PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Isle of Wight in February 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 failure of a man, at HMP Isle of Wight in February 2014. He was 51 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at HMP Isle of Wight was undertaken. The prison cooperated fully with the investigation. The investigation was suspended to await the results of the post-mortem examination and I am sorry that this led to a delay in issuing this report.

In November 2013, the man was sentenced to 11 years imprisonment and transferred to HMP Isle of Wight in January 2014. He had longstanding medical conditions, including epilepsy, angina and arthritis. Healthcare staff conducted appropriate health screens when he arrived at the prison, including cardiac tests which did not indicate any problem.

At the beginning of February, an officer found the man unresponsive in his cell. Healthcare staff were unable to resuscitate him and a prison doctor pronounced him dead at 9.35am.

The clinical reviewer concludes that the man's care in prison was equivalent to that he could have expected to receive in the community and I agree. However, I am concerned that officers did not check his welfare appropriately when he was first unlocked on the morning of 3 February, did not begin attempts at resuscitation until healthcare staff arrived and an ambulance was not called immediately as part of the emergency response, as required by Prison Service instructions.

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 **March 2015**

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SUMMARY

1. The man was remanded to HMP Bristol on 18 October 2013. In November 2013, he was sentenced to 11 years in prison for sexual offences. He transferred to HMP Isle of Wight on 9 January 2014.

2. The man had longstanding medical conditions, including epilepsy, angina and arthritis. He was a lifelong smoker and clinically obese. After reception health screens, a prison GP prescribed medication for his conditions and healthcare staff requested his previous community GP and cardiology records.

3. On 16 January, the man had an electrocardiogram (ECG), which was noted as normal. On 30 January, a prison GP noted that, in June 2013, a consultant cardiologist had advised that he should reduce and then stop taking bisoprolol (a beta blocker) and aspirin, which had originally been prescribed as a preventative measure for a possible heart condition. GPs at both Bristol and the Isle of Wight had re-prescribed it after receiving inaccurate and out of date information from a hospital cardiology department.

4. At the beginning of February at approximately 8.20am, an officer unlocked the man's cell but did not check that he was well at the time. A prisoner told the investigator that he had seen him alive after unlock that morning.

5. At about 9.10am, an officer found the man collapsed face down on the floor of his cell. The officer went to the wing office and telephoned a supervising officer (SO) who asked him to radio a code blue medical emergency call to signify that a prisoner was unresponsive. The SO went with the officer to the cell. They failed to find a pulse, but neither officer attempted cardiopulmonary resuscitation (CPR).

6. Two nurses arrived at the cell at 9.20am. They requested an ambulance and the prison doctor to attend and started CPR. On the instruction of the doctor, they used a defibrillator which advised that they should not give a shock. Paramedics arrived at 9.30am and confirmed there was no electrical activity in the man's heart. The prison doctor pronounced him dead at 9.35am.

7. The clinical reviewer is satisfied that the care the man received at Isle of Wight was equivalent to that he could have expected to receive in the community. It appears, from the account of another prisoner, that he was up and about that morning, but we are concerned that, during the morning unlock procedures, officers did not check prisoners' wellbeing. There was also a delay in calling an emergency code and the control room did not call an ambulance immediately it was received. Officers did not attempt to resuscitate him when they found him unresponsive, but waited for healthcare staff to arrive. We make three recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Isle of Wight, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed six members of staff and one prisoner on 21 March and 8 April.

10. NHS England commissioned a clinical reviewer to review the man's clinical care at HMP Isle of Wight. She joined the investigator for some of the interviews.

11. We informed HM Coroner for the Isle of Wight of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report. The investigation was suspended pending the results of the post-mortem examination, which we did not receive until June 2014. We regret the consequent delay in issuing this report.

12. One of the Ombudsman's family liaison officers contacted the man's son's nominated representative to explain the investigation. His representative did not have any specific issues for the investigation to take into account.

