On 7 July, the man's condition deteriorated and the hospital advised the prison that he was unlikely to live much longer. He had been restrained by an escort chain in hospital, but a prison manager instructed the escort officers to remove the restraints and temporarily released him on a special purpose medical licence. As he had lost contact with his family, the prison assigned one officer to stay with him for support. He died several days later. The recorded cause of death was bronchopneumonia and congestive cardiac failure due to ischaemic heart disease.
6. The clinical reviewer found some areas where the man's chronic condition could have been managed better. Prison healthcare staff did not follow the national guidelines for monitoring his blood and his medical records did not always reflect the advice given by hospital specialists. However, the clinical reviewer concluded that, overall, his care was equivalent to that he could have expected in the community. We make three recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and inviting anyone with any relevant information to contact him. No one responded.
8. The man went to Hewell on 28 July, and met the prison liaison officer, healthcare manager and a member of the Independent Monitoring Board. He obtained available copies of the man's relevant prison and medical records.
9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison. She interviewed five healthcare staff at the prison.
10. We notified HM Coroner for Worcestershire of the investigation, who gave the cause of death. We have sent the Coroner a copy of this report.
11. The man's family wanted to have no contact with him after his imprisonment.
12. The prison received a copy of the draft report, and has submitted an action plan detailing what they have done to address the issues we raised in the report. This is included at the end of the report.

HMP HEWELL

13. HMP Hewell comprises two separate sites – a closed local prison (formerly HMP Blakenhurst) and an open prison known as The Grange Resettlement Unit (formerly Hewell Grange). The closed site, where the man lived, takes prisoners from courts in the West Midlands, Warwickshire and Worcestershire and holds up to 1104 men in six houseblocks. Worcestershire Health and Care NHS Trust provides 24 hour health care.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of HMP Hewell was in July 2014. The Inspectorate found that there was a good staff skills mix in the health care unit, but there were staff vacancies. Prisoners they surveyed were generally dissatisfied with the quality of health care services, as well as their access to them. Inspectors found the range and quality of most services were good, except that prisoners waited too long to see a GP. All prisoners had adequate health screens when they arrived. Pharmacy services were satisfactory.

Independent Monitoring Board

15. 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 2013, the IMB noted that there had been some progress in relation to some of the deficiencies in healthcare identified by the Inspectorate at the 2012 inspection, including dealing with staff vacancies, which it hoped would help resolve problems experienced throughout the year with GP waiting times.

Previous deaths at Hewell

16. The man's was the sixth of eight deaths at Hewell this year. In previous investigations, we have had concerns about the management of prisoners with chronic or life threatening illnesses, medical record keeping and the use of restraints.

KEY EVENTS

17. On 23 October 1996, the man received a mandatory life sentence for murder, with a minimum time to serve of sixteen years. He was initially held at HMP Whitemoor and was transferred to HMP Full Sutton on 11 May 1999. He was diagnosed with heart disease and, in April 2001, had a double heart bypass operation at York Hospital.
18. On 27 March 2008, the man transferred to HMP Gartree. He had a heart attack on 2 September and had further heart surgery (replacement valve) on 11 September. In April 2009, the hospital fitted an internal cardiac defibrillator (ICD - a pacemaker).
19. The man transferred to HMP Swaleside on 26 August 2011. On 6 September, the prison GP diagnosed that he had severe left-sided heart failure.
20. The man transferred to HMP Hewell on 16 May 2013. A doctor noted his history of heart disease at his reception health screen and continued his medication to manage his heart condition and reduce his blood pressure. He took warfarin to thin the blood and help to reduce the potential of blood clotting due to abnormal heart function and painkillers to relieve the discomfort of the pacemaker.
21. A nurse examined the man in the prison cardiovascular disease clinic on 22 May. He weighed 66.45Kg and his BP was 103/67 (low). The nurse noted that his weight was within normal limits, but he told her that there were many days where he did not eat at all, so she prescribed Fortisips (a nutritional supplement drink).
22. Nurses took blood tests every few days to monitor the man's warfarin levels and blood clotting time (known as the International Normalised Ratio - INR) and to revise his medication as necessary. However, there was no record of his target INR level.
23. Hospital specialists monitored the man's pacemaker every six months. On 11 June, a prison GP referred him to hospital for his twice-yearly check. At his appointment, on 25 June, he told the hospital doctor that he felt dizzy most days. The doctor was satisfied that his pacemaker was working correctly, but advised him to take his blood pressure medication, (bisoprolol and ramipril), at different ends of the day to stop the dizziness. (Prison doctors later adjusted the medication.)
24. The next day, a nurse reviewed the man and noted that he had lost 5.44Kg. She reminded him to collect Fortisips drinks in the morning as well as the afternoon. In July, a prison doctor noted the man's weight loss and reduced appetite and urgently referred him to a geriatrician (elderly care consultant) to rule out the possibility that his weight loss was due to cancer. A month later, a GP noted that an appointment had not been received and asked for this to be chased. Subsequent

hospital tests confirmed an inflammation of his food pipe and stomach lining.

