



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
in October 2014 at HMP Leyhill**

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 from a heart attack in October 2014 at HMP Leyhill. He was 44 years old. I offer my condolences to the man's family and friends.

A review was conducted. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 1987 and had been at Leyhill since May 2010. He appeared fit and healthy and had little contact with healthcare staff during his time in prison and none since 2011. He did not respond to the offer of an NHS general health check in 2013.

During the early morning checks on a Saturday in October, prison staff found the man lying, unresponsive, on the floor of his room. Officers and paramedics were unable to resuscitate him.

I agree with the clinical reviewer that the man's sudden death could not have been predicted or prevented. Although it was not clear that staff used an emergency medical code, in line with national and local instructions, the emergency response was quick. I am concerned that there was a significant delay in notifying the man's mother of his death, which was done by the police rather than Prison Service staff, as I would expect.

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

CONTENTS

Summary

The investigation process

HMP Leyhill

Key events

Issues

Recommendation

Action plan

SUMMARY

1. The man was sentenced to life imprisonment on 5 November 1987 and had been at HMP Leyhill since May 2010. He had a health assessment when he first arrived at Leyhill. Other than a review for Asperger syndrome in August 2011, he had no further contact with healthcare staff. In September 2013, the healthcare department offered him an NHS general health check, but he did not respond.
2. One of the man's friends, who lived in the cell next to him, said that he had complained of chest pains a few days before he died and a pain in his side the day before. However, he did not report any concerns to healthcare staff. His friend said he heard him snoring or grunting loudly during that night, but thought nothing of it.
3. Just after 5.30am on a Saturday in October 2014, a night patrol officer found the man apparently unconscious on the floor in his room. He radioed for help and he and other officers began chest compressions. Paramedics arrived and continued to try to resuscitate him, but they pronounced him dead at 6.19am.
4. The clinical reviewer considered staff at Leyhill could not have predicted or prevented the man's sudden death.
5. Although it is not clear whether an emergency medical code was called, in line with national and local instructions, staff responded quickly to the emergency. The prison did not have up to date contact details for the man's next of kin and, after some delay, the police, rather than Prison Service staff informed his mother of his death. We make one recommendation.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Leyhill informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. On 26 November 2014, she interviewed three members of staff and a prisoner at Leyhill. She informed the Governor of her preliminary findings.
8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
9. We informed HM Coroner for Avon of the investigation, who provided the cause of death. We have sent the Coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's mother to let her know about the investigation. She had no specific issues she wanted the investigation to cover.
11. The man's mother received a copy of the draft report. She raised a number issues/questions that do not impact on the factual inaccuracy of this report and have been addressed through separate correspondence. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP LEYHILL

12. Leyhill is an open prison in South Gloucestershire, holding up 527 category D prisoners who require only minimum security. Some are life-sentenced prisoners preparing for release.
13. Bristol Community Health provides primary care services at Leyhill from 7.30am to 4.30pm, Monday to Friday. A local NHS centre, Hanham Health, provides GP and out of hours services.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Leyhill was in April 2012. The Inspectorate noted there was a high standard of care at the prison, although there was some concern about the staffing mix and the disproportionate responsibility carried by healthcare support workers. Inspectors found good provision of chronic disease management and an excellent palliative care service.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In their annual report for the year to January 2014, the IMB commented on improvements to healthcare at Leyhill. However, they were concerned about access to healthcare services for the growing number of older prisoners.

Previous deaths at HMP Leyhill

16. This man was the second prisoner to die of natural causes at Leyhill in the last twelve months. There were no similarities between the circumstances of the previous death.