13. The man's son's nominated representative was offered the opportunity to receive a copy of the draft report. However, they did not request the draft report so have not made any comments.

14. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

HMP ISLE OF WIGHT

14. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison mostly holds sex offenders. The man lived on the Parkhurst site.

15. Since 1 June 2013, Care UK has provided healthcare at the prison. There is an inpatient healthcare unit with 18 beds on the Albany site, catering for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

16. In its most recent inspection of HMP Isle of Wight in May 2012, the Inspectorate noted that health services had improved considerably since the previous inspection and that the management of prisoners with long term conditions was good.

Independent Monitoring Board (IMB)

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to 2012, the IMB noted that the prison's effort to promote the physical and mental health of prisoners was impressive. The IMB noted that monthly in-house monitoring of healthcare services had shown a general trend of increased satisfaction from prisoners.

Previous deaths at HMP Isle of Wight

18. The man was the twelfth prisoner to die from natural causes at the prison since January 2013. The investigation has found no similarities between the circumstances of the previous deaths and his death, but we have previously made recommendations about emergency response procedures.

KEY EVENTS

19. The man was remanded into custody at HMP Bristol on 18 October 2013, charged with sexual offences. During his healthcare reception screen, on 19 October, he told a prison GP that he had epilepsy, angina and arthritis. As he had no medication with him, she contacted his cardiology clinic at hospital the next day. She then reviewed his prescribed medication and, on the information received from the hospital, re-prescribed aspirin and bisoprolol (a beta-blocker which slows down the activity of the heart). Both medications are used to prevent heart attacks. He was a lifelong smoker and he was considered to be clinically obese.

20. On 15 November 2013, the man was sentenced to 11 years imprisonment.

HMP Isle of Wight

21. On 9 January 2014, the man transferred to HMP Isle of Wight. He had an initial health screen, followed by a full medical screen the next day. This included cardiovascular and fitness assessments and advice about stopping smoking. After the health screen, a prison GP reviewed his medical history and arranged an electrocardiogram (ECG) and blood tests to check his cholesterol and monitor his risk of diabetes and heart disease. A review was planned for four weeks later. The ECG took place on 16 January and the results of this and his blood tests were noted as normal.

22. On 30 January, a prison GP reviewed the man's community GP records, which had been received on 14 January. The GP discovered that the hospital staff who had given the information to the GP at Bristol had not taken into account advice in a letter dated 10 June 2013, from a consultant cardiologist, that the man should reduce and then stop taking the aspirin and bisoprolol. The GP therefore prescribed a gradual reduction of the bisoprolol, with a view to stopping both medications, in accordance with the consultant's advice.

Day of the incident

23. At the beginning of February at approximately 7.00am, an officer conducted a roll check (count of prisoners). In his statement, he said that he saw nothing of concern when he checked the man's cell.

24. At 8.20am, another officer unlocked the cells on the first floor of G wing and went back to the wing office. He told the investigator that he did not remember seeing the man when he unlocked him but two other prisoners told him he had spoken to him. He said that officers unlocking cells in the morning do not try to get a verbal response from prisoners but simply check to ensure they are moving.

25. A prisoner told the investigator that he had seen the man in his cell doorway that morning, but was not sure what time that was. He said that another prisoner had told him that he had seen him go upstairs to get hot water. (This prisoner has since died.) A nurse told the investigator that she had found a

warm drink in his cell, which suggested he had been out to get some hot water that morning.

26. At about 9.10am, an officer locked the cells of prisoners who had remained on the wing. He saw that the man's cell door was ajar and opened it further. He found him collapsed face down on the floor, and unresponsive. He did not check for a pulse.

27. The officer did not stay with the man but left the cell, locked it and went to the wing office. On the way, he said he called a Supervising Officer (SO) and when he arrived at the office he tried to telephone healthcare staff to ask them to attend. He told the investigator that initially he had forgotten he was carrying a radio. He told the SO that a prisoner had collapsed and the SO instructed him to radio a code blue (signifying a medical emergency where a person is unresponsive, unconscious or not breathing). The code blue call was recorded at 9.17am.

