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 17 September 2014 while in the custody of HMP Gartree

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 from a brain haemorrhage on 17 September 2014, while a prisoner at HMP Gartree. He was 58 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Gartree was undertaken. The prison cooperated fully with the investigation.

The man was serving a life sentence and had been at Gartree since July 2014. In September, an officer unlocking his cell found him unresponsive. Healthcare staff attended quickly and an emergency ambulance took him to hospital, where he died later that day.

The clinical reviewer was satisfied that the man received a standard of care in prison equivalent to that he could have expected to receive in the community. I agree and consider that prison healthcare staff could not have predicted or prevented his sudden death. While it did not affect the outcome for him, I must once again express concern about Gartree's emergency response arrangements, which need to be brought in line with national instructions.

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 **March 2015**

CONTENTS

SUMMARY

1. On 31 May 2013, the man received a life sentence for murder and was sent to HMP Exeter. On 16 July 2014, he transferred to HMP Gartree.

2. The man had a history of heart disease and took medication to control his blood pressure and cholesterol. He had attempted to commit suicide just before his arrest and a psychiatrist had prescribed antidepressants. He had a number of mental health assessments during his early time in prison.

3. On 17 September 2014, at a routine morning check, an officer saw the man lying on the bed in his cell and he appeared to be all right. However, at about 8.06am, the officer who unlocked his cell found him unresponsive with white liquid running down the side of his face. He immediately radioed a code blue medical emergency.

4. Other officers and a nurse joined the officer almost immediately. They placed the man in the recovery position and the nurse asked the officers to call an ambulance. More nurses arrived and established that he had a pulse and was breathing. They continued to monitor him until paramedics arrived.

5. An ambulance crew took the man to hospital. Two prison officers accompanied him, but they did not use restraints. His condition did not improve and he died in hospital that evening. A post-mortem examination found that he had suffered a brain haemorrhage.

6. The clinical reviewer was satisfied that the care the man received at Gartree was equivalent to that he could have expected in the community and his death could not have been predicted or prevented. However, the investigation found some weaknesses in the emergency response. Although the control room called an ambulance quickly after the officer found him unwell, this was at the request of a nurse and not done automatically as soon as the emergency medical code as should have happened. It took ten minutes for the first paramedic to get from the prison gate to the cell, which is too long. While this did not affect the outcome for him, we are concerned that Gartree's local emergency procedures are not in line with national instructions, a matter we have raised before. We repeat a recommendation we have previously made to the prison about this issue.

THE INVESTIGATION PROCESS

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

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. He interviewed a member of staff and a prisoner at Gartree on 29 September. He informed the Governor of the preliminary findings of the investigation.

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

10. We informed HM Coroner for Leicester City and South Leicestershire District of the investigation. We suspended our report pending confirmation of the cause of death, which we received on 5 February 2015. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's cousin, his nominated next of kin, on 27 October, to explain the investigation. She did not have any specific issues for the investigation to consider. She told the family liaison officer that prison staff had been helpful and kind after her cousin's death.

12. The man's family received a copy of the draft report. They did not make any comments. The prison has submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP GARTREE

13. HMP Gartree is a category B Prison, near Market Harborough in Leicestershire, which holds up to 708 men sentenced to life and other indeterminate sentences. Leicestershire Partnership Trust is responsible for delivering primary physical and mental health services in the prison and Northamptonshire Healthcare NHS Foundation Trust runs secondary mental health in-reach services.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Gartree was in March 2014. Inspectors were positive about the standard of health services and noted there was a stable healthcare workforce, who were qualified to deliver a range of appropriate services. There were satisfactory facilities in reception for initial health screens. Prisoners' access to healthcare services was very good and waiting times for all clinics were short. Nurses held triage clinics daily with open access for prisoners with urgent needs. Prisoners were able to see a GP routinely within three days. There was sufficient emergency resuscitation equipment, including automated external defibrillators, which were appropriately positioned around the prison

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 published annual report for the year to November 2013, the IMB reported that health services at the prison were good and waiting times had improved.

Previous deaths at HMP Gartree

16. The man was the third of four prisoners to die from natural causes at Gartree in the last two years. We have previously raised issues about the correct use of emergency codes and emergency response procedures at Gartree. We repeat similar concerns in this report.

KEY EVENTS

18. In March 2013, the man killed his wife and tried to kill himself by taking an overdose of medication, which caused him some ongoing physical health problems. He was treated in hospital and prescribed antidepressant medication. On 9 March 2013, he was remanded to HMP Exeter. At a reception health screen, he said he had a history of heart disease, arthritis and depression. The reception nurse listed his medication, which included 75mg aspirin daily. On 31 May 2013, he was sentenced to life imprisonment, with a minimum term to serve of 12 years and three months.

