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 on 30 August 2014 at HMP Usk

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 from heart disease of a man, at HMP Usk on 30 August 2014. He was 74 years old. I offer my condolences to the man's family and friends.

An investigator for the Prisons and Probation Ombudsman carried out the investigation and Healthcare Inspectorate Wales (HIW) reviewed the clinical care the man received in custody. The prison cooperated fully with the investigation.

The man was sentenced to 15 years in prison in May 2009 and arrived at Usk in June 2013. He received treatment for skin problems and had infrequent contact with healthcare services. In July 2014, healthcare staff found that the man had high blood pressure. Doctors gave him medication to reduce his blood pressure, which was successful.

On the morning of 30 August, the man's cellmate found him unresponsive in bed. Officers attended but could not find any signs of life. They telephoned for an emergency ambulance and attempted to resuscitate the man. Shortly afterwards, paramedics attended and pronounced the man dead.

I share HIW's opinion that the standard of healthcare the man received at Usk was at least equivalent to that which he could have expected to receive in the community. The investigation identified a need for Usk to improve its unlock and emergency response procedures for the future, but I am satisfied that these issues did not affect the outcome for the man.

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 **April 2015**

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SUMMARY

1. In May 2009, the man was sentenced to 15 years in prison. His medical history included cancer and a minor stroke in 2004. The man was a moderate cigarette smoker.

2. After spending time at HMP Swansea and HMP Parc, the man arrived at HMP Usk in June 2013. He had infrequent treatment for skin problems, and healthcare staff recorded no major concerns.

3. On 2 July 2014, a nurse reviewed the man at an elderly person assessment, and found that he had high blood pressure. A week later, a prison GP reviewed the man as his blood pressure was still high. The GP prescribed medication to reduce his blood pressure and cholesterol.

4. Over the following weeks, healthcare staff reviewed the man frequently and adjusted his medication to help reduce his blood pressure. On 20 August, a GP recorded that the man's blood pressure had improved. The GP increased the man's dose of medication again and noted that this should help him to maintain healthy blood pressure.

5. On the morning of 30 August, the man's cellmate found the man unresponsive in bed. Officers attended but could not find any signs of life. They telephoned for an ambulance and attempted to resuscitate the man. Paramedics arrived around 15 minutes later and pronounced him dead.

6. HIW concluded that the standard of healthcare the man received at Usk was at least equivalent to that which he could have expected to receive in the community. We make two recommendations, about unlock procedures at the prison and responding to emergencies in line with Prison Service instructions, but do not consider that these issues would have affected the outcome for the man.

THE INVESTIGATION PROCESS

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

8. Healthcare Inspectorate Wales (HIW) reviewed the man's clinical care in prison.

9. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. The investigator and HIW interviewed staff at Usk in October and November 2014. The investigator wrote to the Governor about the preliminary findings of the investigation.

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

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. The man's daughter, his nominated next of kin, did not have any specific issues for the investigation to consider.

12. The man's next of kin was provided with a copy of the draft report. They did not make any comment on the factual accuracy of the report. The prison also received a copy of the draft report. Their response to our recommendations and action plan is included at the end of this report.

HMP USK

13. HMP Usk holds up to 273 men convicted of sexual offences. The prison is managed jointly with nearby HMP Prescoed. The Aneurin Bevan Health Board delivers healthcare services at Usk. Healthcare services are available between Monday and Friday from 8.00am to 4.30pm. There is a GP surgery every weekday morning and doctors from the practice are on call until 6.30pm each weekday.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Usk was in May 2013. Inspectors found that health services at the prison were generally good, and chronic disease management was starting to develop. However, medicine management and support for older prisoners needed improvement.

Independent Monitoring Board

15. 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 recent annual report for the year 2013-14, the IMB reported that a change in health care provision at the prison had led to a more effective service. The IMB was concerned that reduced staffing levels at the prison could impact on the management of unforeseen incidents.

Previous deaths at HMP Usk

16. The man was the third prisoner to die at Usk since the start of 2013. All three deaths were from natural causes. One death, in April 2013, was also as a result of heart disease and we recommended that prisoners should be screened and monitored for cardiac risk factors. While ultimately it did not prevent his death, we recognise that screening identified that the man had high blood pressure for which he received treatment and was monitored.

KEY EVENTS

17. In May 2009, the man was sentenced to 15 years in prison for historic sexual offences. This was his first time in prison. The man's medical history included non-Hodgkin lymphoma (a circulatory cancer), and a small stroke in 2004. He was a moderate cigarette smoker.

