Independent investigation report by the Prisons and Probation Ombudsman Nigel Newcomen CBE into the death of a man, a prisoner at HMP Channings Wood, in February 2015

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man died of chronic obstructive pulmonary disease at HMP Channings Wood on in 2015. He was 74 years old. I offer my condolences to his family and friends.

Although the man's care planning could have been more comprehensive, I agree with the clinical reviewer that, overall, he received a good standard of care at Channings Wood, equivalent to that he could have expected to receive in the community. However, I am not satisfied that the use of restraints when he was taken to hospital was justified by fully considered risk assessments. On the day he died, the officer who unlocked his cell did not check his wellbeing, and when he was found unresponsive, it was evident that he had been dead for some time. Despite this, nurses attempted to resuscitate him, which is unnecessary and distressing for those involved.

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 **August 2015**

CONTENTS

Summary

The investigation process

Background information

Key events

Findings

Action plan

SUMMARY

Events

1. In September 2011, the man was sentenced to ten years in prison. He spent most of his sentence at HMP Channings Wood. He had several health conditions, including type two diabetes, osteoarthritis and a leg ulcer. Healthcare staff saw him frequently to monitor and treat his conditions.

2. In 2014, the man suffered from increasing breathlessness and crackling noises when he inhaled that indicated respiratory disease. In October, a hospital doctor diagnosed him with advanced pulmonary fibrosis and emphysema, a progressive lung disease.

3. The man's lung conditions were diagnosed at a late stage and, other than oxygen therapy, there was little that could be done for him. He was nursed at the prison and declined a move to HMP Exeter, which has 24-hour healthcare provision. Over the following months, his condition gradually declined. In February 2015, two prisoners found him unresponsive in his cell. An officer called an emergency and three nurses attended. Although there were signs that he had been dead for some time, the nurses attempted resuscitation. Paramedics arrived and pronounced him dead.

Findings

4. The clinical reviewer considered that the man received a good standard of care at the prison, equivalent to that he could have expected to receive in the community. However, he considered a GP should have reviewed his care plans more systematically after his diagnosis and discussed his views about resuscitation if his heart or breathing stopped.

5. After the man's diagnosis, and as his condition worsened, officers used an escort chain to restrain him for four hospital visits. We are not satisfied that this was justified by fully considered risk assessments which took into account of his condition and mobility at the time.

6. We are concerned that the officer who unlocked the man's cell on the day he died, did not check his wellbeing. Nurses responded quickly to the emergency but we do not consider it was necessary or appropriate to attempt resuscitation, as it was apparent that he had been dead for some time.

Recommendations

- The Head of Healthcare should ensure that GPs discuss and record advance care planning with terminally ill prisoners, including their views about resuscitation.

- The Governor and Head of Healthcare 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.

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

- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate, in line with national guidelines.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

9. The investigator obtained copies of relevant extracts from the man's prison and medical records. He and the clinical reviewer interviewed three members of staff and two prisoners at Channings Wood on 8 May. He interviewed two members of staff by video link on 15 May.

10. We informed HM Coroner for Torbay and South West Devon District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted the man's ex-wife, who he had named as his next of kin. She did not want to be involved in the investigation.

12. The initial 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.

BACKGROUND INFORMATION

HMP Channings Wood

13. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds over 700 men. Dorset Healthcare University Foundation Trust provides health services at the prison. There is one permanent GP, and locum GPs run additional clinics. Nurses are on duty everyday and there is an out of hours GP service.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of Channings Wood was in September 2012. The Inspectorate noted that healthcare staff were generally helpful and respectful, although many prisoners were unhappy with the support provided. Prisoners had reasonably good access to nurses and a GP, and urgent problems could be dealt with the same day. There were delays for some clinics and chronic disease management was not always systematic.

Independent Monitoring Board

15. Each prison 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 recent annual report for the year to August 2014, the IMB noted that there have been improvements in the delivery of healthcare services, but it was still not of an acceptable consistency. Some clinics, including for chronic disease management, were still not being run. Recruitment for healthcare staff was ongoing.

