A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in August 2014, while a prisoner at HMP Woodhill**

***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 on 25 August 2014, while a prisoner at HMP Woodhill. He was 60 years old. I offer my condolences to the man's family and friends.

The investigator carried out the investigation. The clinical reviewer reviewed the man's clinical care at HMP Woodhill. The prison cooperated fully with the investigation.

In March 2014, the man was sentenced to 15 months in prison and sent to Woodhill. His health and mobility was already poor at the time. The man was admitted to hospital twice, but declined to be admitted to the prison's inpatient unit for observation when he returned in May and July. On 25 August 2014, other prisoners found the man unresponsive in his cell. He did not have a pulse and was not breathing. Prison officers and healthcare staff treated him until paramedics arrived and took him to hospital. Shortly after he arrived at the hospital, doctors pronounced the man dead.

The investigation found that the man received a good standard of care at Woodhill with appropriate care plans to manage his health conditions. Although the man was not restrained when he was taken to hospital as an emergency on the day he died, I am concerned that the prison used restraints for his previous hospital admissions without proper justification, when his health and mobility were poor. It appears that The man did not want the prison to inform his family about his poor health when he was admitted to hospital as he did not wish to worry them, but this information should have been fully recorded to justify the prison's decision.

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** **April 2015**

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## SUMMARY

1. On 28 March 2014, the man was convicted of fraud, sentenced to 15 months in prison, and sent to HMP Woodhill. The man's health was poor, and he had a number of chronic health problems including chronic obstructive lung disease (COPD), ischaemic heart disease and diabetes, which caused breathlessness and affected his mobility. He took a range of prescribed medication.

2. Healthcare staff at the prison saw the man frequently and created care plans to manage his conditions. Prison doctors reviewed his medications regularly.

3. In May 2014, a prison GP diagnosed the man with atrial fibrillation (an irregular heartbeat) and he had a brief hospital admission. In June, he was admitted to hospital again with suspected pneumonia. In hospital, tests showed he had an abnormal heartbeat and he remained in hospital for cardiologists to monitor this. When the hospital discharged him, the man declined to stay in the prison's inpatient unit for observation, against the advice of healthcare staff, but they monitored him frequently on his wing.

4. The man attended a cardiology appointment on 12 August, but the cardiologist cancelled a planned test because of his poor condition. The cardiologist planned further treatment later.

5. On 25 August, two prisoners found the man unresponsive in his cell. Prison and healthcare staff tried to resuscitate him and paramedics continued when they arrived. The paramedics took him to hospital, but doctors pronounced him dead shortly after he arrived.

6. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Woodhill was equivalent to that he could have expected to receive in the community. Healthcare staff at the prison regularly monitored the man's health conditions and reviewed his medications. However, we are concerned that the man was restrained when he went to hospital in the months before his death, without a fully considered risk assessment that took account of his health and its impact on his risk. We also consider that the prison should have recorded their reasons for not informing the man's wife immediately after he was taken to hospital as an emergency. We make two recommendations.

## THE INVESTIGATION PROCESS

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

8. NHS England commissioned a clinical reviewer to review the man’s clinical care in prison.

9. The investigator obtained copies of the man’s prison medical records and relevant extracts from his prison record. He visited HMP Woodhill on 5 September 2014 and spoke to staff involved in the man’s care. The investigator informed the Governor of the preliminary findings of the investigation.

10. We informed HM Coroner for Milton Keynes of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

11. The investigator and one of the Ombudsman’s family liaison officers visited the man’s wife and son on 23 October, to explain the investigation and discuss any issues that they wanted the investigation to consider. The man’s family had the following questions:

    - Was there a delay in the man getting a pacemaker fitted?
    - Were the man’s hospital appointments kept and timely?
    - Were changes in the man's medication by prison healthcare staff appropriate?
    - Were risk assessments for the use of restraints for hospital visits appropriate?
    - Why his family were not informed about the decline in the man's health and his hospital admissions?

12. The man’s family received a copy of the draft report. They pointed out some omissions and this report has been amended accordingly. The man’s family also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

13. The draft report was issued for consultation with the prison service. They pointed out some factual inaccuracies. This report has been amended accordingly. The action plan has been added to the end of this report.

## HMP WOODHILL

14. HMP Woodhill has the dual role of a local prison and a high security prison and can hold more than 800 men. It takes prisoners from the Magistrates' and Crown courts in the Milton Keynes area. Central and North West London NHS Foundation Trust provides health services at the prison.

### Her Majesty's Inspectorate of Prisons

15. The most recent inspection of HMP Woodhill was in January 2014. Inspectors found that prisoners had good access to health services. There was a wide range of nursing and specialist clinics and prisoners were positive about the support they received from prison healthcare staff. The report noted that the management of medicines was good. Inspectors reported that clinical areas were well equipped and that emergency resuscitation equipment was generally well maintained and located on each of the house units, in reception and in the health centre.

### Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2014, the IMB reported positively on the prison's healthcare department. The Board noted that the use of handcuffs on hospital patients had been the subject of a High Court ruling, which made clear that security was not an over-riding issue and should be balanced with humanity when making decisions about their use.

### Previous deaths at HMP Woodhill

17. The man was the second prisoner to die from natural causes at HMP Woodhill since July 2013. In the other case, we also made a recommendation about the need for fully considered security risk assessments for the use of restraints which take into account the prisoner's health.

## KEY EVENTS

18. On 28 March 2014 the man was sentenced to 15 months in prison for fraud offences and sent to HMP Woodhill. A nurse and a prison GP carried out the man's initial health screen. They recorded that he had chronic obstructive pulmonary disease (COPD – lung disease), diabetes, asthma and noted a history of heart disease, including a heart attack some time before. The GP re-prescribed the man's medications including bisoprolol (a beta-blocker to stabilise his heart rate), a glyceryl trinitrate spray (GTN - to ease pain caused by angina) and metformin (to treat diabetes).

19. The next day, a nurse carried out a second health screen and noted that the man was on a hospital waiting list to have a pacemaker fitted and had reduced mobility due to his heart condition. Healthcare staff created care plans to manage the man's clinical and physical needs and reviewed these as necessary such as after his hospital admissions and changes in his heart condition.

20. On 2 May, the man told the nurse that he had lost use of his left arm and had numbness in his hand. The nurse recorded that his heart rate was high and advised him to use his GTN spray. She told a prison GP about this and the GP asked nurses to monitor the man's vital signs regularly. Nurses recorded the man's heart rate, which remained irregular over the next few days.

21. On 6 May, a prison GP assessed the man and took an ECG. He diagnosed atrial fibrillation (an abnormal heart rhythm) and referred the man to hospital. Two officers took the man to Milton Keynes General Hospital the same day, using handcuffs to restrain him. In hospital, the man had a further ECG and the hospital arranged a scan for 6 June, with a follow up appointment on 10 June. The prison subsequently rearranged both appointments for 24 June so they could take place on the same day. The man stayed in hospital until 9 May.

22. When he returned to the prison, the man refused to be admitted to the prison's healthcare centre, which is the usual routine for prisoners at Woodhill after a hospital admission. He said that he wanted to be in his old cell. A nurse explained the risks to the man, who signed a disclaimer stating that he understood.

23. The next day, the GP saw the man and noted that the hospital had stopped his clopidogrel medication (an anticoagulant used to thin the blood) and prescribed an alternative anti-coagulant, warfarin. Hospital doctors had also increased his prescription for bisoprolol. Over the next month, nurses measured the man's blood pressure weekly and this remained within a normal range. Healthcare staff also tested his blood regularly as required to monitor his warfarin medication.

24. On 3 June, a nurse reviewed the man's diabetes and noted his blood sugar levels were high. Later that day, a GP increased his metformin medication.

Healthcare staff reviewed him again on 6 June, 15 July and July 25 and noted that the increase in medication had stabilised the man's blood sugar levels.

25. On 11 June, the man collapsed on the wing. The nurse assessed him and administered oxygen. He recorded that the man was conscious and his vital signs were stable, but he could not respond to questions. An emergency ambulance took the man to Milton Keynes General Hospital. Two officers escorted him and restrained him with handcuffs. Tests showed no evidence of a heart attack and hospital doctors prescribed antibiotics for suspected pneumonia. While in hospital, tests indicated that the man's heart rhythm was abnormal and he remained in hospital so that cardiologists could monitor this.

26. On 13 June, a Duty Governor telephoned the man's wife to inform her that her husband was in hospital and explained how to visit.

27. The man returned to Woodhill on 24 June. (The hospital had cancelled his appointment for a scan that day and instead had booked a stress echocardiogram for 12 August). The nurse assessed him and recorded that his basic medical observations were normal. He again did not want to be admitted to the prison's healthcare centre and declined an appointment to see the prison GP. He went back to his previous cell on the ground floor of the wing. The nurse advised him not to use the stairs, as this was not good for his heart condition. Healthcare staff visited the man daily and recorded his vital signs. They continued to take blood tests to manage his warfarin dose.

28. On 25 July, during a routine review of the man's diabetes, he told the nurse that he could feel a pins and needles sensation in his arm and a bounding pulse. The nurse examined him, recorded that the pulse in his right arm was irregular and referred him to see the GP immediately. The doctor examined the man and recorded that he looked well, was comfortable and not having any difficulty breathing. The doctor recorded that the irregular pulse was likely to be due to his ongoing atrial fibrillation. The doctor decided against further medication as the man was already taking warfarin to manage this condition. He gave the man advice about how to identify symptoms that could suggest deterioration in his condition and told him to alert staff if any of these occurred.