19. On 8 September 2013, a nurse assessed the man's mental health at the request of wing staff at Exeter, who had noticed a deterioration in his mental state and physical appearance. The nurse diagnosed stress-induced psychosis (which causes people to perceive or interpret things differently from those around them). A prison GP prescribed olanzapine (used to treat the symptoms of psychotic conditions, anxiety and stress). During his time at Exeter, healthcare staff monitored his mental health and reviewed his medication.

20. On 11 March 2014, as part of a general health check, the man had an electrocardiogram (ECG), a test that records the electrical activity of the heart, which is recommended for people taking olanzapine. The ECG identified ischemia (a shortage of blood and oxygen to the heart usually caused by a narrowing or blockage of one or more of the coronary arteries). He told a healthcare assistant that he had no symptoms and felt fit and well. A prison GP examined him on 12 March. He recorded no recent symptoms and that the ECG had identified only old changes.

21. The next day, a nurse responded to an emergency call and found the man pale, clammy and having difficulties breathing. He was taken to hospital, where doctors diagnosed endocarditis (an infection of the inner lining of the heart). He spent two weeks in hospital for treatment. The hospital discharge information included instructions for the prison to arrange follow up cardiology investigation, including an angiogram (to provide detailed pictures of the heart and its blood vessels). There is no record that this was done at Exeter, but on 1 July, when assessing him as fit to transfer to HMP Gartree, a nurse noted that he would need a referral for an angiogram.

22. On 12 July, the man told a nurse he had back pain and she prescribed painkillers. Two days later, he told another nurse that his back pain did not seem to be getting better and asked for a higher dose. She advised him to see the prison GP, but he said he was due to transfer the next day. A nurse noted in his medical record that he had an outstanding hospital referral about his heart.

23. The man left HMP Exeter on 15 July. He spent a night at HMP Highdown and arrived at Gartree on 16 July. When he arrived at and left Highdown, healthcare staff recorded in his medical record that he had no outstanding hospital or doctors' appointments.

24. At an initial health screen at Gartree, the man told a nurse he took olanzapine, which he planned to stop, and sertraline (an antidepressant). He said he had high cholesterol and took statins (used to lower cholesterol) and that he suffered back pain and arthritis in his hips. He said that the GP at Highdown had informed him of an outstanding hospital appointment which would be transferred. The nurse referred him to the primary care mental health team and the prison GP. Gartree did not follow up the hospital appointment noted at Exeter. The nursing manager believed that this might have been missed, as the most recent entries in his medical record, at Highdown, had indicated no outstanding appointments.

25. On 24 July, the man told a prison GP that he had stopped taking olanzapine as he felt he no longer needed it, but he continued to take sertraline. Between July and September, healthcare staff monitored his back pain. They prescribed painkillers and referred him to a physiotherapist. On 16 September, he told a nurse he felt much better. His mobility had improved and he could manage gentle stretches.

Events of 17 September 2014

26. On 17 September, at about 7.15am, an officer did an early morning roll check on C wing. The roll check is primarily a security procedure to check all prisoners are present and not a welfare check. He remembered seeing the man on his bed in his cell at the time. He said he saw his head move and that he had no bedding covering him. He had no concerns about him at the time.

27. At about 8.00am, an officer and a Supervising Officer (SO) began unlocking the cells on C wing. The officer unlocked the man's cell at 8.06am and saw immediately that he was unwell. He was lying on his bed, his eyes were glazed and he had white froth or vomit running down the side of his face. He was gurgling, as if choking on his vomit and shaking as if fitting.

28. The officer radioed a code blue medical emergency code (to indicate a serious medical emergency, such as where a prisoner is not breathing or unresponsive). The SO, who was only two cells away, joined him almost immediately. They moved the man onto his side to put him into the recovery position. The nurse manager arrived within a minute of the code blue call and helped them. As they rolled him over, he vomited and his breathing became easier. The nurse asked the officers to call an ambulance. (The local protocol at Gartree at that time did not direct staff to call an ambulance automatically when an emergency medical code is called.) Control room staff called the ambulance at 8.08am.

29. Two nurses got to the cell with the emergency equipment bag two to three minutes after the emergency call. Another nurse joined them shortly after. The nurses found that the man had a pulse and monitored his vital signs. They used a suction pump to clear his airway and gave him oxygen, but he remained unresponsive and his breathing was laboured.

30. The first paramedic arrived at the prison at approximately 8.13am. In his statement, he said it took about ten minutes to get to the cell after he arrived. An ambulance arrived at 8.26am. The paramedic and ambulance crew made further attempts to clear the man's airway and stabilise his condition before taking him to hospital.

31. The ambulance left the prison at 9.13am. Two prison officers accompanied the man to hospital. They did not use restraints.