18. After spending time at both HMP Swansea and HMP Parc, the man arrived at HMP Usk on 6 June 2013. At his initial health screen, he told a nurse that he had had cancer 15 years earlier, and now had annual reviews with a specialist. The nurse noted that the man suffered from shingles (an infection of a nerve and skin area), but he had no prescribed medication. Medical observations showed that his blood pressure was raised.

19. The man had a second health screen on 11 June. He told another nurse that he smoked up to nine cigarettes each day. The nurse took his medical observations, which showed his blood pressure was normal.

20. A prison GP reviewed the man on 21 June. The GP prescribed gabapentin to reduce pain caused by the man's shingles, and a topical cream to treat eczema (inflamed skin). Over the following months, healthcare staff continued to treat the man for his skin problems.

21. On 19 November, a nurse reviewed the man. The man told her about his medical history, and the nurse noted that the man had not had any recent blood tests. She ordered a full set of tests, and the results were normal. The nurse also gave the man advice to help him stop smoking, but he did not give up.

22. On 23 December, a nurse reviewed the man at an elderly person clinic. The nurse recorded no concerns about the man's physical and mental health, although he had raised blood pressure. The nurse advised the man to stop smoking. Over the following months, the man had infrequent contact with healthcare services, including some treatment for skin problems.

23. On 2 July 2014, a nurse reviewed the man at another elderly person clinic. She recorded that the man appeared physically and mentally well, but he had high blood pressure. The next day, the man had a full set of blood tests. The results showed that he had high cholesterol (a fatty substance in blood).

24. The man took a QRISK2 test (to identify the risk of heart and blood vessel disease) on 4 July. The results showed that he had a 39% (high) risk of developing heart disease over the next 10 years.

25. On 9 July, a nurse reviewed the man's blood pressure, which was still high. A prison GP reviewed the man later that day and prescribed ramipril to reduce his blood pressure.

26. On 18 July, another prison GP reviewed the man. He recorded that the man had improved blood pressure, and increased the dose of ramipril. The GP also prescribed atorvastatin to help reduce the man's cholesterol levels.

27. Healthcare staff continued to review the man frequently and changed his dose of ramipril as required. On 20 August, a doctor recorded that the man had normal blood pressure. He increased the man's dose of ramipril again, and said that this should help him to maintain healthy blood pressure.

28. Over the following days, the man collected his regular medication. On 25 August, the man's personal officer met with the man. The personal officer recorded that he was well and had no concerns.

Saturday 30 August

29. At around 6.45am on Saturday 30 August, a senior officer said he had counted the prisoners on the wing by looking into their cells. He told us that the man was lying in bed and appeared to be sleeping. The senior officer did not have any concerns.

30. At around 8.45am, an officer unlocked the man's cell, but it does not appear that he tried to obtain a response from either occupant. At about 9.25am, the man's cellmate woke up and noticed that the man did not seem to be breathing. The cellmate called out to the man and shook him, but he did not respond.

31. The cellmate left the cell and told the officer that the man was unresponsive. The officer went to the wing office to get the senior officer and another officer. The officers went to the man's cell, and the senior officer checked the man for signs of life. He told us that the man was cold and unresponsive, and he thought he was dead.

32. The senior officer asked one of the officers to return to the wing office and call an ambulance. The senior officer and the other officer started cardiopulmonary resuscitation by giving chest compressions. (Both officers believed that the man had died.) Around a minute later, the senior officer left the cell to update the duty governor. The officer continued the resuscitation attempt.

33. At around 9.35am, the senior officer returned to the cell and took over chest compressions. The officer left to help lock up other prisoners. Paramedics arrived at around 9.40am. They could not find any signs of activity in the man's heart, and pronounced him dead at 9.50am. The paramedics considered that the man had been dead for some time.

34. The duty governor debriefed the staff involved in the emergency response before they left the prison and ensured they were offered support. The staff offered prisoners on the wing support. Officers moved the man's cellmate to a cell with Listeners (volunteer prisoners trained by the Samaritans to support other prisoners).

35. The duty governor visited the recorded address of the man's daughter, his nominated next of kin, at around 12.00pm, but no one was there. He knew that the man's daughter was planning to visit the prison that afternoon, so went back to Usk. The duty governor and the prison chaplain, a reverend, met the man's daughter at the prison and informed her of his death.

36. A trained family liaison officer, a senior officer, continued to support the man's daughter after his death. In line with national guidance, the prison contributed to the funeral costs.

