Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Usk in February 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

Our Vision

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

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We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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.

The man died of a pulmonary embolism in February 2015 while at prisoner at HMP Usk. He was 28 years old. I offer my condolences to his family and friends.

The man had collapsed in the prison on the Saturday before his death and continued to report feeling unwell the next day. There are no healthcare staff on duty at Usk at the weekend, and I am concerned that, despite his symptoms, officers did not take him to hospital or seek help from the out of hours GP service. However, a nurse examined him on Monday morning and he had no concerning symptoms. Later that afternoon he collapsed and had a cardiac arrest when returning to the prison's healthcare centre for further tests. I am satisfied that there was a prompt emergency response and it would have been difficult to have predicted or prevented his death.

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 **October 2015**

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Summary

Events

1. The man was sentenced to 12 months imprisonment on 14 November 2014 and was sent to HMP Parc. At a GP review the next day, a doctor noted that he had inflamed leg veins and prescribed a pain-relief gel. There were no symptoms of deep vein thrombosis (DVT). On 27 November, a GP prescribed an antidepressant that he had been taking in the community.

2. On 4 December, the man transferred to HMP Usk. At an initial health screen, a nurse noted his history of depression. She recorded his weight as 89.6kg and that his blood pressure was high (146/90).

3. A manager became concerned that the man was not eating much and a nurse discussed this with him on 17 December. He said he did not like the prison food and had no appetite. On 30 December, staff began to monitor him under Prison Service suicide and self-harm prevention procedures. He began cognitive behavioural therapy. On 26 January, a doctor noted that he was a healthy weight. The next day, staff ended the suicide and self-harm prevention procedures but continued to monitor his health and diet.

4. On Saturday 21 February, the man collapsed. Healthcare staff are not on duty at the weekend and officers took him to his cell and arranged a healthcare appointment for Monday morning. They did not seek medical advice. On Sunday 22 February, his cellmate reported that he still felt unwell and had a tight chest. Officers decided to monitor him and again did not seek any medical help or advice.

5. On Monday morning, a nurse examined the man and found no concerns. She arranged to do an electrocardiogram (ECG) test that afternoon. Just after 1.30pm, he collapsed. Officers radioed an emergency, nurses attended, and the control room immediately called an ambulance. He was conscious at first, but his condition deteriorated quickly and he appeared to go into cardiac arrest. Nurses began cardiopulmonary resuscitation. Paramedics took him to hospital, but could not stabilise him and he was pronounced dead at 3.21pm.

Findings

6. The man died suddenly from a pulmonary embolism as a result of deep vein thrombosis, with no evident risk factors. It is not possible to know whether his death could have been prevented had he received medical care over the weekend, but we consider that prison staff should have sought help, either by taking him to hospital or using the out of hours service.

Recommendation

- The Governor should take active steps to ensure that all prison staff understand that, when healthcare staff are not on duty, they should call the out of hours service or an ambulance when prisoners report pain or have other concerning symptoms suggesting they are unwell.

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 her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed five members of staff and two prisoners on 16 April.

9. Health Inspectorate Wales (HIW) reviewed the man's clinical care.

10. We informed HM Coroner 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 mother to explain the investigation. She was concerned that he had been ill for the whole time he was in prison, had lost around three stone and was depressed. She said the prison did not take her concerns seriously and did not monitor him appropriately. She believed that officers had intimidated him.

12. The man's mother received a copy of the draft report. She pointed out some factual inaccuracies. This report has been amended accordingly. She also raised a number of issues 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.

Background Information

HM Prison 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. Nurses are on duty from 8.00am to 4.30pm, Mondays to Fridays. There is a GP surgery every weekday morning and doctors are on call until 6.30pm each weekday. Out of hours and weekend services are provided through the Gwent Out of Hours cover, which provides telephone triage and signposting by a nurse or doctor. Calls that require medical intervention are directed to Nevill Hall Hospital, Abergavenny.