25. On 22 September, the man reported chest pain to wing officers. A nurse went to see him but was unable to measure his heart activity as there was no working electrocardiograph (ECG a diagnostic machine that measures heart activity and abnormalities). She therefore sent him to hospital by emergency ambulance. Hospital staff suspected his pacemaker had been damaged and gave him an urgent follow-up appointment. At an appointment on 27 September, the hospital found that his pacemaker was working properly.
26. A doctor referred the man to a cardiologist and a neurologist on 4 December, as he was short of breath, dizzy, had low blood pressure and palpitations. She also prescribed medication for angina (muscle pain in the heart).
27. At 4.35pm on 31 December, a wing officer asked a nurse to see the man, who was feeling unwell, with chest pains, dizziness and vomiting. He said his pacemaker had been activated and he felt short of breath. She recorded that he was fully alert and breathing on his own. She gave him oxygen and requested an emergency ambulance, which took him to hospital. The hospital admitted him for a cardiac review and prescribed nicorandil, a different angina medication. The hospital discharged him on 2 January 2014.
28. On 4 February, the man attended the cardiology clinic at hospital, where a consultant diagnosed postural hypotension (a fall in blood pressure when standing, causing dizziness or fainting). The doctor arranged a test to examine his heart in more detail and the hospital reported, on 24 March, that the test results showed life-limiting congestive heart failure.
29. The man's blood pressure remained low and he continued to lose weight. On 9 April, a doctor examined him and wanted to monitor him in the prison's healthcare inpatient unit, but he refused to be admitted. On 11 April, his cardiologist advised the prison that the functioning of the left side of his heart was severely impaired.
30. The man's blood pressure remained low throughout April. On 23 April, a nurse was concerned about his weight loss. She referred him to the prison doctor and arranged for him to receive extra milk. He weighed 52.61kg.
31. On 5 May, the man reported to a doctor that he had intermittent chest pain which had started the day before. The doctor sent him to hospital as an emergency and he returned to Hewell the next day.
32. A doctor examined the man on 28 May and noted his blood pressure was low, he had a cough, a high temperature and crackles in his right

lung. He appeared cachexic (a wasting syndrome caused by ill health). The doctor admitted him to the healthcare inpatient unit and instructed that his blood pressure should be checked daily.

33. The man returned to his wing on 10 June, but was re-admitted to the healthcare centre on 17 June, for another period of assessment. His blood pressure and oxygen saturation levels were measured daily until 23 June and improved. During his time as an inpatient, he collected his own medication and looked after himself. He interacted well with other prisoners, ate well and was able to move around the inpatient unit. Staff noted that his mood was settled and he made no complaints. During the day, he sat on his chair which had been brought from his cell on the wing.
34. On 25 June, a doctor examined the man as he was short of breath. The doctor noted, 'Looks like heart failure and cardiac cachexia [deteriorating heart]'. The doctor asked staff to monitor his blood pressure once or twice a day and inform him if it dropped further. He also referred him to the cardiologist.
35. In the early hours of 29 June, a nurse examined the man in his cell as he was short of breath. His oxygen level was 88% (normal levels are 95-100%). She did not give him any oxygen, but raised him to a more upright position and monitored him during the night. Over the next few hours, his breathing improved and his oxygen level increased.
36. The man became very breathless again the next day. His oxygen level was 91% and his blood pressure was low. A doctor prescribed medication to help reduce the fluid on his lungs (a symptom of heart failure). She instructed healthcare staff to continue monitoring his blood pressure and oxygen daily and alert a GP if had difficulty breathing, or his oxygen fell below 90%.
37. A doctor reviewed the man on 1 July and found his oxygen level was 93%. He told staff to give him oxygen if it fell below this level and send him to hospital if it persisted. He also asked them to develop a care plan. A senior nurse created a care plan, but the records show that this was for chronic obstructive pulmonary disorder, rather than his diagnosed condition of heart failure.
38. On 2 July, the man went to hospital for a heart scan. There were no observations or entries in his medical record that day.
39. When a doctor examined the man at 1.29pm on 3 July, he found him frail. He was short of breath when he spoke and had difficulty completing sentences. He had a productive cough. The doctor noted crackles on the base of both lungs and his oxygen level was 93%. He telephoned a doctor at the hospital, who agreed to admit him for assessment.

