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 at HMP Elmley on 22 August 2014**

## *Our Vision*

*‘To be a leading, independent investigatory body,*
*a model to others, that makes a significant contribution to*
*safer, fairer custody and offender supervision’*

This is the investigation report into the death of a man, who died of a pulmonary thromboembolism and deep vein thrombosis on 22 August 2014 at HMP Elmley. He was 62 years old. I offer my condolences to the man's family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man was remanded to HMP Elmley on 15 August 2014. A doctor prescribed him medication for existing anxiety, depression and thyroid problems, but he did not receive the medication until 19 August.

On 22 August, the man collapsed on the wing. Prison staff called a code blue emergency but did not call an ambulance until a nurse arrived and requested one, after assessing him. After the ambulance arrived, his heart stopped and paramedics, with help from prison officers and healthcare staff, resuscitated him. The paramedics called an air ambulance and tried to stabilise the man. His heart stopped at least one more time. Paramedics pronounced him dead at 2.05pm.

I am satisfied that the man received a standard of care at Elmley equivalent to that he could have expected to receive in the community and that prison staff could not have done anything to prevent his sudden and unexpected death. However, the investigation has identified a need for better prescribing arrangements for prisoners arriving at Elmley. I am also concerned that there was a delay of eight minutes before an ambulance was called after the emergency code was broadcast. This is contrary to National Prison Service Instructions and is a matter I have raised with Elmley many times before. While in this case it did not affect the outcome for the man, in other emergencies such a delay could be crucial.

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. The man was remanded to HMP Elmley on Friday 15 August 2014. He had a long history of depression and thyroid problems. A doctor in reception noted that he did not have any medication with him and prescribed this for him. The man did not receive his medication until Tuesday 19 August.

2. At 11.38am on 22 August, the man collapsed in his houseblock and was unconscious for a short time. Officers radioed a code blue but the control room did not call an ambulance immediately. A nurse arrived and assessed him. The man was conscious and told the nurse he had lower abdomen pain. The nurse asked for an ambulance to be called at 11.46am.

3. Paramedics arrived at 12.30pm and prison officers and healthcare staff helped them take the man to the ambulance. At 12.55pm, when he was in the ambulance, his heart stopped. Prison staff and paramedics resuscitated him and the paramedics called an air ambulance. When the air ambulance arrived, the man's heart stopped again. The ambulance crews continued to try to resuscitate him but he was pronounced dead at 2.05pm. He died of a pulmonary thromboembolism and deep vein thrombosis.

4. The investigation found that the man's death was sudden and unexpected and could not have been prevented. However, there is a need to ensure that newly arrived prisoners receive prescribed medication without significant delay. There is also an ongoing problem with the incorrect use of medical emergency codes at Elmley, which needs to be rectified urgently. We make two recommendations.

## THE INVESTIGATION PROCESS

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

6. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator interviewed three members of staff at Elmley on 25 September 2014, and had two telephone interviews on 26 September. The investigator gave the prison initial feedback about the preliminary findings of the investigation.

7. NHS England commissioned a GP to review the man's clinical care at the prison.

8. We informed HM Coroner for Mid Kent and Medway of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

9. One of the Ombudsman's family liaison officers contacted the man's daughter, his nominated next of kin, on 17 September, to explain the investigation. His daughter wanted to know whether the man had received his medication in prison as she was aware the police had forgotten to send it on. She also wanted to know why the man was not taken to hospital sooner on the 22 August.

10. The man's family received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The prison has also 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 ELMLEY

11. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves the courts in Kent and holds more than 1,200 men in five wings, with a mixture of single, double and triple cells.

12. NHS England, Kent and Medway commission Integrated Care 24 Ltd (IC24) to provide primary healthcare services at Elmley. The prison's healthcare centre includes a 29-bed inpatient unit.

## HM Inspectorate of Prisons

13. The most recent inspection of Elmley was in June 2014. The Inspectorate found that most aspects of health care were good. Emergency resuscitation equipment was checked daily and GP and mental health appointments for those at risk were prioritised appropriately. Healthcare staff had up-to-date life support training. However, the limited regime caused booked appointments to be missed and delays in the administration of medications. The management of medicines was very poor with trading between prisoners, although the emergency stock was noted to be reasonable.

## Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to October 2013, the IMB noted that the standard of healthcare had improved after IC24 took over the services.

## Previous deaths at HMP Elmley

15. The man was the fifth person to die of natural causes at Elmley since January 2014. We have made a number of previous recommendations about the need to call an ambulance immediately when an emergency code is radioed.