KEY EVENTS

17. In November 1987, the man was sentenced to life imprisonment for murder. He progressed in his sentence through several prisons, before transferring to HMP Leyhill in May 2010. During his medical assessment, he said that he was a heavy cigarette smoker and had Asperger syndrome. He had no significant health issues, but healthcare staff checked and recorded his weight, height and blood pressure. There is no record that he was offered advice about giving up smoking, but he had previously rejected offers to help him give up.
18. The man completed a full gym induction, including a physical activity questionnaire. He did not use the gym often, and there was no record of him using any of the gym facilities in the six months before he died.
19. On 9 August 2011, an assessment concluded that the man had no learning difficulties. He had a mental health assessment two days later which showed that he had no enduring mental illness. He had no further recorded contact with healthcare staff at the prison during his time there.
20. On 19 September 2013, the healthcare department invited the man to a routine NHS health check for men over 40, but he did not attend. The healthcare manager told the investigator that, as in the community, they do not follow up invitations to health checks if men do not respond.
21. The prisoner who lived in the room next to the man, told the investigator that he and the man spoke to each other frequently. He said that a few days before he died, he had told him and some other prisoners that he had chest pains. They had encouraged him to see a doctor but he did not and he attributed the pains to his age and his job, which involved lifting boxes.
22. On the evening of his death, the man told his next-door-neighbour that he felt pain down one side of his body, but he did not report this to staff. His next-door-neighbour said the man used to snore and that night, the noises seemed louder than usual, but he had not thought anything of it at the time.
23. At about 11.00pm, a night patrol officer checked to establish that all prisoners were present in the unit. He said that when he looked into the man's room, he was in bed asleep.
24. Just after 5.30am on a Saturday in October, the night patrol officer was making a further check. When he opened the man's door he found him lying on the floor and unresponsive. He called for help from a colleague who was nearby. He and his colleague went into the man's room. The night patrol officer said that the man looked very pale and his lips were blue.
25. Although he did not recall using an emergency code, the night patrol officer radioed the communications desk, explained that a prisoner was unconscious, and asked for the night manager to attend. He had recently had first aid training and began chest compressions to try to resuscitate the man. He said

that he knew there were emergency codes but he was unsure of them. He knew that he had used the word unconscious so that the night manager would know that it was a serious emergency and pass this information to the ambulance service.

26. The night manager said that he was based at the prison gate (in the communications room) when he received a radio call from the night patrol officer asking him to come immediately to A Unit. An operational support grade arrived to take over from the night manager at the gate and he then received a second message from the night patrol officer asking him to call an ambulance, which he did immediately. The night manager said that the night patrol officer had said it was a code blue emergency, indicating the man was unconscious. He then went to the unit, taking the defibrillator from the gate with him (there was also one on A Unit). When he arrived, the night patrol officer was doing chest compressions. The night manager, who is a first aid trainer, immediately used the defibrillator, which did not detect a shockable heart rhythm. He then helped the night patrol officer with the chest compressions.
27. Records show that the ambulance was called at 5.35am and arrived at the prison at 5.54am. The paramedics reached the cell at 5.55am and continued emergency treatment. At 6.19am, a paramedic declared that the man had died.

Support for staff and prisoners

28. A senior manager debriefed staff involved in the emergency response and the care team offered support if needed. At the debrief, the night manager noted that he had been unable to go to the man's room immediately as he had to wait for another member of staff to relieve him, which caused a slight delay. (However, the night patrol officer had already begun chest compressions.)
29. Prison Staff reviewed prisoners identified as at risk of suicide and self-harm, in case they had been adversely affected by the news of the man's death.

Contact with the man's family

30. Prison staff said they were uncertain about the man's next of kin details. They had two different names and an old address for his mother. When the police searched his room, shortly after his death, they found his mother's current contact details. The man's mother lived some distance away and the police said that they would arrange for someone from her local force to contact her. It was not until the early hours of the next morning, at 12.30am, that police officers visited the man's mother to break the news and asked her to ring the prison. She then spoke to the night manager, who explained what had happened.
31. The next morning the duty governor rang the man's mother, offered condolences and discussed funeral arrangements. He told her that they would shortly appoint a prison family liaison officer to act as her point of

contact. The family liaison officer contacted the man's mother the next day and frequently after that.

