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 in November 2014 at HMP Exeter

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 pulmonary embolism, in November 2014, at HMP Exeter. He was 74 years old. I offer my condolences to his family and friends.

The investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at HMP Exeter. The prison cooperated fully with the investigation.

The man had been in prison since September 2012, serving a 13 year sentence. He was frail and suffered from various chronic conditions including heart disease and chronic obstructive pulmonary disease. In May 2013, doctors diagnosed him with bone cancer, for which he was receiving chemotherapy at the time of his death.

Healthcare staff saw the man frequently because of recurrent breathing problems and chest infections. They regularly reviewed his health conditions and medication, and records show his general health steadily declined.

Just before midday on 26 November 2014, an officer radioed an emergency medical code after a prisoner found the man unresponsive in his cell. The officer and a nurse, who had been nearby, immediately began to try to resuscitate the man, but no one called an ambulance automatically, as should have happened. Other healthcare staff arrived with emergency equipment and a nurse asked for an ambulance to be called, about four minutes after the original emergency code. Paramedics arrived but were unable to resuscitate the man and pronounced him dead.

I agree with the clinical reviewer that the standard of health care the man received was equivalent to that he could have expected to receive in the community, and his sudden death could not have been prevented. However, his serious health conditions would have been better managed with coordinated care plans. I am also concerned that the prison did not call an ambulance immediately the emergency code was broadcast. Although it is unlikely the outcome would have been different for the man, such a delay could be critical in other circumstances.

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 **July 2015**

CONTENTS

SUMMARY

1. The man was serving a 13 year sentence for sexual offences. He had been in prison since 14 September 2012, most of the time at HMP Exeter.

2. The man was a frail and suffered from long term chronic conditions, including heart disease and chronic obstructive pulmonary disease (COPD – lung disease). In May 2013, doctors diagnosed him with bone cancer, which they treated with oral chemotherapy. He had limited mobility and used a walking frame and a wheelchair.

3. The man suffered from recurrent chest infections, for which prison GPs prescribed antibiotics and a nebuliser. The man lived on a social care wing, but there were no care plans to manage his conditions effectively. This meant that there were several times at night when his pain was not adequately controlled.

4. On the morning of 26 November 2014, the man had his breakfast as usual and tried out a newly delivered electric wheelchair up and down the wing. No one had any concerns about him and he did not complain of feeling unwell or being in pain.

5. At around 11.50am, the man thanked an officer for bringing his lunch. Three minutes later, another prisoner took the man a cup of tea and found him sitting unresponsive in his wheelchair. He called for help and an officer responded. At 11.55am, the officer radioed an emergency code blue to indicate a prisoner is unresponsive or has difficulty breathing.

6. A nurse was in the treatment room near to the man's cell and responded within seconds. He and the officer moved the man to the floor and began cardiopulmonary resuscitation. At around 11.58am, a healthcare assistant and an emergency response nurse arrived with emergency equipment. They attached a defibrillator which showed no shockable heart rhythm. The emergency nurse asked the communications room to call an ambulance, which was requested at 11.59am.

7. Paramedics arrived at 12.06am and took over the resuscitation attempts. However, at 12.30pm, the paramedics pronounced the man dead.

8. We agree with the clinical reviewer that the standard of healthcare the man received at Exeter was equivalent to that he might have expected to receive in the community. However, the investigation found that the man did not have care plans to ensure he received consistent pain management and to allow staff caring for him to have a clear record of any deterioration in his condition. We are also concerned about the delay in calling an ambulance. We make two recommendations.

THE INVESTIGATION PROCESS

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

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator and the clinical reviewer interviewed three members of staff at Exeter on 30 January 2015. The investigator interviewed two more staff by telephone.

11. NHS England commissioned a clinical reviewer to review the man's clinical care HMP Exeter.

12. We informed HM Coroner for Exeter and Greater Devon of the investigation, who provided the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers, contacted the man's friend, his nominated next of kin, about our investigation. The man's friend said that she was grateful that she had been able to contact the prison directly about the man's condition and medications. She wanted to know whether the man's pain had been effectively controlled. We have dealt with other matters, not directly related to the circumstances of the man's death, in separate correspondence.

14. The man's friend and brother received a copy of the draft report. They noted a factual inaccuracy relating to the man's sentence, which has been amended accordingly. They also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The man's friend and brother highlighted that they were not satisfied with the level of care the man received while in custody.

15. 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 EXETER

16. HMP Exeter is a local prison holding about 500 men. Dorset NHS University Foundation Trust provides health services. There are 10 cells on F wing (where the man lived) for prisoners who need social care and one cell for end of life palliative care.

Her Majesty's Inspectorate of Prisons

17. The most recent inspection of Exeter was in August 2013. The Inspectorate found that care for prisoners on F wing with complex needs and disabilities was impressive. Health services were available 24-hours a day with a wide range of clinics, including for chronic diseases. Two nurses led the care of older prisoners. Palliative care was supported through an excellent new suite which had been created for the care of terminally ill prisoners.