## KEY EVENTS

16. On 15 August 2014, the man was remanded into custody, charged with sexual offences. At a reception health screen, a doctor noted that the man had a long history of depression and problems with his thyroid gland. The man had arrived at the prison without his medications and the doctor prescribed them. They were busiprone (for anxiety), folic acid, gabapentin (for pain relief), levothyroxine (for thyroid problems), propranolol (for high blood pressure and anxiety) and sertraline (depression and anxiety disorders).

17. Later that day the man had a routine mental health assessment. Another mental health nurse, saw him the next day for a follow up review and referred him for anxiety management. Both nurses assessed that he was not at risk to himself, although he had moderately severe depression.

18. On 18 August, an administrator requested the man's community medical records. He did not have any medication with him when he arrived and the prison had none in stock. He did not receive his prescribed medication until 19 August.

### 22 August

19. At 11.38am on 22 August, prisoners alerted staff that the man had collapsed after collecting his lunch and was unconscious. Two officers attended within 30 seconds and placed the man in the recovery position. An officer radioed a code blue (indicating a life-threatening emergency due to loss of consciousness or difficulty breathing).

20. Within two minutes of the code blue, a nurse and a healthcare assistant arrived with emergency equipment. They took over from the officers, who said that the man might have hit his head when he fell. He was now conscious and able to tell the nurse that he had lower abdominal pain, which he had felt all morning. The nurse took his clinical observations. The man's temperature was slightly low (34.3), his oxygen was below normal range (84%) and his pulse was normal (74). The nurse was not able to take his blood pressure because it was too low. At 11.46am, he asked for an ambulance to be called and gave the man oxygen. The healthcare assistant went back to the healthcare centre to collect intravenous equipment, a heart monitor and to ask for a prison GP to attend.

21. The healthcare assistant returned with the extra equipment and a doctor arrived about ten minutes later. The nurse had inserted a drip in the man's arm to try and get a blood pressure reading and the doctor inserted another canula for the same purpose but neither could get a reading. The man was conscious and talking throughout.

22. An ambulance arrived at 12.30pm and paramedics took control of the man's care, assisted by the nurse and the healthcare assistant. The doctor left to continue with his surgery duties. Two officers were detailed to escort the man to hospital and arrived while the paramedics were preparing to move him to

the ambulance. At about 12.40pm, an officer helped put the man on a stretcher and with the nurse and healthcare assistant, moved him to the ambulance. The man was not restrained. At about 12.55pm, his heart stopped beating, while the ambulance was still in the prison, and the paramedics, an officer and the prison nursing staff began cardiopulmonary resuscitation. The healthcare assistant radioed for the doctor to re-attend urgently. He arrived moments later.

23. An officer did chest compressions while a paramedic maintained the man's airway and successfully resuscitated him. The paramedics called an air ambulance at 12.58pm and tried to stabilise him. The paramedics recorded that his heart stopped at least once more. The air ambulance arrived at about 1.05pm and the crew took control of the man's care but were unable to get him into a stable enough condition to move him to hospital.

24. The ambulance crews, with help from prison medical staff, continued to try to resuscitate the man, but were unsuccessful. At 2.05pm, paramedics pronounced him dead.

**Informing the man's next of kin**

25. At 4.45pm, a prison manager and a colleague arrived at the man's daughter's house and informed her that her father had died. They offered condolences and ongoing support.

**Support for staff and prisoners**

26. The prison issued notices to prisoners and staff informing them of the man's death and offered support to anyone affected. A manager debriefed the staff involved in the man's care and the emergency response to provide support and reassurance. The prison held a memorial service in the chapel on 26 August.

27. The man's funeral took place on 11 September. In line with national guidance, the prison contributed to the costs.

**Post-mortem**

28. The man died of a pulmonary embolism, caused by deep vein thrombosis. The post-mortem concluded that there was no evidence that anything else had contributed to his death.

## ISSUES

### Clinical care

29. The clinical reviewer was satisfied that the clinical care the man received at Elmley was equivalent to that he could have expected to receive in the community. He concluded that the man's death could not have been foreseen or prevented and that the resuscitation attempts were appropriate. There is some discrepancy in the records about the time that the man had his first heart arrest, but it is apparent from CCTV and accounts of the incident, that this was after paramedics arrived. Despite swift emergency treatment after his heart arrested, the man was never stable enough to transfer to hospital

### Medication

30. The prison has a contract with a local pharmacy who supply medications. If a prescription is sent to them before 11.30am, it will arrive in the prison by 4.30pm the same day. If it is sent later, then it should arrive the next working day. The pharmacy does not supply medication over the weekend. The man arrived in prison without his medication on the evening of Friday 15 August when the doctor prescribed it for him, but the pharmacy would not have received his prescription until Monday 18 August.