28. The SO then arrived on the landing and went with the officer to the man's cell. The officer said he checked and thought he had found a very weak pulse, therefore the SO advised him to wait. He later explained to the investigator that he and the SO thought if there was a pulse, they should not attempt CPR. He had not had first training since his initial prison officer training course nine years previously. While they waited for healthcare staff, they tried to rouse the man by calling his name, for around one and a half minutes. Another SO arrived and the officer explained what had happened. The officer checked again for a pulse, but he could not find one.

29. Two nurses arrived at the cell at 9.20am, with an emergency bag and a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The officers helped them to turn the man on to his back. The nurses began cardiopulmonary resuscitation (CPR) and asked for the doctor and an ambulance to be called. A SO radioed the control room to request the ambulance. He told the investigator that control room staff do not call an ambulance unless a nurse requests one.

30. A GP arrived at 9.25am. He asked the nurses to attach the defibrillator, but this advised that no shock should be given, so they continued cardiopulmonary resuscitation. Paramedics arrived at 9.30am, though the initial paramedic on scene refused to enter the establishment, and carried out an ECG test which confirmed that there was no electrical activity in the heart. The GP pronounced the man dead at 9.35am.

Family liaison

31. A prison officer was nominated the prison's family liaison officer. The man's nominated next of kin was his son. The family liaison officer consulted social services and agreed that all contact would be carried out through a nominated representative.

32. The prison offered financial assistance towards the funeral, in line with national guidance.

Support for staff and prisoners

33. A debrief was held at lunchtime for staff included in the emergency responses. Staff told the investigator that they had felt supported. A notice to prisoners informed them of the man's death and those subject to suicide and self-harm monitoring had their cases reviewed in case they had been affected by the news of his death.

Post-mortem

34. After a post-mortem examination, the Coroner gave the cause of death as, 1(a) probable acute myocardial insufficiency (sudden failure of the heart to pump) and 1(b) ischaemic heart disease (damage to the heart muscles and reduced blood supply to the heart).

ISSUES

Clinical care

35. The clinical reviewer found that the man received appropriate health screens. Healthcare staff sought medical information from his GP and a hospital where he had undergone tests and received treatment. Prison doctors had originally prescribed bisoprolol and aspirin, in error, as a result of information received from the hospital, but a doctor at Isle of Wight corrected this. The clinical reviewer considers it is unlikely that he suffered any harm as a result of this.

36. Overall, the clinical reviewer found that the clinical care the man received was comparable with the care he could have expected to receive in the community.

Unlocking cells

37. An officer unlocked prisoners' cells at about 8.20am. The officer told the investigator that he did not remember seeing the man that morning and could not recall speaking to him. He said that staff do not routinely check prisoners' welfare when unlocking cells.

38. For their own safety, officers are supposed to look through the observation hatch before unlocking a cell door. When unlocking cells, they should also take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

39. HMP Isle of Wight issued an operational instruction in 2012, stating that when unlocking a prisoner staff should, "ensure that they check on the welfare of the prisoner(s)". Another officer told the investigator that, "the officer taking over in the morning is supposed to get a verbal response". However, he explained that this is not what happens in practice. Although it appears that the man had left his cell that morning, in other circumstances, failure to adhere to the unlock procedures could lead to a delay in treating a seriously ill prisoner. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention

Emergency response

40. An officer did not radio for help when he found the man collapsed and unresponsive in his cell, but left to call for medical assistance. The officer said he had forgotten he had a radio with him that morning so he went to the wing office to use the telephone. This led to a slight delay in summoning help.

41. PSI 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called. It also explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.