Independent Monitoring Board (IMB)

18. 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 report for the year to December 2013, the IMB said GP cover had been problematic with insufficient numbers and little continuity. However, health services were generally good. The IMB noted that F wing had been refurbished and provided good care for terminally ill prisoners. .

Previous deaths at Exeter

19. The man was the fifth prisoner to die of natural causes at HMP Exeter since January 2012 (there has been another since the man). There were no significant similarities with the circumstances of the previous deaths.

KEY EVENTS

20. On 14 September 2012, the man began a sentence of 13 years in prison for sexual offences, at HMP Exeter. The man was frail and suffered from heart disease and COPD. In the years before he was sentenced to prison, he had suffered a heart attack and a stroke. He had slight paralysis down his left side and sometimes used a walking stick for support.

21. Healthcare staff saw the man frequently for shortness of breath and recurrent chest infections. Doctors prescribed him antibiotics and other medications, including anticoagulants (to thin the blood), basic pain relief, medication to help control his blood pressure and cholesterol, medication to help relieve water retention and inhalers to help his breathing. GPs reviewed his medications regularly.

22. The man transferred to HMP Dartmoor for five months between 23 January and 30 May 2013. During his time at Dartmoor, the man became anaemic and he was admitted to hospital in March and May for blood transfusions and further investigation. .

23. In May, the man was diagnosed with bone cancer and started oral chemotherapy. He returned to HMP Exeter on 30 May, to F wing, a social care unit, which better met his needs. By this time, the man used a walking frame, but was able to wash and dress independently.

24. Throughout the rest of 2013, doctors saw the man often and prescribed antibiotics and a nebuliser for chest infections. Officers noted that he used his walking frame well to get around the unit.

25. In September 2013, records show the man complained of being in pain several times but did not always get timely opiate pain relief, particularly for break-through pain relief.

26. The man went to hospital for outpatient appointments and admissions for chest infections four times between June and December 2013. Staff did not restrain him for any of these visits.

27. In January 2014, doctors found a lesion on the man's spine which compressed his spinal cord. This caused weakness in his legs, which affected his mobility. He had a course of radiotherapy to help ease the pain. He had a pressure relieving mattress and a wheelchair to help him move around more easily.

28. In January and February, records show further occasions, mostly at night, when the man's pain relief was poorly managed. He continued to suffer from recurrent chest infections and prison GPs prescribed antibiotics and encouraged him to use his nebuliser. Nurses gave him oxygen when he needed it.

29. On 13 May, hospital doctors told the man that his cancer was not curable, but he could continue taking the chemotherapy tablets to help prolong his life. The man was upset at the news, but decided to continue with the treatment. A prison GP offered support to the man and suggested arranging a meeting with his brother and a friend, who he had named as his next of kin, to discuss his diagnosis. However, no such meeting took place.

30. As the man was mostly immobile, nurses had asked that the man should have water and a call bell left within his reach, so that he could keep hydrated and get the attention of wing staff when he needed. In June, nurses noted several occasions when staff carers had left the man's cell bell and drinks out of his reach.

31. The man continued to suffer from chest infections. Healthcare staff advised him to sit and sleep as upright as he could to help his breathing. Records from August to November show a slow decline in the man's health, although prison staff said they did not notice any significant change in the man's condition in the weeks before his death.

Events of 26 November

32. At 7.45am on 26 November, a prisoner who helped to serve the meals on F wing, went into the man's cell and gave him milk and cereal for breakfast. He said the man was his usual self and did not give him any cause for concern.

33. Later that morning, a new electric wheelchair for the man arrived and he tried it out up and down the wing, helped by the prisoner and the carer staff manager. The carer staff manager said the man's condition was not any worse than usual and he did not complain of feeling unwell.

34. At around 11.50am, the officer took the man's lunch to him in his cell. The man thanked him and the officer left. The officer said he did not look in discomfort and he had no concerns for him. About three minutes later, the prisoner took the man a cup of tea and found him slumped in his wheelchair. He did not respond when the prisoner called his name, so he called to wing staff for help.

35. The officer went straight to the man's cell. He said it was not unusual for the man to fall asleep sitting in his chair, and he tried calling his name and gently shaking him, but he did not respond. At 11.55am the officer radioed a code blue emergency, which indicates a prisoner is not breathing or is unresponsive and should result in an ambulance being called automatically.

36. A nurse was in the wing treatment room (about 80 feet from the cell) and arrived at the man's cell within seconds. The officer and nurse moved the man to the floor and started cardiopulmonary resuscitation. A healthcare assistant arrived with an emergency bag and, at 11.58am, the emergency response nurse brought a defibrillator. She attached the defibrillator, which indicated no shockable rhythm. She asked the officer to radio the communications room for an ambulance. The control room requested an ambulance at 11.59am.

37. The ambulance arrived at the prison at 12.04pm and paramedics arrived at the man's cell at 12.06pm. The paramedics took over emergency treatment but at 12.39am, pronounced the man dead.