29. On 12 August, the man attended an appointment at the cardiology department at St Guys and St Thomas' Hospital in London. Two officers escorted him using handcuffs. The man had been due to have a stress echocardiogram (tests carried out while exercising on a treadmill or stationary cycle) but a cardiology specialist at the hospital cancelled this procedure as tests showed that the man had an atrial flutter. The cardiologist believed it was not safe to do the stress echocardiogram at the time.

30. Doctors planned for the man to have cardioversion treatment (a dose of electrical current to normalise the rhythm of the heart) and a procedure to fit a device to monitor his heart rhythm. (This is a cardiac monitor that is fitted under the skin and continuously records the rate and rhythm of the heart. It is not a pacemaker). Hospital doctors re-prescribed warfarin in preparation for

the cardioversion treatment, but did not schedule a date at the time. They also prescribed digoxin and bisoprolol (beta-blockers). The man returned to prison later that day. Healthcare staff continued to monitor and record the man's vital signs regularly.

**25 August 2014**

31. About 8.45am, on the 25 August, a nurse assessed the man's blood pressure, pulse and oxygen saturation levels. She recorded that these were consistent with previous readings and within normal limits.

32. At 2.26pm, two prisoners shouted for help from the man's cell. The officer attended immediately and found the man motionless on the bed. The prisoners told the officer that the man had a heart condition. The officer arrived at 2.28pm and initially radioed for immediate medical assistance, but a minute later called a code blue (an emergency code indicating a prisoner is unresponsive or not breathing) when he realised the man was not breathing. The prison incident log shows that the control room called an ambulance at 2.31pm.

33. An officer and a custodial manager arrived at the cell. The officers lifted the man from the bed to the floor and began cardiopulmonary resuscitation (CPR). Shortly afterwards, the man vomited. At around 2.30pm, two nurses arrived. One nurse noticed the vomit around the man's mouth and applied a suction mask to clear his airway. Officers continued to apply chest compressions. At 2.32pm, another nurse arrived with an emergency bag. She applied a defibrillator to the man's chest and a pulse oximeter to the man's left hand, which showed his blood oxygen saturation levels were low (40%). The defibrillator did not indicate any shockable heart rhythm during the resuscitation attempt. A nurse inserted an airway and administered oxygen.

34. At 2.41pm, the control room contacted the prison GP after the nurses asked for a doctor to attend. The GP was on call at home at the time. At around 2.45pm, paramedics arrived at the cell and continued emergency treatment. They carried out an ECG, which showed no electrical activity in the man's heart. At 2.54pm, the paramedics and nurses considered whether they should stop the resuscitation attempt, as the man had been unresponsive for around 25 minutes. However, they decided to continue until the doctor arrived.

35. At 3.03pm, the GP arrived. The paramedics' equipment then indicated that the man had a small electrical current in his heart. The paramedics gave the man several doses of adrenaline. At around 3.40pm, the paramedics took the man to Milton Keynes General Hospital by emergency ambulance. Three officers escorted him, but he was not restrained.

36. As the ambulance left, the duty governor telephoned the man's wife to inform her that the man was in a serious condition and on his way to the hospital.

37. Paramedics continued emergency treatment on the way to the hospital, but the man did not respond. At 4.00pm, shortly after they arrived at the hospital, doctors pronounced the man dead.

38. At around 5.30pm, a custodial manager the prison's family liaison officer, met the man's wife and son soon after they arrived at the hospital. She told them that the man had died and offered her condolences.

39. The prison issued notices informing staff and prisoners of the man's death and offering support. A manager debriefed the staff involved in the emergency response and offered them support. The prison held a memorial service for the man on 8 September.

40. The family liaison officer remained in contact with the man's wife to offer support. In line with national guidance, the prison offered a contribution to the cost of the funeral, which was on 11 September.

## Post-mortem

41. After a post-mortem examination, the Coroner gave the cause of death as myocardial infarction (heart attack) with severe narrowing of the arteries in the heart. The report also showed diabetes as a contributing factor.

## ISSUES

### Clinical care

42. The clinical reviewer concluded that the man's clinical care in prison was equivalent to that which he could have expected to receive in the community. Staff reviewed his health care needs appropriately and made timely referrals to secondary care in hospital when required. They created care plans to manage his heart condition, COPD and diabetes. These were reviewed regularly and after his hospital admissions. He received appropriate medication for his conditions in line with specialist advice. Although the man declined to be monitored in the prison healthcare centre after his two admissions to hospital in May and June, we are satisfied that healthcare staff monitored him appropriately on his wing, in line with his wishes.