42. Vital minutes were lost in starting CPR. There was also a delay in calling an ambulance as the control room did not request one as soon as the code blue was called but waited for the nurse to ask for one. This delay was added to by the first paramedic's refusal to enter the establishment. We make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Isle of Wight has a Medical Emergency Response Code protocol which:

    - **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
    - **Ensures staff initiate basic life support as needed until health care staff arrive;**
    - **Ensures staff called to the scene bring the relevant equipment; and**
    - **Ensures there are no delays in calling, directing or discharging ambulances.**

Resuscitation

43. When the officers returned to the man's cell, although he was unresponsive they did not attempt resuscitation. They initially believed there were signs of life as the officer thought he had found a pulse. It seems that they did not know what to do in an emergency. The emergency policy in force, at the time of his death, did not specify that the first person on scene should attempt to administer first aid. This policy has since been revised.

44. The Resuscitation Council (UK) says that resuscitation should be carried out until qualified help arrives, either a doctor or a paramedic, unless resuscitation is impossible because there are clear signs of rigor mortis

45. We are concerned that the man was left alone, in a serious condition. Neither the officer nor other prison staff attempted resuscitation, but waited for nurses to arrive. It is vital that if a person is unconscious cardiopulmonary resuscitation is started as soon as possible to improve the chances of survival, unless there are clear signs of death such as the onset of rigor mortis which would indicate that resuscitation would be futile. None of the staff who saw him indicated that rigor mortis was evident.

The Governor should ensure that staff receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation for a prisoner who is not breathing and that resuscitation should be attempted, unless there is clear evidence that it would be futile in the circumstances.

RECOMMENDATIONS

1. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention

2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Isle of Wight has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff initiate basic life support as needed until health care staff arrive;
    - Ensures staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances.

3. The Governor should ensure that staff receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation for a prisoner who is not breathing and that resuscitation should be attempted, unless there is clear evidence that it would be futile in the circumstances.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention	Accepted	Operational instruction to be re-issued, advising staff to undertake welfare check at unlock. This will also be raised at morning staff briefings and Functional meetings.	31st October 2014 Head of Safer Custody and Equalities	
2	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Isle of Wight has a Medical Emergency Response Code protocol which: - Provides guidance to staff on efficiently communicating the nature of a medical emergency; - Ensures staff initiate basic life support as needed until health care staff arrive; - Ensures staff called to the scene bring the relevant equipment; and - Ensures there are no delays in calling, directing or	Accepted	Updated Medical Emergency response Operational instruction to be published. The prison has adopted the Code Red/Code Blue protocol outlined in PSI 03/2013. This was agreed and referenced in the operational instruction 27/2012 and again in operational instruction 2/2014. All operational staff have been briefed on the appropriate use of emergency codes following publication of operational instruction 2/2014. Staff have also been briefed on the procedure to be adopted for ambulances, to expedite entry and exit from the prison consistent with maintaining security. This process is fully embedded. The updated Operational instruction issued will be raised with staff at daily briefings and functional meetings	30th November 2014 Head of Safer Custody and Equalities	

	discharging ambulances.				
3	The Governor should ensure that staff receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation for a prisoner who is not breathing and that resuscitation should be attempted, unless there is clear evidence that it would be futile in the circumstances	Accepted	There is insufficient training resource to ensure that all staff are trained in emergency first aid at work. A risk assessment has been completed in order to identify staff to be trained and ensure that there is appropriate cover across HMP Isle of Wight. This includes operational and nonoperational staff covering all areas of the prison and providing cover to prisoners, staff and visitors. This process has been undertaken and has provided a breakdown of staff who need to be prioritised for training. Significant progress has been made against training, priority being given to managers and supervisors who are operational, as well as operational support grades (particularly those who work nights) This includes (automated external defibrillator) AED training. Advice to staff of the requirement to attempt to resuscitate prisoners is contained in the medical emergency response operational instruction.	31st December 2014 Head of Health and Safety Head of Corporate Services	