Previous deaths at HMP Channings Wood

16. The man was the fourth prisoner to die from natural causes at Channings Wood since the start of 2014. We have raised the issue of the inadequately justified use of restraints before.

KEY EVENTS

17. In September 2011, the man was sentenced to ten years in prison and was sent to HMP Channings Wood on 5 October 2011. He had a number of health problems, including type two diabetes and osteoarthritis. He received regular treatment for a leg ulcer. Healthcare staff saw him frequently to monitor and treat his conditions.

18. On 20 May 2014, a GP examined the man, as he was suffering from shortness of breath. She found he had crackles on his chest and thought that he might be suffering from congestive cardiac failure. She ordered a blood test. The results of the test were satisfactory.

19. On 3 June, a GP examined the man and noted he was not suffering from shortness of breath at the time. He referred him to hospital for an echocardiogram (a test to produce images of the heart).

20. On 4 August, a GP examined the man, who was suffering from increased shortness of breath. He said that his symptoms were gradually worsening. The GP noted that he had an outstanding hospital referral and decided that no further action was needed.

21. On 28 August, a cardiology consultant at the hospital examined the man and found that he was breathless and hyperventilating, with bibasal crackles (noises made during inhalation that indicate respiratory disease). He ordered a chest X-ray and concluded that the symptoms were caused by lung fibrosis (a condition that causes scarring of the lungs) rather than being cardiac in origin. He referred him to the hospital's respiratory unit.

22. On 27 October, the man was taken to hospital by two officers who 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.) A respiratory consultant diagnosed advanced pulmonary fibrosis. He said there was not much that could be done to help the man. He referred him for oxygen therapy.

23. On 31 October, the man was given an oxygen concentrator to supply him with 15 hours of oxygen each day. The lead nurse for patient safety at Channings Wood asked him if he wanted to transfer to HMP Exeter for palliative care, but he wanted to stay with his friends at Channings Wood.

24. The man's condition gradually deteriorated. On 20 November, he went to hospital twice; in the morning to have a catheter removed and in the afternoon for a scan of his bladder. Both times, he was restrained by an escort chain.

25. On 3 December, a nurse and a healthcare manager met the man to discuss an end of life care plan aimed at maintaining a good quality of life during the final stages of his illness. The plan covered his treatment, diet and personal care but did not include whether he wanted to be resuscitated if his heart or

breathing stopped. The healthcare manager asked him about a transfer to Exeter, but again he said he wanted to stay at Channings Wood.

26. Over the next three months, the man's health declined and healthcare staff frequently monitored and treated his breathing problems and other symptoms. On 29 January 2015, he went to hospital for an X-ray. Again, officers used an escort chain.

27. At approximately 8.05am one morning in February 2015, Officer A unlocked the cells on the man's unit. CCTV footage showed that she unlocked his cell but did not enter. Just over 20 minutes later Prisoner A, who helped look after him, went into his cell. He said that the man was dressed and lying on top of the bed. The prisoner thought he was sleeping, so left and closed the door behind him.

28. At approximately 11.45am, Officer A began unlocking cells for lunch. Again, CCTV footage shows that she unlocked the man's cell but did not go in. Shortly afterwards, Prisoner A went into the cell and noted that he was the same position he had been in, three hours earlier. He asked another prisoner to help him check the man. They realised he was not breathing so Prisoner A ran for help and the other prisoner stood by the cell door.

29. Within a minute two nurses arrived. Meanwhile, Officer A called an emergency code blue (used to indicate circumstances such as when a prisoner is unresponsive, unconscious or has breathing difficulties). The control room called an ambulance immediately. One nurse said that rigor mortis was present and she thought he had been dead for sometime. Another nurse arrived three minutes after the other nurses and noted that his jaw and neck were stiff.

