



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in
November 2014 while a prisoner at
HMP Stafford.**

Our Vision

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

This is the investigation report into the death of a man who died of a heart attack in November 2014, while a prisoner at HMP Stafford. He was 85 years old. I offer my condolences to the man's family and friends.

One of my investigators carried out the investigation. A clinical reviewer reviewed the clinical care the man received at HMP Stafford. The prison cooperated fully with the investigation.

The man had been in prison since March 2014 and at Stafford since 14 April. He had an irregular heartbeat and had suffered a stroke in 2013, which caused a deterioration in his mental health. On 12 November, a prison doctor noticed abnormalities after an ECG test and sent him to outside hospital. In hospital, doctors diagnosed that he had suffered a major heart attack. He remained in hospital and died there three days later.

The clinical reviewer noted that the man's heart attack was sudden and unexpected. I am satisfied that he received a good standard of care at Stafford and there was nothing the prison could have done to prevent his death. However, I am concerned that the prison used an escort chain to restrain him when he first went to hospital, without a fully completed and considered risk assessment which took into account his advanced age and medical condition.

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

May 2015

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SUMMARY

1. The man was sentenced to 18 months imprisonment in March 2014, and sent to HMP Hewell. He had a history of irregular heartbeat and had suffered a stroke in 2013, which had affected his personality and mental health.
2. On 14 April, the man transferred to HMP Stafford. From July, healthcare staff had increasing concerns about his mental health and vulnerability. On 30 July, his cellmate wrote to the prison's healthcare department outlining concerns about his behaviour and state of mind. A multidisciplinary team managed his mental health over the following months. On 5 November, a consultant psychiatrist prescribed olanzapine, an antipsychotic medication.
3. On 11 November, the man had an electrocardiogram (ECG), as is standard practice when starting olanzapine. The next day, a prison GP reviewed the results and noted abnormalities. The man said he was tired all the time and increasingly short of breath. The GP sent him to hospital for assessment. Hospital doctors diagnosed that he had had a major heart attack and moved him to the hospital's acute cardiac unit on 13 November. The man died shortly thereafter.
4. The clinical reviewer was satisfied that the man received a good standard of care at Stafford. We are satisfied that the prison could not have prevented his death, but are concerned that the prison used restraints when he was taken to hospital on 12 November and for the first day he was an inpatient, without appropriate healthcare input into the escort risk assessment. This is a matter we have raised with the prison before. We make one recommendation.

THE INVESTIGATION PROCESS

5. The investigator issued notices to staff and prisoners at HMP Stafford, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
6. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She visited the prison on 21 November 2014 and met two of his wing officers, his offender supervisor and his cellmate.
7. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
8. We informed HM Coroner for the South Staffordshire District of the investigation, who sent us the post-mortem report. We have sent the coroner a copy of this investigation report.
9. One of the Ombudsman's family liaison officers contacted the man's niece to explain the investigation process. She asked for the following issues be considered:
 - Clarification of her uncle's admission to hospital and the delay in contacting her. She understood her uncle had had a heart attack on 12 November, but no one contacted her until the next day.
 - The management of her uncle's care during his time in prison, particularly in relation to the stroke he had suffered before he went to prison.
10. The draft report was issued for consultation with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of this report.
11. The man's niece received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP STAFFORD

12. HMP Stafford is a category C training prison which holds more than 700 prisoners across seven wings. Staffordshire and Stoke-on-Trent Partnership NHS Trust provides healthcare. There are no inpatient facilities. Nurses and doctors provide care daily between 8.00am and 5.00pm. There is an on-call GP service outside these hours.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Stafford was in July 2011. The Inspectorate found that there was no specific policy for older prisoners or those with disabilities. Prisoners were able to access all health services reasonably quickly and there were no long waiting lists. Access to the prison GP was good and a wide range of visiting health professionals brought services into the prison. The relationship between prisoners and health service staff, and the management of lifelong conditions were both regarded as excellent.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its report for the year ending April 2014, the IMB noted that there were several vacancies for nurses, and sometimes staffing was on the verge of being critical. However, healthcare staff did well to provide a high level of service.

Previous deaths at Stafford

15. This man's death was the third from natural causes at Stafford since January 2013. We have made a previous recommendation about risk assessments for hospital escorts.