Liaison with the man's family

32. After the man was admitted to hospital, the prison asked an officer to act as the prison's family liaison officer (FLO). The FLO telephoned the man's cousin, his nominated next of kin, but repeatedly got no reply and did not consider it appropriate to leave a voicemail message. Instead, he looked at his telephone records and found the number of another cousin who he had recently called. The FLO contacted her at 1.00pm, explained that her cousin was in hospital. The FLO and a prison manager met this cousin and her husband at the hospital that afternoon. She phoned his other cousin who he had nominated as his next of kin and told her he was in hospital.

33. The man's condition did not improve and he died at 6.33pm that evening. The FLO was present at the time. His cousin phoned his next of kin to let her know he had died.

34. The FLO was unable to contact the man's next of kin over the next few days, but checked with his other cousin who confirmed that he had the correct phone number and that she was all right. On 26 September, the FLO was able to speak to the next of kin and they discussed funeral and other arrangements. The funeral was held on 17 October 2014 and the prison contributed towards the cost, in line with national guidance.

Support for prisoners and staff

35. The Governor issued a notice to prisoners and staff informing them of the man's death and the support available. Staff reviewed the cases of all prisoners subject to suicide and self-harm prevention procedures, in case they had been affected by his death. On 21 September, the prison held a memorial service and 16 prisoners attended

36. A senior manager debriefed the staff involved in the emergency response and offered them support if they needed it.

Post-mortem

37. A post-mortem report concluded that the man died of a subdural haemorrhage.

ISSUES

Clinical care

38. The man died from a brain haemorrhage. The clinical reviewer was satisfied that healthcare staff could not have been expected to foresee or prevent his death and that the overall level of care he received at HMP Gartree was equivalent to that which he might have expected to receive in the community.

39. The clinical reviewer made some recommendations for improvements, which the Head of Healthcare will need to address. These include arrangements for transferring information about outstanding hospital referrals between prisons. As the clinical reviewer did not consider that these matters were related to the circumstances of the man's death, we do not repeat them in this report.

Emergency Response

40. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires governors to have a medical emergency response code protocol that instructs staff how to communicate the nature of a medical emergency using agreed emergency codes and ensures that the control room calls an ambulance automatically, as soon as a member of staff calls an emergency code.

41. The control room did not call an ambulance immediately in response to the emergency code, as PSI 03/2013 requires. They requested it when a nurse specifically asked for one. Although we recognise that this was only two minutes later, prison and healthcare staff statements indicate that the practice at Gartree was not to request an ambulance until healthcare staff or the orderly officer attend the scene and confirm that one is required. The PSI explicitly states:

> "local procedures must ensure that staff understand they should not delay summoning emergency assistance. For example, it must not be a requirement for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are called".

42. The first paramedic said that it took around ten minutes to get through security procedures and reach the man's cell. It is unlikely that this delay affected the outcome for him, but in an emergency where someone is unconscious, speed is crucial and we consider that this is too long. The national instruction requires prisons to have local protocols that 'prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison.'

43. We have previously made recommendations to Gartree about the correct use of emergency codes and calling an ambulance. On 16 October, in response to a death in July 2014, the prison issued a new Staff Information Notice 123/2014, about emergency procedures. Although this goes some way to addressing our concerns, it suggests to staff that they should consider

whether someone needs an ambulance before calling an emergency code, which is not what the national instruction requires. We make the following recommendation:

The Governor should ensure that all prison staff understand PSI 03/2013 and their responsibilities during medical emergencies. Gartree should have a medical emergency response protocol in line with the PSI, which ensures that staff use medical emergency codes as necessary, that the control room calls an ambulance automatically and that there is no delay in emergency services reaching prisoners.

RECOMMENDATION

The Governor should ensure that all prison staff understand PSI 03/2013 and their responsibilities during medical emergencies. Gartree should have a medical emergency response protocol in line with the PSI, which ensures that staff use medical emergency codes as necessary, that the control room calls an ambulance automatically and that there is no delay in emergency services reaching prisoners.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that all prison staff understand PSI 03/2013 and their responsibilities during medical emergencies. Gartree should have a medical emergency response protocol in line with the PSI, which ensures that staff use medical emergency codes as necessary, that the control room calls an ambulance automatically and that there is no delay in emergency services reaching prisoners.	Accepted	A local emergency response policy is now in place which is compliant with PSI 03/2013 and ensures that an ambulance is called automatically when a code red or blue is called by a member of staff. The policy also sets out the steps that staff should take to ensure that emergency vehicles are not delayed in reaching those in need, and this point is reiterated in the prison's Local Security Instructions as well. The policy has been published locally and communicated to all staff, and recent checks demonstrate that the required actions are taking place.	Completed Head of Residence, Safety & Equalities. Safer Custody