30. The nurses started cardiopulmonary resuscitation using chest compressions. They attached a defibrillator, which indicated no shockable heart rhythm. At 12.08pm, paramedics arrived. They declared the man dead at 12.12pm.

Contact with the man's family

31. When the man was first sentenced to prison, he had named his wife as his next of kin. On 19 May 2014, his wife wrote to the prison and said that she no longer wanted to be listed as his next of kin as they had divorced. However, he continued to list her as his next of kin, and wrote on the next of kin form, "After 52 years of marriage I am sure she would want to know if I passed away". He did not name anyone else.

32. At 2.30pm, on the day the man died, the Governor of Channings Wood and a prison chaplain visited the man's ex-wife and told her that he had died. They offered condolences and support. An officer acted as the prison's family liaison officer. The officer tried to telephone the man's ex-wife but the number the prison had recorded was no longer operational. He eventually obtained a new telephone number and spoke to her, who said she did not want to be involved in anything further to do with her ex-husband's death.

33. The prison arranged and paid for the funeral, which was held on 19 March 2015.

Support for prisoners and staff

34. After the man's death the Head of Residence and Safety debriefed the staff involved in the emergency response and offered support. The prison's staff care team also offered support.

35. The prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by his death.

36. On the day of the man's death, a chaplain and a Listener (a prisoner trained by the Samaritans to offer confidential support to other prisoners) gave Prisoner A individual support.

Post-mortem report

37. A post-mortem examination found that the man had died from chronic obstructive pulmonary disease (the name used for a collection of lung diseases including chronic bronchitis and emphysema).

FINDINGS

End of life care

38. The clinical reviewer considered that the general standard of care that the man received at Channings Wood was good, and equivalent to that he could have expected to receive in the community. His condition was appropriately diagnosed, but was at an advanced stage and treatment options were limited. There was good continuity of care with the prison nurses and healthcare assistants and effective communication with the local hospital. He was unsteady on his feet from the time he arrived at Channings Wood and needed a walking stick. We are satisfied he had suitable accommodation and had the help of a prisoner carer for day to day tasks. Towards the end of his life he needed a wheelchair and his carer helped him get about. The possibility of a transfer to Exeter was considered but staff appropriately took into account his preferences and allowed him to remain at Channings Wood.

39. While overall care was good, the clinical reviewer identified some areas for improvement in end of life care. In particular, he noted that the man had nurse led reviews towards the end of his life, but there was no systematic review with the prison GP to discuss any areas of concern and any specific wishes, including whether he wanted to be resuscitated if his heart or breathing stopped. We make the following recommendation:

    The Head of Healthcare should ensure that GPs discuss and record advance care planning with terminally ill prisoners, including their views about resuscitation.

Restraints, security and escorts

40. 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 a 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 judgment indicated that medical opinion about the prisoner’s ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

41. On 16 October 2014, officers escorted the man to hospital. As part of the risk assessment, a nurse recorded that he had a cardiac condition. In the light of this, a custodial manager decided that he should not be restrained.

42. However, when the man went to hospital appointments on 27 October and on 20 November, the Head of Security, Operations and Intelligence, authorised that he should be restrained by an escort chain. The assessments noted that

he was a “normal” risk to the public and of escape. The only input from healthcare staff was a ticked box which indicated that there were no known health risks. At the time of these appointments, his health was very poor and his mobility was severely limited.

43. On 29 January, the risk assessment for the man’s hospital appointment, clearly said that restraints should not be used due to his “age and mobility issues”. Despite this, the records show that officers used an escort chain to restrain him for this appointment.

44. Public protection is fundamental but security measures must be proportionate to a prisoner’s individual circumstances. We are not satisfied that decisions about the use of restraints were based on a proper assessment of the man’s health and mobility at the time, as the court judgment requires. It is particularly concerning that restraints were used on 29 January, after a risk assessment concluded that he should not be restrained. We have made a number of recommendations to Channing Wood about the need for properly considered risk assessments for the use or restraints. The prison has accepted these recommendations but we are not satisfied that managers at the prison have done sufficient to implement them. We make the following recommendation:

The Governor and Head of Healthcare 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.