31. The man received his medication on Tuesday 19, after he had been in prison four days. This was within the expected contractual time frame of delivery and there is no evidence the man complained or that healthcare staff were concerned that his required medications were not in general stock in the prison over the weekend. However, the clinical reviewer noted it was the man's first time in prison and his level of stress was likely to have been increased, yet he had no medication to control his anxiety for four days. Although the clinical reviewer considers this did not impact on the man's death, he considered that waits of up to three to four days is too long. We do not consider that such delays are equivalent to standards expected in the community and we make the following recommendation:

    **The Head of Healthcare should ensure that prescribed medications are issued without delay.**

### Emergency response

32. When the man collapsed an officer radioed a code blue immediately and healthcare staff attended. A code blue is used to indicate chest pain, difficulty breathing, unconsciousness, choking, fitting, concussion or a severe allergic reaction. A nurse asked for an ambulance to be called, eight minutes later.

*33.* Prison Service Instruction 03/2013 contains a mandatory instruction that the control room should call an ambulance as soon as a code blue is called and that local procedures should ensure that staff understand they should not delay summoning emergency assistance such as by waiting for a member of healthcare staff or a manager to attend first. The instruction makes it clear

that it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required.

34. There appears to be considerable confusion about the operation of emergency procedures at Elmley. The investigator was given a protocol dated 2010 which was out of line with the mandatory requirements of the national instruction and stated that an ambulance should be called by the control room when advised by the prison's duty operational manager. The protocol was specifically for a medical emergency at night but a manager told the investigator that the protocol was the same day or night and that this was the current protocol. In a previous investigation into a death at the prison in February 2014, another investigator was given a protocol dated 2013, which staff had not followed.

35. In this case and six other investigations at Elmley since 2012, we have found that an ambulance was not called immediately in an emergency as it should have been. We are currently investigating other deaths at the prison where there are similar concerns. We have not yet received a response to a recommendation we made in September 2013 that the Governor needed to make active efforts to ensure that all prison staff follow national instructions.

36. Calling an ambulance immediately would not have affected the outcome for the man, as paramedics were present when his heart arrested and were able to administer emergency treatment. However, in other circumstances it could have serious consequences. It is apparent from this and other investigations into deaths at Elmley that emergency codes are frequently used inappropriately by prison staff to summon a member of healthcare staff when it is not an emergency. On 22 August, emergency codes were broadcast in the prison four other times and an ambulance was not called on any occasion.

37. Prison staff need to understand the importance of using the codes only in defined emergencies as set out in Prison Service Instruction 3/2013 and that misuse is dangerous. We have raised this issue with Elmley a number of times before but there seems to be either an unwillingness or inability to change the practice. We consider the Deputy Director of Custody for the Kent and Sussex Area, responsible for Elmley, needs to ensure that the prison operates appropriate emergency procedures in line with national instructions. We make the following recommendations:

**The Deputy Director of Custody for Kent and Sussex should ensure that Elmley has an appropriate emergency protocol in line with PSI 3/2013, that all prison staff at Elmley understand the need to use emergency medical codes in line with the national instruction and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation.**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that prescribed medications are issued without delay.

2. The Deputy Director of Custody for Kent and Sussex should ensure that Elmley has an appropriate emergency protocol in line with PSI 3/2013, that all prison staff at Elmley understand the need to use emergency medical codes in line with the national instruction and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation.

## ACTION PLAN: The man – HMP Elmley

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible |
|---|---|---|---|---|
| 1 | The Head of Healthcare should ensure that prescribed medications are issued without delay. | Accepted | Healthcare staff will continue to ensure that prescribed medications are provided to prisoners within agreed timeframes.<br><br>A review will take place to consider whether the current services should be re-commissioned or contract variations are required. This review will consider provision for pharmaceutical services at weekends, staffing resources and the amount of stock held onsite. | Head of Healthcare<br><br>31 May 2015 |
| 2 | The Deputy Director of Custody for Kent and Sussex should ensure that Elmley has an appropriate emergency protocol in line with PSI 3/2013, that all prison staff at Elmley understand the need to use emergency medical codes in line with the national instruction and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation. | Accepted | The Deputy Director of Custody (DDC) for Kent and Sussex has received assurance from the Head of Safety and Equalities at HMP Elmley that local procedures are in line with PSI 03/2013. The local emergency protocol has been reviewed, in consultation with NHS England and Kent Ambulance Trust.<br><br>The DDC will gain additional assurance through discussion of this requirement during regular bilateral meetings with the Governor and via staff engagement forums. The requirement for local emergency protocols will also be reinforced via the monthly Kent and Sussex senior management team meetings and the quarterly regional safer custody forum. | DDC Office<br><br>31 March 2015 |