HM Inspectorate of Prisons

14. The most recent inspection of Usk was in May 2013. Inspectors were generally very positive about the prison but noted that relationships between staff and prisoners, which they had previously described as excellent, had deteriorated. Although they observed some good and caring interactions, some staff appeared indifferent to prisoners. Survey results about the food were more positive than comparator prisons, but many prisoners they spoke to were negative about the quality of the food. Prisoners were positive about health services and inspectors noted there was a good service with regular GP clinics. Prisoners could see nurses each weekday at triage clinics and inspectors noted clinically thorough and polite consultations.

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 recently published report for the year 2013 - 2014, the IMB noted that a change in healthcare provision at the prison had led to a more effective service. The IMB was concerned that reduced staffing at the prison could affect the management of unforeseen incidents.

Previous deaths at HMP Usk

16. The man was the sixth prisoner to die of natural causes at the prison since January 2013. There were no significant similarities with the circumstances of these deaths, although we have previously recommended that staff should call an ambulance immediately when a prisoner complains of chest pains.

Key Events

17. On 28 August 2014, the man was convicted of sexual offences and released on bail. On 14 November, he was sentenced to 12 months in prison and sent to HMP Parc. At an initial health screen, a nurse noted that he suffered from depression for which he said he had been prescribed citalopram. He did not have any medication with him when he arrived at Parc. He said he had no thoughts of suicide or self-harm. The prison requested his medical records from his community GP.

18. On 15 November, a prison GP examined the man and noted that he had phlebitis (inflammation of veins, usually in the leg) which was painful, but he had no symptoms of deep vein thrombosis. His blood pressure was slightly high (134/89) and his pulse rate was normal. The GP prescribed a pain relief gel for his leg, and made a note to wait for confirmation from his community GP that he was taking citalopram before he prescribed it. His GP records arrived in the prison on 16 November, but he was not prescribed citalopram until 27 November.

19. On 4 December, the man transferred to Usk. At an initial health assessment, a nurse noted his history of depression. She recorded his blood pressure was high (146/90) and he weighed 89.6kg. The next day, he was prescribed citalopram and pain relief gel.

20. At 2.15am on 6 December, the man went to hospital as an emergency because he had chest and shoulder pain. The hospital diagnosed a chest infection and prescribed antibiotics. He returned to prison at 6.40am.

21. On 10 December, a prison manager spoke to the man because staff had noticed that he was not eating much. She noted in his prison record that staff should monitor him and reported her concerns to healthcare staff.

22. On 12 December, the man had an appointment with a prison GP and said he was depressed and not eating much. The GP prescribed sertraline (another anti-depressant) to replace citalopram, because the man did not think the citalopram was effective. He told the GP that he was not eating because he had no appetite and did not like the food; he was not trying to harm himself and it was not a protest. The GP referred him to the mental health team because the man felt low and anxious.

23. A nurse saw the man on 17 December, to discuss his eating habits. He said that he ate small amounts and was taking his medication. She noted that he had lost three kilograms in the past month and weighed 86.6kg. He had slightly high blood pressure (134/88) and his pulse rate was normal. Staff continued to monitor how much food he ate.

24. The nurse saw the man again on 22 December because the sertraline was causing adverse side effects. She explained that because of staff sickness, no one from the mental health team had been able to see him yet. She noted that he said he had no thoughts of suicide or self-harm. Later that day, a prison GP saw him and prescribed lofepramine instead of sertraline.

25. On 30 December, a prison manager began Assessment, Care in Custody and Teamwork (ACCT) procedures, the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm, because the man was still not eating much, and losing a lot of weight. He weighed 84.4kg, (a loss of 5.2kg since 4 December). A nurse referred him to the doctor. He saw a GP the next day. The GP planned that a doctor would review him weekly.

26. On 2 January 2015, a nurse noted that the man had lost more weight and was now 82.8kg. She discussed him with a mental health nurse and they agreed that he should have blood tests and be prescribed food supplements. A prison GP saw him later that day, and noted he had eczema on his neck. The results of the blood tests were normal.

27. On 7 January, a nurse from the mental health team saw the man and referred him for cognitive behavioural therapy, to begin the next week. He continued to see nurses and doctors and have his weight monitored. On 26 January, a prison GP noted that, although he had lost weight, his Body Mass Index (BMI) was healthy. He recorded that the man felt better after speaking to the mental health team and this contact should continue.

