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 in August 2014 at HMP Littlehey

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 a heart attack of a man in August 2014, at HMP Littlehey. I offer my condolences to his family and friends.

One of our investigators carried out the investigation. A clinical reviewer reviewed the man's clinical care. The prison cooperated fully with the investigation.

The man was released from prison in February 2013, but recalled in May 2013, after breaching the terms of his licence. In September, a prison doctor at HMP Brixton referred him to a cardiologist who requested an angiogram. There was some delay at the hospital, but an appointment was eventually arranged for 9 July 2014. In June, Brixton cancelled the appointment because the man was due to transfer to Littlehey on 7 July and the doctor did not regard the angiogram as urgent. At Littlehey, a doctor noted that the man had missed an angiogram appointment, but because he had no obvious heart problems, did not immediately refer him for another appointment.

In August 2014, an officer found the man unresponsive in his cell and radioed an emergency code. Officers did not attempt resuscitation, but waited for nurses to arrive and start treatment. When paramedics arrived, they took over emergency care but declared the man dead shortly after.

The clinical reviewer found that the overall standard of care the man received at Littlehey was equivalent to that which he could have expected to receive in the community. It was unfortunate that the man transferred just two days before a medical appointment for which he had been waiting some months, but I accept the clinical judgement that this was not urgent. Another appointment should have been arranged when the man arrived at Littlehey in July, but I recognise that this would have been unlikely to have taken place before he died. A specialist heart disease nurse had examined the man the week before he died, but found no cause for concern and I am satisfied that his death was not foreseeable.

I am concerned that prison staff did not call an ambulance as soon as an emergency code was called. I am also concerned that the first officers on the scene lacked first aid training and did not begin basic life support immediately they found the man unresponsive. It does not appear that a swifter response would have changed the outcome for the man, but it could be crucial in other circumstances.

The version of my report, published on my website, has been amended to remove the names of the man who died and those of my staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2015**

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SUMMARY

1. The man was sentenced to three years and six months in prison in July 2011. In February 2013, he was released from HMP Littlehey on licence. He was recalled to prison in May 2013, after breaching his licence conditions.

2. At an initial health screen at HMP Wormwood Scrubs in May, a nurse noted that the man had a history of chronic fatigue syndrome (Myalgic Encephalomyelitis – ME) and skin cancer. On 6 June, the man transferred to HMP Brixton and had frequent contact with the healthcare services as he had high blood pressure and felt constantly tired. On 10 September, an X-ray showed the man had an enlarged heart and an ECG indicated a possible irregular heartbeat. A prison GP referred the man to a cardiologist for assessment.

3. A cardiologist at King's College Hospital, London, examined the man on 23 December and requested an angiogram (a diagnostic test where a tube is inserted into the heart to help diagnose problems). The man began to take medication to treat high blood pressure. The hospital originally arranged the angiogram for May 2014, but then re-arranged this for 9 July 2014. The prison later cancelled the appointment because the man was due to transfer to Littlehey. They did not hold up the transfer as the doctor did not regard the angiogram as urgent.

4. On 7 July 2014, the man transferred to Littlehey. At an initial health screen, a nurse recorded that he had blood pressure problems and had suffered heart attacks in the past. (Although there is no record of this.) On 9 July, a prison GP assessed the man and noted he had no symptoms of heart disease. The GP recorded that Brixton had cancelled the man' angiogram appointment. She did not make another referral to the local hospital.

5. At 8.50am on 2 August, a prison officer found the man unresponsive in his cell. The officer immediately radioed a code blue emergency but he and other officers present did not begin basic life support. Nurses arrived and began to attempt resuscitation. At 8.55am, five minutes after the officer called the emergency code, the control room officer called an ambulance. Paramedics arrived at the man' cell at 9.12am and continued trying to resuscitate him. At 9.35am, they confirmed that the man had died.

6. We agree with the clinical reviewer that overall the standard of care provided to the man at Littlehey was equivalent to that which he could have expected to receive in the community. We consider that the prison GP should have re-referred the man for an angiogram when he arrived but recognise this would not have affected the outcome. The man would not have received an appointment before his death and the clinical reviewer considered it unlikely it would have prevented it, had it gone ahead. None of the officers who found the man were trained in basic life support and were not confident enough to attempt to resuscitate him. The communication room did not call an ambulance immediately when the medical emergency code was broadcast. We make three recommendations about these matters.