40. Later that day, two prison officers took him to the hospital, by taxi, using a single pair of handcuffs. The escort risk assessment noted that there were no medical objections to the use of restraints. Healthcare staff also indicated that the man might have difficulties with stairs and that staff handcuffed to him might experience a shock if his pacemaker was activated. They did not comment on how his condition impacted on his risk of escape.
41. The hospital diagnosed congestive heart failure and pneumonia and the man remained as an inpatient. Prison managers did not review the risk assessment. While he was in hospital, the officers used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Hewell healthcare team contacted the hospital daily.
42. At 1.50am on 7 July, the man's condition suddenly deteriorated. The escort staff contacted the prison and managers authorised them to remove the escort chain. At 6.33am, the hospital told prison healthcare staff that he was extremely unwell and unlikely to live much longer.
43. In view of the man's medical condition and prognosis, a prison manager authorised his release on a (special purpose) temporary licence on 7 July. One officer stayed with him for support, as his family had stopped contact with him after his conviction.
44. On 8 July, doctors diagnosed a chest infection and a liver scan revealed some abnormalities. The man agreed that the hospital should not attempt to resuscitate him if he had a cardiac or respiratory arrest and signed an order to confirm this.
45. On 16 July, a prison nurse visited the man and noted that he was in end stage heart failure and the hospital was finding it difficult to treat his chest infection. Hospital staff switched off his pacemaker, but continued to treat his pneumonia. They began end of life care and gave him palliative medication. He died a few days later. The Coroner accepted and recorded the cause of his death as bronchopneumonia and congestive cardiac failure due to ischaemic heart disease. The prison arranged and paid for his funeral, which took place on 7 August.

ISSUES

Clinical care

46. The man had longstanding heart disease and other serious medical conditions. The clinical reviewer noted that his complex medical needs would have been difficult to manage in any health setting. Nevertheless, she identified some areas where his care could have been better. The areas for improvement are noted below. However, the clinical reviewer concluded that, overall, healthcare staff at Hewell managed him compassionately and helped to prolong his life. In view of this, she considered that his care was equivalent to that he would reasonably have expected within the community.
47. The man had been prescribed warfarin, which required frequent monitoring of his blood clotting time – INR. Nurses at Hewell took blood tests every few days, but his target INR was not noted in his medical record. National guidelines indicate the INR range for patients with heart disease and heart valve replacement should be between 2 and 3, with a target of 2.5. While he was at Hewell, he was within range 46% of the time, above range (blood too thin) 33% and below (blood too thick) 21%. The clinical reviewer noted that healthcare staff should consider alternative management for patients whose results are less than 50% within range, as was the case with him.
48. The man's medical notes suggested that there was some confusion and uncertainty between the prison doctors about his INR level and the correct dose of warfarin when his blood clotting was not within normal range. The NHS Trust had a policy for a prison-based anticoagulation service, but it was undated. The clinical reviewer considered that the anticoagulation service at Hewell was below the expected standard. We make the following recommendation:

The Head of Healthcare should ensure that the management and care of prisoners taking warfarin is in line with NICE guidelines, including:

- **Developing a protocol for the prescription and monitoring of warfarin and training staff in managing abnormalities.**
 - **Clearly recording the target INR and making it available to GPs to make decisions on dosage.**
52. Owing to shortcomings in record keeping it is not clear whether healthcare staff implemented the advice received from the man's hospital consultants. For example, there was no evidence in the clinical notes that his blood pressure medication had been split into separate ends of the day as a cardiologist had advised. The clinical reviewer also noted that staff had not recorded the rationale for prescribing a higher dose of ramipril, after it had been decreased

several months earlier. It was therefore unclear whether this was a prescribing error.

53. The clinical reviewer also found other shortcomings in the management of the man's cardiovascular disease. A nurse was unable to do a heart reading as there was no working ECG machine. Healthcare staff did not always take blood pressure readings as instructed by GPs and, on one occasion, they took a reading after 12 days, rather than the seven days requested. On at least two days, no blood pressure readings were recorded, although they should have been taken once, or preferably twice daily. A senior nurse created a care plan for chronic obstructive pulmonary disease, rather than heart failure.
54. When the man was diagnosed with postural hypotension in February 2014, there is no record that GPs took any action to address or monitor this. Staff measured his oxygen levels regularly in the last two months but they did not administer oxygen when the readings went below 95% or when he became increasingly breathless at night. When interviewed, prison healthcare staff agreed, in hindsight, that they should have given oxygen to him.
55. The clinical reviewer found a number of weaknesses in record keeping. Healthcare staff often failed to record or refer to the man's attendance at hospital, or note his secondary care and consultants' advice. Changes to medication dosages were not always noted.
56. We make the following recommendation:

The Head of Healthcare should ensure that:

- **A named member of the prison healthcare team coordinates the care of prisoners receiving treatment from specialist services;**
- **There are appropriate care plans for prisoners with chronic diseases and that they are communicated effectively to relevant staff;**
- **Nurses carry out observations in line with clinical instructions; and**
- **All healthcare staff fully comply with professional requirements for accurate record keeping.**

Use of restraints

57. When prisoners travel outside of prison to a hospital, prison staff conduct a risk assessment to determine the nature and level of any security arrangements, including any restraints. The level of restraints used should be necessary in the circumstances and based on the risk of escape, the risk to the public and also takes account of factors such as the prisoner's health and mobility.
58. 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. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and should be kept under review was circumstances changed. It found that restraining a prisoner by handcuffs who was receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
59. When the man was taken to hospital on 3 July, prison staff assessed him as medium risk to the public, based on his conviction for a violent offence. They used handcuffs for the journey and an escort chain in hospital. There were no medical objections to the use of restraints but this is not the test that the court judgement requires. There was no indication that healthcare staff considered or advised how his health and mobility affected his risk of escape. After he was admitted to hospital and doctors diagnosed congestive heart failure and pneumonia there was no review of his risk assessment as should have happened.
18. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which staff should fully consider and balance against the security risks. We are pleased to note that the prison did not use restraints towards the end of the man's life. However, without appropriate healthcare input, we cannot be satisfied that the earlier use of restraints was justified by fully considered risk assessments that took into account his risk and condition at the time or kept it under review. This is a matter we have raised with Hewell before. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the management and care of prisoners taking warfarin is in line with NICE guidelines, including:
 - Developing a protocol for the prescription and monitoring of warfarin and training staff in managing abnormalities.
 - Clearly recording the target INR and making it available to GPs to make decisions on dosage.

2. The Head of Healthcare should review the management of chronic diseases to ensure that:
 - A named member of the prison healthcare team coordinates the care of prisoners receiving treatment from specialist services; There are appropriate care plans for prisoners with chronic diseases and that they are communicated effectively to relevant staff;
Nurses carry out observations in line with clinical instructions;
and
 - All healthcare staff fully comply with professional requirements for accurate record keeping.

3. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner 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	<p>The Head of Healthcare should ensure that the management and care of prisoners taking warfarin is in line with NICE guidelines, including:</p> <ul style="list-style-type: none"> • Developing a protocol for the prescription and monitoring of warfarin and training staff in managing abnormalities. • Clearly recording the target INR and making it available to GPs to make decisions on dosage. 	Accepted	<p>Working in conjunction with GP's, where clinically appropriate, HMP Hewell has transferred patients across to the alternative therapy of Rivoroxban which does not require monitoring and is the Healthcare Trust's agreed drug of choice.</p> <p>Those who remain on the drug warfarin have their international normalised ratio (INR) results recorded on the INR Template on the patient healthcare system, SystemOne. They are also recorded on the paper prescription for the attention of the GP.</p> <p>A Trust protocol is in place, and prisons will also be included within this.</p> <p>The GP is tasked via SystemOne to ensure that the prescription is completed appropriately.</p>	<p>Completed Head of Healthcare</p> <p>Completed Head of Healthcare</p> <p>February 2015 Head of Healthcare</p> <p>Completed Head of Healthcare</p>
2	<p>The Head of Healthcare should review the management of chronic diseases to ensure that:</p> <ul style="list-style-type: none"> • A named member of the prison healthcare team coordinates the 		<p>A primary care multi-disciplinary team is in place where all men with chronic diseases are discussed and held on a caseload.</p> <p>The salaried GP's, with the Pharmacist, Primary Care Lead and Associate Nurse/Non-Medical Prescriber meet on a weekly basis to discuss the men. All men on the caseload have care plans in place.</p>	Completed Head of Healthcare

	<p>care of prisoners receiving treatment from specialist services; There are appropriate care plans for prisoners with chronic diseases and that they are communicated effectively to relevant staff; Nurses carry out observations in line with clinical instructions; and</p> <ul style="list-style-type: none"> All healthcare staff fully comply with professional requirements for accurate record keeping. 		<p>All staff have been reminded to adhere to and comply with their appropriate professional bodies and the Healthcare Trust's record keeping policy regarding accurate record keeping.</p>	<p>Completed Head of Healthcare</p>
3	<p>The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.</p>		<p>The hospital bed watch risk assessment will be updated to include guidance so that the decision maker fully considers the health of the prisoner, current risk of escape as well as public protection in terms of reoffending particularly in relation to harm to others.</p>	<p>31 December 2014 The Governor</p>