28. The next day, a Supervising Officer held an ACCT case review and closed the ACCT. He noted that the doctor had said that the man's BMI was healthy although he did not eat much, and mental health nurses had no concerns about him. The health checks would continue. On 6 February, a psychiatrist assessed him and concluded he had full mental capacity to make decisions. Prison and healthcare staff continued to monitor his eating.

29. At about 2.15pm on Saturday 21 February, the man collapsed in the prison, outside the library. Prisoners alerted staff and an officer attended. He recorded that the man was sitting up but disorientated. He said he had felt dizzy and fell. He said he had taken no drugs and had eaten lunch. After a few minutes, he walked back to his cell with officers. The officer discussed the incident with a prison manager, and they decided not to call the out of hours medical service because they thought it was most likely he had collapsed because he had not eaten. Officers monitored him over the afternoon and booked him an urgent healthcare appointment on Monday morning. The officer saw him collecting his meal later that day, and noted he looked better. He told the evening officers about the incident during their handover.

30. At 11.30am the next day, the man told his cellmate that he felt unwell and had a tight chest. The cellmate told an officer, who went to see him in his cell and noted he was sitting on a chair gasping slightly. He said his chest felt tight and he had no history of heart problems or other health problems. The officer informed a Supervising Officer, who went to see him. The SO said that the man told him that he was OK but in a little pain, although he did not specify where. Later that day, the SO checked on him, who said he felt a bit better.

31. At 9.20am on Monday, a nurse examined the man. She took his observations and noted he had a regular pulse rhythm, but at 97 beats per minute, it was near the top of the normal range. His blood pressure was normal at 115/86. She

arranged for him to come back later in the day for an electrocardiogram (ECG) test (which records the rhythm and electrical activity in the heart).

32. At around 1.30pm, on the way to the healthcare centre for his ECG, the man collapsed and hit his head on a door frame, causing a bleeding wound. This was on an outside door near the healthcare centre, in view of the wing office. Officers and prisoners saw him fall. An officer radioed a code red medical emergency (to indicate bleeding or a broken bone), and a few seconds later another officer radioed a code blue (which indicates a collapse, loss of consciousness or difficulty breathing). The control room called an ambulance immediately.

33. Two nurses and a healthcare assistant attended with emergency equipment. The man was sitting and leaning against the wall. He was awake and surrounded by prison staff. They took observations, and noted his oxygen saturations were below normal (77%), his pulse was within normal range (86 beats per minute) and he had high blood glucose levels (9.7). They could not take his blood pressure because he was agitated and hyperventilating. He kept taking the oxygen mask from his face when nurses tried to apply oxygen.

34. The man's condition deteriorated and a nurse noted he was unstable, and about to go into cardiac arrest. They laid him on the floor and attached a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest to re-establish a normal heart rhythm). He had no pulse and the healthcare staff started cardiopulmonary resuscitation, but the defibrillator did not advise a shock. At 1.56pm, a first response paramedic arrived and helped with the resuscitation attempt. An ambulance arrived at 2.10pm and paramedics took over emergency treatment with healthcare staff assistance. The ambulance left for the hospital with him at 2.35pm. At 3.21pm, a hospital doctor pronounced him dead.

Contact with the family.

35. At 2.45pm, a family liaison officer contacted the man's mother and told her that her son had been taken to hospital. The family liaison officer and a prison chaplain arrived at the hospital at 3.40pm. The man's mother arrived shortly afterwards, and they told her her son had died. They spent some time with her at the hospital and visited her at home, the next day. In line with Prison Service instruction, the prison paid towards the cost of the funeral.

Support for prisoners and staff

36. Notices were issued to inform staff and prisoners of the man's death. The prisoners we interviewed said that staff had supported them. On the day he died, a manager debriefed the staff involved in the emergency response and offered support.

Post-mortem report

37. A post-mortem examination found that the man had died from pulmonary thrombo-embolus and deep vein thrombosis. The pathologist commented that there were large clots obstructing the main pulmonary artery to each lung, which would account for his shortness of breath and collapse.