Post-mortem

37. After a post-mortem examination, the Coroner gave the cause of death as coronary artery disease.

ISSUES

Clinical care

38. HIW concluded that the man's care in prison was at least equivalent to that which he could have expected to receive in the community. They found that healthcare staff diagnosed and treated the man's high blood pressure and cholesterol appropriately. HIW considered that the root cause of the man's death was a lifetime of smoking.

39. We agree with HIW's assessment of the standard of the man's care in prison, and we are satisfied that he received appropriate support.

Unlocking cells

40. 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 10/2011 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."

41. When the officer unlocked the man's cell on the morning of Saturday 30 August, it does not appear that he waited to get a response from him. While it is unlikely that this would have changed the outcome, as it appears that the man died some time earlier, this meant that staff missed an opportunity to check on the man's wellbeing.

42. Usk does not currently direct officers to wait for a response from prisoners when unlocking cells. The officer told us that officers usually check on prisoners when unlocking cells only if there are ongoing concerns about their welfare. This is contrary to current Prison Service instructions. We make the following recommendation:

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

Emergency response

43. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains a mandatory instruction that prisons should have a local protocol which gives guidance on efficiently

communicating the nature of a medical emergency (a code blue emergency call should be used for respiratory issues or if a prisoner is unconscious), ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. 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. It states that one of the minimum requirements of local protocols is that they should define what should be done when there is no nurse or doctor on duty.

44. Usk's current protocol directs nurses to identify the need for an emergency ambulance and inform the control room. However, at weekends, there are no healthcare or control room staff working in the prison. The protocol does not clearly set out the responsibilities of prison staff in an emergency. There is no requirement for staff to use emergency codes which specify the nature of the emergency, or guidance about the correct equipment to bring.

45. The officers who found the man unresponsive did not use a recognised emergency code to relay the nature of the emergency to other staff on duty. It should be normal practice for a defibrillator (which analyses heart rhythm and delivers electric shocks to restart the heart) to be taken to all code blue emergencies. Although there is a defibrillator on the wing where the man lived, officers did not bring this to his cell. The correct use of an emergency code would have clarified the nature of the emergency and ensured that staff brought the most appropriate medical equipment immediately.

46. We agree with HIW that the emergency treatment provided on 30 August was satisfactory in the circumstances as the man had already died. We recognise that there was no delay in calling an ambulance. However, it is a concern that emergency procedures at the prison do not reflect current Prison Service requirements or set out the responsibilities of staff in an emergency, especially during the reduced regime at weekends. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Usk has a medical emergency response code protocol based on the PSI which ensures:

- **staff efficiently communicate the nature of a medical emergency;**
- **relevant emergency equipment is brought; and**
- **that there are no delays in calling, directing or discharging ambulances**

RECOMMENDATIONS

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

2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Usk has a medical emergency response code protocol based on the PSI which ensures:

    - staff efficiently communicate the nature of a medical emergency;
    - relevant emergency equipment is brought; and
    - that there are no delays in calling, directing or discharging ambulances.

ACTION PLAN: The man – HMP Usk

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	A Notice to Staff has been issued, and ongoing emphasis of good practice will be included in staff meetings, communications and regularly checked by way of peer review from the Regional NOMS Wales Safer Custody lead. Duty governor and residential managers will be asked to verify that staff are checking on the welfare of the prisoner when cell doors are unlocked.	April 2015 Governor and Head of Residence to communicate regularly and embed good practice .
2	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Usk has a medical emergency response code protocol based on the PSI which ensures: - staff efficiently communicate the nature of a medical emergency; - relevant emergency equipment is brought; and - that there are no delays in calling, directing or discharging	Accepted	All residential staff have been updated by the Head of Residence and clear written communications issued and displayed at key points around the establishment, in relation to the correct practice to be adopted as per PSI 03/2014 and emergency codes to be used. PPO Action Plan will be discussed at Prison Partnership Board meeting on 29 January and lessons learned (in particular this recommendation) will be explored and if possible factored into the monthly regular staff training days – with guidance sought from the Regional Safer Custody lead, in terms of support to do this and to benefit from their broader knowledge of good safer custody practice.	Completed All staff to be trained throughout 2015

	ambulances.		A meeting has been held with the lead practitioner for resuscitation services from Aneurin Bevan Healthcare and a full on-site assessment undertaken to ensure the right equipment is available and readily accessible to staff at key points around the establishment. Any need for additional equipment to be purchased will also be assessed. Training to be arranged by regional training for prison staff (to include defibrillator training) and immediate steps taken to ensure that current defibrillators (and resuscitation equipment) are appropriately located in the establishment.	June 2015 Head of Residence / Regional Training Leads