32. The man's funeral was held on 4 November 2014. Staff from the prison attended. The prison contributed to the funeral costs, in line with national guidance.

Cause of death

33. The Coroner confirmed that the cause of the man's death was coronary stenosis (decreased blood to the heart), atheroma (blocked arteries) and hypercholesterolemia (high cholesterol).

ISSUES

Clinical care

34. The clinical reviewer noted that prevention is the best protection against heart disease and noted that there was no record that the man had been offered any help to stop smoking since 2009, although he had turned it down at the time. He has made recommendations about better recording of initial health assessments and actively promoting the health benefits of giving up smoking which the healthcare manager will need to address. NHS guidelines recommend that all people between 40 and 74 should have a routine cardiovascular risk assessment. The man was invited for a health review, which would have covered this, but did not attend. The healthcare manager said that in line with community provision, they offered prisoners voluntary screening. As in the community, they had the right not to attend and there was no follow up if chose not to.
35. While the clinical reviewer found little evidence of a proactive approach to health promotion, he noted that it was positive that the prison now offered NHS health checks. He did not consider there were any omissions in the man's care and he was satisfied that his sudden death could not have been predicted or prevented.

Emergency response

36. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, requires governors to have a medical emergency response code protocol that instructs staff how to communicate the nature of a medical emergency using agreed emergency codes, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. Leyhill issued a notice to staff about medical emergency codes on 18 March 2013.
37. There are conflicting accounts as to whether a code was used when the emergency was reported. The night manager's recollection was that he received two calls from the night patrol officer and that he had said there was a code blue emergency. The night patrol officer said that he did not think he had used the actual code, but had said there was an unconscious non-breathing casualty. When interviewed, he said he was unsure about the emergency code procedures.
38. Although it is not entirely clear that an appropriate emergency code was used, (and we remind the prison of their importance) there was no delay in the emergency response. Even if the night patrol officer did not use a code blue, his call to the night manager resulted in an emergency ambulance being called and paramedics arrived quickly. We are satisfied that the night patrol officer and the night manager appropriately attempted to resuscitate the man until the ambulance paramedics arrived.

Contact with the man's family

39. The man's records did not contain up to date details of his next of kin. The police later found his mother's contact details in his room and police broke the news to her more than 18 hours after his death was pronounced.
40. Prison Service Instruction (PSI) 64/2011, Safer Custody, gives guidance on contacting families and states, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death". Detailed instructions are in Chapter 13 of the PSI and require prisons to try to deliver the news themselves or at the very least through prison staff from a prison near to the deceased's next of kin.
41. The duty governor said the police decided to break the news to the man's mother as it was an unexpected death and because of the distance between the prison and her home. He explained he had not handled this type of incident before and was unaware of the standard procedures. However, the significant delay in informing the man's mother of his death could have been avoided if Leyhill staff had done so themselves, or arranged for staff from a local prison to do so on their behalf, in line with national instructions. No one from the prison offered to visit the man's mother after his death as the PSI requires. We make the following recommendation:

The Governor should remind prisoners to keep next of kin details up to date and ensure that contact with families after a death follows the requirements of Prison Service Instruction 64/2011.

RECOMMENDATION

1. The Governor should remind prisoners to keep next of kin details up to date and ensure that contact with families after a death follows the requirements of Prison Service Instruction 64/2011.

ACTION PLAN: [man's name] – HMP Leyhill

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Governor should remind prisoners to keep next of kin details up to date and ensure that contact with families after a death follows the requirements of Prison Service Instruction 64/2011.	Accepted	<p>A Notice to Prisoners will be issued to remind prisoners to keep next of kin details up to date. Application forms to inform a change of next of kin will be available in application boxes.</p> <p>The notice will be reissued to prisoners every six months and change of kin application forms will be permanently available.</p>	<p>Head of Residence</p> <p>31 March 2015</p>