43. A prison GP assessed the man on 25 July 2014 after he had complained of a pins and needles sensation in his arm and a bounding pulse. The clinical reviewer noted that this assessment was appropriate for someone showing these symptoms. The notes indicate that the man did not have any symptoms, which would indicate progressive coronary artery disease at this stage. The man did not present with any further symptoms between the assessment of 25 July and his collapse on 25 August 2014.

44. The man's medical records show that when he arrived at Woodhill he was on a hospital waiting list to have a pacemaker fitted. The investigation has not found any evidence to suggest that the hospital had scheduled this procedure to take place. The man visited the cardiology department at St Thomas' Hospital on 12 August for a separate procedure. Cardiologists discussed his care following an assessment and correspondence after this does not suggest a pacemaker was being considered at the time.

45. We agree with the clinical reviewer's assessment that the man received care at the prison equivalent to that in the community and we are satisfied that he received appropriate support for his known health problems.

### Restraints, security and escorts

46. When prisoners have to travel outside prison, such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

47. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition.

The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process.

48. We are pleased to note that the man was not restrained when taken to hospital as an emergency on 25 August. He was escorted by three officers. However, the man went to hospital on three occasions before his emergency admission on the 25 August, on each of these occasions he was escorted by two officers who restrained him with handcuffs. The risk assessments show he was considered low risk of escape and a low risk to the public. The man had a heart condition and this caused him breathlessness and poor mobility, yet the medical information section of the risk assessment does not record any medical condition or whether his condition impacted on his risk of escape, as the court judgement requires.

49. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. The man was serving a relatively short prison sentence for a non-violent offence. He had a heart condition that meant his mobility was limited. His medical records show that he could not walk long distances, could not manage stairs and could only perform light work duties. We are not satisfied that the use of restraints was justified by fully considered risk assessments that took into account The man's risk and condition at the time, in line with the 2007 High Court judgement. We have raised this matter with Woodhill before.

50. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but 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 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.**

**Liaison with the man's family**

51. The man's family were concerned that the prison did not informed them immediately when he was taken to hospital. Prison Rule 22(1) states:

"If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

52. When the man was admitted to hospital on 6 May, he was not seriously ill but given his general poor state of health and possible serious consequences for

him, we consider it would normally be good practice for the prison to have informed his family. The prison did not contact the man's wife until 9 May, after the man had returned to prison.

53. On 11 June, the man collapsed and was taken to hospital by emergency ambulance. On 13 June, the acting duty governor, telephoned the man's wife to inform her that her husband was in hospital. The governor told the investigator that she recalled that the man had told the prison not to contact his wife sooner, as he had not wanted her to worry about him. However, this decision is not recorded in the man's prison records or in the escort records from hospital.

54. We consider that when a prisoner is so ill that he needs to be taken to hospital as an emergency, then the prison should regard him a seriously ill and inform his family, in line with the requirement of Prison Rules. We see too many cases where this is not done and families do not have the opportunity to see seriously ill prisoners before they die. We accept that if a prisoner expressly indicates that he does not want the prison to inform his family then it would usually be appropriate to act in accordance with his wishes. However, we would expect to see such decisions fully recorded in the prisoner's record. We make the following recommendation:

**The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed promptly and that, where possible, they are able to visit them in hospital without delay. When prisoners do not want their families informed, this decision should be fully recorded in their prison record.**

**RECOMMENDATIONS**

1. 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.

2. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed promptly and that, where possible, they are able to visit them in hospital without delay. When prisoners do not want their families informed, this decision should be fully recorded in their prison record.

**ACTION PLAN**

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible |
|---|---|---|---|---|
| 1 | 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 | All staff involved in completing risk assessments for prisoners who need to attend hospital have been fully briefed and reminded of the processes they must follow.<br><br>The Healthcare Manager will publish an instruction for the nurses who complete healthcare risk assessments to remind them that they should take each prisoner's current healthcare information into account. | 28 February 2015<br><br>Healthcare |
| 2 | The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed promptly and that, where possible, they are able to visit them in hospital without delay. When prisoners do not want their families informed, this decision should be fully recorded in their prison record. | Accepted | Healthcare staff brief prison duty managers when prisoners are taken to hospital due to an emergency condition and inform them whether the condition is serious or life threatening.<br><br>In accordance with prison rule 22, the duty Governor will inform the prisoner's next of kin once confirmation of the seriousness of the condition has been confirmed by healthcare staff. If a prisoner expresses a wish that they do not want their next of kin to be informed, this will be documented on their case notes. A Governor's Order will be issued to inform staff of this process. | 28 February 2015<br><br>Safer Custody |