KEY EVENTS

16. On 28 March 2014, the man received an 18-month prison sentence for indecent assault against children. He was taken to HMP Hewell.
17. A reception nurse noted that he had been diagnosed with high blood pressure, acid reflux and gout. The man said he had no concerns about his physical health. A GP reviewed him, and prescribed perindopril (to help reduce his blood pressure) and simvastatin (to lower cholesterol). Healthcare staff requested his community GP records.
18. On 3 April, the man's niece faxed a letter to the prison's healthcare department to inform staff that her uncle had suffered a stroke in 2013. She was concerned that, since then, his personality had changed significantly.
19. At a review with a nurse practitioner on 8 April, the man confirmed that he had had a stroke about a year before, but could not remember any details. His blood pressure was high at 190/80, so the nurse noted that it should be reviewed again in one week.
20. On 10 April, the healthcare department received a letter from the man's community GP, summarising his past care. The doctor said that he had been treated for high blood pressure, an atrial flutter (irregular heartbeat) and had suffered a stroke in January 2013. He had referred him to the old age psychiatry team in November 2013, after noticing a complete change in his mental health and behaviour; he had become erratic and showed symptoms of vascular dementia. His GP strongly suspected this change had been caused by the stroke. His community GP had not been notified of an old age psychiatry appointment.
21. On 14 April, the man transferred to HMP Stafford. A nurse carried out a reception health screen the same day and identified no concerns.
22. On 30 July, the man's cellmate wrote to the prison's healthcare department alerting them to his concerns about his cellmate's mental health. He listed some concerning behaviour, including elevated and reduced moods, aggressive outbursts, a decline in his personal hygiene and inappropriate interactions.
23. A nurse made an initial assessment of the man's mental ability the same day and referred him to the prison's mental health team. A healthcare team meeting on 7 August agreed to a mental health review. A mental health nurse went to see the man in his cell on 9 September, but he refused to speak to him and said he did not want to see anyone from the mental health team.
24. Concerns about the man's mood and behaviour increased. After a review on 3 October, a nurse concluded that his delusional beliefs, sexual statements and behaviour, meant he was vulnerable and a high risk to himself and from other prisoners. The man said he had no concerns about his mental health, but agreed to a mental health assessment. On 13 October, a community

psychiatric nurse saw him and made detailed notes of his history and physical and mental health. She arranged to see him again.

25. On 5 November, a consultant psychiatrist assessed the man and noted that he had an 'elevated sense of self' and had symptoms of mania. (Mania is an abnormally elated mental state, typically characterised by feelings of euphoria, lack of inhibitions, talkativeness, risk taking and irritability). The consultant psychiatrist believed that his mood disorder had been caused by his stroke the previous year. He commented that he would be concerned if the man were released in his current state. He prescribed olanzapine (an antipsychotic) and planned to review him a week later. If there was no improvement, he would consider referring him to a medium secure hospital in Birmingham for treatment and assessment of his needs.
26. Multidisciplinary case reviews were held to discuss the man's risks and the options for supporting him when he was released. These included referral to a medium secure unit, supported housing with mental health support or a return to his home with referral to the local community mental health team. A multidisciplinary review on 10 November recommended an ECG, to measure the electrical activity of the man's heart, which is standard practice when starting olanzapine. The ECG was carried out the next day, 11 November.
27. After the ECG, a nurse noted the man's existing (and history of) atrial flutter and referred him to see the prison doctor the next day. He showed no other symptoms of concern. At around 3.15pm that afternoon, the man told an officer that he felt unwell. The officer advised him to rest in his cell and come back to him if he did not improve. The man collected his evening meal, participated in an evening association period with other prisoners and did not raise any further concerns.
28. On 12 November, a doctor reviewed the man and noted that his ECG results showed abnormalities. The man told the doctor that he was tired all the time, and had recently become increasingly breathless. His blood pressure was normal at 108/66 and he had no chest pain. In view of the ECG test results and the man's symptoms, the doctor sent him to hospital for assessment.
29. A prison escort risk assessment concluded the man was a medium risk to the public and of escape. A nurse contributed to the risk assessment and said that there were no objections to him being restrained, but did not comment on whether his age, condition or mobility affected his ability to escape. The man was taken by ambulance to outside hospital, escorted by two prison officers who used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.)
30. When they arrived, hospital staff admitted the man for tests. His breathing later deteriorated and staff used a nebuliser to assist his breathing. The next morning, 13 November, the hospital medical team examined him and conducted an echocardiogram (an ultrasound scan of the heart). A

cardiologist told the man that it appeared he had suffered a major heart attack.