Liaison with the man's next of kin

38. At 3.15pm, the prison chaplain, the Reverend and the deputy governor visited the man's friend, who he had named as his next of kin. The man's friend said

she would inform his brother. An officer was the prison's family liaison officer and contacted the man's friend that evening to offer condolences and support. The funeral was on 18 December, and the prison contributed to the costs, in line with national guidance.

Support for prisoners and staff

39. A Governor's notice informed staff and prisoners of the man's death and offered appropriate support. A prison manager debriefed the staff involved in the emergency response and the care team offered support.

40. A prison manager spoke to all residents on F Wing and offered them support. Staff checked prisoners considered at risk of suicide or self-harm, in case they were adversely affected by the man's death.

Post-mortem

41. The post-mortem report shows that the man died of a pulmonary embolism (a blood clot to the lung), also multiple myeloma, coronary artery disease and COPD.

ISSUES

Clinical care

42. The clinical reviewer considered that the care the man received in prison was equivalent to that he might have expected to receive in the community. The man was an older prisoner who suffered from a number of chronic conditions, including heart disease and COPD. In 2013, doctors diagnosed him with bone cancer, and treated this with oral chemotherapy. The man frequently complained of chest pain and breathlessness. Nurses and prison GPs frequently reviewed his conditions and medication.

43. The man died suddenly from a pulmonary embolism and the clinical reviewer noted that his cancer treatment and immobility would have put him at greater risk of developing one. However, the clinical reviewer said that even if an embolism had been suspected, further investigation and preventative medication would have posed serious additional risks, which would have outweighed the benefits of investigation and treatment.

44. Although the man lived in a designated social care wing, we noted that he did not have any care plans. Care plans are a useful tool to help staff manage and monitor a patient's condition and medication, especially pain relief. There were several occasions during the night when the man asked for pain relief, but there were delays in him receiving it. We were told this was because wing staff had to request the duty nurse to come to the wing at night, and nurses were reluctant to administer additional pain relief outside scheduled times. There were also occasions where carers did not ensure the man was able to reach his drinks and call bell, as nurses had advised. The carer staff manager said she was not aware of these issues and it was the responsibility of all staff to ensure that this did not happen. While we are satisfied that the man received a generally good standard of care, implementing care plans would have helped achieve a more consistent approach to managing his pain and might have helped identify any deterioration in his condition. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with complex and chronic health conditions are actively monitored using coordinated care plans, which are regularly reviewed and updated.

Emergency response

45. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, issued in February 2013, says that prisons should have a local protocol which gives guidance on efficiently communicating the nature of any medical emergency. A code blue emergency call should be used for respiratory issues or if a prisoner is unconscious. This should ensure that staff take the right equipment to an incident and that the control or communications room staff call an ambulance automatically. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies and that it should not be necessary to wait for a member of healthcare staff or a manager to attend before calling an ambulance.

46. HMP Exeter has an emergency protocol in line with the PSI. A Governor's notice in 2014 reminded all staff that a code blue requires a mandatory

response, where the communications room automatically calls an ambulance and awaits an update from the scene. The communications room can cancel the ambulance if it is then assessed as not needed.

47. When the man was found unresponsive at 11.55am, the officer radioed a code blue. Healthcare staff and officers responded accordingly. However, an officer in the communications room did not call an ambulance automatically but waited till an emergency response nurse specifically requested one four minutes after the code blue had been called. An officer and a nurse started cardiopulmonary resuscitation quickly when they found the man unresponsive and the delay in this case does not appear to have affected the outcome. However, in other cases such a delay could be crucial. We make the following recommendation:

The Governor should ensure, in line with national instructions, that communications room staff call an ambulance as soon as an emergency medical code is broadcast.

RECOMMENDATION

1. The Head of Healthcare should ensure that prisoners with complex and chronic health conditions are actively monitored using coordinated care plans, which are regularly reviewed and updated.

2. The Governor should ensure, in line with national instructions, that communications room staff call an ambulance as soon as an emergency medical code is broadcast.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1.	The Head of Healthcare should ensure that prisoners with complex and chronic health conditions are actively monitored using coordinated care plans, which are regularly reviewed and updated.	Accepted	All prisoners suffering from complex and chronic diseases are monitored through care plans at HMP Exeter. Issues identified on F Wing have been addressed by allocating a nurse on the wing to act as a lead for clinical activities and a link between discipline, social care and healthcare staff. HMP Exeter is in the process of restructuring the healthcare services at the prison and once this is complete there will be a nurse allocated in the main prison to act as a lead for chronic/complex healthcare needs.	31 May 2015 Healthcare Manager
2.	The Governor should ensure, in line with national instructions, that communications room staff call an ambulance as soon as an emergency medical code is broadcast.	Accepted	The relevant national instructions and a Governor's Notice to Staff have been reissued at HMP Exeter to reinforce actions that need to be taken by staff.	Completed Head of Residential /Safety