Unlock procedures

45. When the man was found unresponsive at 11.45am, nurses noted the presence of rigor mortis. This would indicate that he had been dead for some time. We are concerned that Officer A did not check his wellbeing when she unlocked his cell in the morning and at lunchtime. CCTV footage shows her unlocking the cell and quickly moving on. She said she normally spoke to prisoners as she unlocked their cells but could not specifically remember speaking to him that day. She said that she checked all sleeping prisoners for movement and was satisfied that he had moved when she had first unlocked his cell in the morning.

46. Prison officers are expected to check on a prisoner’s wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that “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”. Prison Service Instruction 75/2011 states that “there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock… Where prisoners

are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".

47. When Officer A unlocked the man's cell on the morning of his death, the speed of her actions make it unlikely that she waited to get a response from him. While it is unlikely that this would have changed the outcome, it meant that staff missed an opportunity to check his wellbeing and resulted in other prisoners finding him dead. We make the following recommendation:

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

Resuscitation

48. European Resuscitation Council Guidelines 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile…" The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation and not by 'blanket' policies. Resuscitation should not be attempted when someone is clearly dead.

49. A nurse told us that rigor mortis had affected the man's neck and she thought he had been dead for some time. Another nurse supported this and recorded in his medical record that his jaw and neck were stiff, and his head was not in contact with the floor, when they moved him to the floor to begin resuscitation. The nurses said that as there was no indication that he had said he did not want to be resuscitated in an emergency, they felt obliged to attempt resuscitation. They continued chest compressions until paramedics arrived and pronounced him dead.

50. We understand that the nurses acted in what they considered to be the man's best interests and do not criticise them for their actions. However, attempting resuscitation when someone is clearly dead can be distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate, in line with national guidelines.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that GPs discuss and record advance care planning with terminally ill prisoners, including their views about resuscitation.	Accepted	Treatment Escalation Plan (TEP) forms have been in place since July 2015. These documents allow for proactive planning in regards to escalating health needs and provide clear care plans for GP's to follow, when recording advance planning with terminally ill prisoners, and this includes their views about resuscitation. TEP forms form part of the patients records and will be followed up by the appointed nurse and monitored by the Healthcare manager.	Health Care Manager Completed	
2	The Governor and Head of Healthcare 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	Healthcare staff provide all necessary clinical information to Prison colleagues to fully inform risk planning when patients are escorted out of prison for health reasons. The Head of Healthcare will work with safer custody and security staff to confirm that this process is informed in real time and that information regarding all known health conditions and mobility issues affecting the use of restraints is made available to prison staff and that they understand the legal position. The local risk assessment document at HMP Channings Wood will take into account the requirements contained in the standard risk assessment form within the National Security	Governor Head of Healthcare Head of Security and Intelligence Target date for completion: 30/08/2015	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			Framework. All operational managers will be briefed on the PPO "lessons learned" documents, all future risk assessments will consider and evidence the actual risk posed at the time of escort and all risk assessments carried out will be monitored via external and internal audits processes.		
3	The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	A notice to staff will be published by 30 August 2015 to remind staff of the importance of receiving a response from each prisoner confirming his wellbeing at each unlock period. Short term assurance tests will be completed and findings will be discussed at the safer custody meetings.	Governor Head of Residence and Head of Safety Target date for completion: 30/08/2015	
4	The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate, in line with national guidelines.	Accepted	Treatment Escalation Plan (TEP) forms are now in place and staff were made aware of the guidance on resuscitation in July 2015, through a staff notice. DHC (Dorset Healthcare) Resuscitation Policy was reviewed in July 2015 to include guidance for prison healthcare staff as to when resuscitation is not appropriate in line with national guidelines. The Healthcare Manager will be monitoring this recommendation to ensure it is adhered to.	Governor Head of Healthcare Completed	