31. At 10.30am on 13 November, a prison family liaison officer contacted the man's niece and informed her that he was in hospital. He gave her contact details to one of the hospital nurses. He later visited the man in hospital.
32. At 11.30am, a prison manager agreed that the escort officers should remove the escort chain. Shortly afterwards, the hospital moved the man to the acute cardiac unit. The man told the doctor in charge of his care that, if he had another heart attack, he did not want to be resuscitated
33. Later that afternoon, the prison manager spoke to a prison nurse about the possibility of releasing the man on temporary licence, due to his ill health. The nurse said that the man was waiting for a psychiatric assessment and it was possible he would be admitted to a secure mental health hospital. The prison manager passed this information to the Governor who decided not to approve temporary release as his mental health and risk had not yet been fully assessed.
34. The man's niece visited him in hospital that afternoon. Prison escort records show that he was in good spirits while chatting to her. At 9.00am the next morning, 14 November, the man's consultant noted some improvement in his health but said he would be in hospital for at least another week. However, by 2.00am the following morning the man was struggling to breathe. His condition deteriorated quickly and he died. A doctor certified his death at 6.45am. The hospital telephoned the man's niece to inform her that her uncle had died.

Liaison with the man's family

35. At 7.00am on a day in November, the prison's family liaison officer heard that the man had died and that the hospital had already spoken to his niece. The family liaison officer telephoned the man's niece straight away to offer condolences and support. He agreed to call her later that morning, after he had debriefed the escort officers. On 19 November, he visited the man's niece with a prison manager, who was also a trained family liaison officer.
36. On 21 November, the prison held a memorial service for the man. His funeral took place on 1 December. The prison contributed towards the costs, in line with national policy.

Support for staff and prisoners

37. The Governor issued a notice to inform staff and prisoners of the man's death. A senior manager debriefed the escort staff and offered them the support of the prison's care team.

38. Staff offered prisoners on the man's wing support and access to Listeners (prisoners trained by the Samaritans to give support and counselling to other prisoners). Staff checked prisoners considered at risk of suicide or self-harm in case they had been affected by the news of the man's death.

Post-mortem

39. A post-mortem examination found that the man had died from myocardial infarction (a heart attack) and severe coronary artery atheroma (narrowing of the arteries, restricting blood flow).

ISSUES

Clinical care

40. The man received treatment for chronic conditions, including high blood pressure and gout. He had suffered a stroke in January 2013, before going into prison, which had resulted in a mental health disorder. We agree with the clinical reviewer that once the man's change in behaviour became obvious, healthcare staff managed his mental health very well with considerable input from mental health and multidisciplinary teams, who worked well together.
41. On 5 November 2014, a psychiatrist prescribed olanzapine to help control the man's elevated mood and signs of mania. Olanzapine carries a warning that it should be used with caution in the elderly, and those with hypertension and a history of stroke. As the drug was prescribed for only a very short time before he was admitted to hospital, the clinical reviewer considered that it was very unlikely to have had any adverse effect.
42. On 12 November, after noting abnormalities in the results of a routine ECG and the man's reports of breathlessness and tiredness, a prison GP immediately sent him to outside hospital. The clinical reviewer commented that there was no evidence that the man showed any other symptoms to warn of the serious heart attack that the hospital found he had suffered, and it is not clear exactly when it had happened.
43. We are satisfied that the man's medical care, including his high blood pressure, was managed appropriately, with GP and nurse reviews, blood pressure checks and medication to manage his blood pressure and reduce the risk of another stroke. The prison GP promptly identified the deterioration in the man's health after his ECG and arranged for him to be admitted to hospital quickly. We agree with the clinical reviewer that the man received a good standard of healthcare at Stafford.

Restraints

43. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.
44. The man was assessed as a medium risk of escape and to the public, when he went to hospital on 12 November 2014. The healthcare section of the risk

assessment noted that he did not have a medical condition that prevented him from being restrained. However, this is not the test required. There are few medical conditions which would prevent this. Healthcare staff did not comment on whether his condition or mobility affected his risk of escape, as the 2007 High Court judgement requires.

45. 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. The man was 85 years old and a doctor had described him as tired and breathless, with abnormal heart rhythms, just before he went to hospital. While we are pleased to note that his restraints were removed when his condition deteriorated the day after his admission, on 13 November, we are not satisfied that the use of restraints was justified by fully considered risk assessments that took into account his risk and condition at the time, in line with the 2007 judgement.
46. Ultimately, it is the Governor's responsibility to ensure that the risk assessment process is managed properly. However, the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities, and have appropriate and considered input into the risk assessment process. 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.

RECOMMENDATION

1. 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: [man's name] – HMP Stafford

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and Function Responsible |
|----|--|-----------------------|--|---|
| 1 | 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. | Accepted | A new risk assessment has been formulated which will 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. Prisoners 65 or over will not be routinely cuffed unless security assessment suggests there is a risk of escape, abscond, risk of harm to staff or public. | 30/04/2015 Head of Security & Operations |