Findings

Clinical care

38. HIW noted that, although there was initially a delay in prescribing the man's anti-depressant medication at Parc, there was ongoing assessment of his mental health and low mood throughout his time in prison. Doctors changed his medication in response to his continuing low mood and appropriately referred him to the mental health team for support.

39. Staff identified concerns about the man's poor nutrition within a week of him arriving at Usk and monitored this. Healthcare staff saw him at least weekly and monitored his weight and nutrition. Appropriate action was taken to address his continuing weight loss, including giving him dietary supplements and advice about his dietary intake. At the end of January, his body mass index was within the normal range. HIW was satisfied that during his time at Usk, he was able to raise health issues with the healthcare team and that they responded appropriately.

40. HIW noted that the man had no clear risk factors for deep vein thrombosis or pulmonary embolism. There was no evidence that he had had any recent prolonged period of immobility or any obvious event which could have caused damage to a vein. He had no known blood disorders that influenced his risks and he had no history of cancer or heart disease. He was a young man and his body mass index was within normal range.

41. The man's symptoms appear to have been intermittent and transient over the weekend of 21 and 22 February 2015. HIW concluded that it was not possible to say that his death could have been prevented, had he received medical or hospital care over the weekend before his death. However, we are concerned that staff did not seek advice from the out of hours GP service or take him to hospital when he was unwell over the weekend.

42. On Saturday 21 February, when the man collapsed, staff decided not to call for out of hours medical advice or an ambulance, as they thought it was because of his poor eating habits. They decided to monitor him and booked an urgent healthcare appointment for Monday morning. The next day, he still felt unwell and has some breathing difficulties. Despite this, the staff again did not call for out of hours advice or an ambulance, although they knew he had collapsed the day before.

43. HIW said that they would have expected staff to have called an ambulance when the man collapsed and continued to feel unwell, or at least sought medical advice from the out of hours service. We agree that this should have been done. We understand that, since his death, the prison had issued guidance to officers to call the out of hours doctor or an ambulance when a prisoner presents with a severe health condition (including when a prisoner collapses). We have raised the need to call an ambulance when prisoners report chest pain in previous investigations into deaths at Usk. We are concerned at the apparent hesitation to seek professional advice and help when healthcare staff are not on duty. As Usk does not have 24-hour health provision, it is important that all officers fully

understand that they should seek medical advice whenever there are concerns about a prisoner's health. We make the following recommendation:

The Governor should ensure that all prison staff understand that, when healthcare staff are not on duty, they should call the out of hours service or an ambulance when prisoners report pain or have other concerning symptoms suggesting they are unwell.

Action plan

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Governor should take active steps to ensure that all prison staff understand that, when healthcare staff are not on duty, they should call the out of hours service or an ambulance when prisoners report pain or have other concerning symptoms suggesting they are unwell	**Accepted**	Notice to Staff and Governor's Order will be re-issued in August 2015, ensuring that all prison staff understand that when healthcare staff are not on duty, they should call the out of hours service or an ambulance when prisoners report pain, or have other concerning symptoms suggesting they are unwell. The Governor's Order will be placed prominently in wings and departmental offices in the prison. Further steps will be taken to educate all staff about this at monthly full staff meetings, through Governor's Blogs and local staff Departmental meetings. The prison will continue ongoing work with Healthcare to further improve joint working and communication between Healthcare and disciplined residential staff at HMP Usk, facilitating joint training where possible and improving communication between both departments. This will be monitored through the quarterly Prison Partnership Board meetings	Governor Target date for completion: 31 August 2015 30 November 2015	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			Staff and prisoners will be further educated in relation to signs and symptoms requiring immediate HealthCare intervention, and in first aid awareness training provided by Aneurin Bevan. Two joint incident training exercises are to be planned and conducted between the Head of Residence at Usk and Head of Healthcare in dealing with out of hours incidents when prisoners report pain or have other concerning symptoms suggesting they are unwell. Any lessons learned from this exercise will be logged, fed into general practice and remedial action evidenced and reviewed. The first of these exercises will be undertaken by August 2015.	31 December 2015 31 October 2015	