THE INVESTIGATION PROCESS

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

8. A clinical reviewer was commissioned to review the man's clinical care at the prison.

9. The investigator obtained copies of the man' medical records and relevant extracts from his prison record. He interviewed members of staff at Littlehey in September and October 2014. The investigator informed the Governor of the preliminary findings of the investigation.

10. We informed HM Coroner for the South and West Cambridgeshire 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 sister, his nominated next of kin, to explain the investigation. The man's sister did not have any specific issues for the investigation to consider.

12. The man sister received a copy of the draft report. She 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 also received a copy of the draft and their response to our recommendations and action plan is added at the end of this report.

HMP LITTLEHEY

13. HMP and YOI Littlehey in Cambridge is a medium security prison holding approximately 1200 men over 21 and young adult men between 18 and 21 in adjoining sites.

14. Cambridgeshire and Peterborough NHS Trust commissions healthcare services. The healthcare centre is open from 7.30am to 5.00pm, Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services, and there are a range of nurse-led clinics. Cambridgeshire and Peterborough NHS run an out of hours service. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

15. The most recent inspection of Littlehey was in October 2011. The Inspectorate found the prison had made good progress in addressing the healthcare-related recommendations made after an inspection in 2007. Prisoners were generally happy about access to, and communication with, healthcare staff. Healthcare facilities were satisfactory.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers who help to ensure that prisoners are treated fairly and decently. In its most recent report, for the year ending January 2013, the IMB noted that healthcare services had suffered because of the length of time it had taken to change the contract for GP services. During this period, 30 locum doctors had visited Littlehey and most were unfamiliar with prison. They concluded that healthcare was continually understaffed and that the recruitment process needed revising.

Previous deaths at Littlehey

17. The man was the fifth prisoner to die from natural causes at Littlehey since 2012. We have raised the issue of emergency response before.

KEY EVENTS

18. The man was sentenced to three years and six months in prison on 8 July 2011. On 22 February 2013, he was released from HMP Littlehey on licence but, on 23 May, his licence was revoked because he had breached his conditions. On 24 May, he was taken to HMP Wormwood Scrubs.

19. At the man's initial health screen, Nurse A noted that the man had a history of chronic fatigue syndrome and skin cancer. The man did not smoke cigarettes or drink alcohol. A prison GP saw the man and noted that he did not have any current medical health problems. He planned to monitor the man's blood pressure as it had fluctuated in the past, and the man had complained about tiredness. While at Wormwood Scrubs, the healthcare team did not record any serious concerns about the man.

20. On 6 June, the man transferred to HMP Brixton. He had frequent contact with the healthcare team because he complained of fatigue and his blood pressure fluctuated. On 19 June, a dermatologist (skin specialist) assessed the man. The dermatologist found that the man had skin damage from sun exposure (actinic keratosis) and prescribed a cream to treat the problem

21. On 30 August, a prison GP, A, examined the man and noted he had a chronic cough. He ordered a chest X-ray. On 10 September, the doctor told the man the chest X-ray showed he had an enlarged heart. The doctor examined the man's chest and did not detect anything of concern. An ECG showed that the man might have an irregular heartbeat and the doctor referred the man to a cardiologist at King's College Hospital, London for assessment.

22. King's College Hospital postponed the man's cardiology appointment on several occasions, but, on 23 December, a cardiologist, A, examined the man. In a letter to the prison, the cardiologist noted that the man had severe left ventricular systolic dysfunction (a failure of the pump function of the heart). The doctor requested that the man had an angiogram (a diagnostic heart test also known as cardiac catheterisation), to investigate the possibility of further heart problems.

23. The cardiologist prescribed ramipril (a medicine to treat high blood pressure and to improve survival after a heart attack) and asked the prison to increase the dose over time. The man started taking ramipril on 24 December.

24. On 14 January 2014, prison GP A checked the man' medication and did not note any concerns. The healthcare team at HMP Brixton frequently reviewed the man's medication and general health. They recorded no issues about the man's heart function or management of his medication during this period.

25. Healthcare staff arranged for the angiogram to take place at King's College Hospital on 1 May, but the hospital cancelled the appointment because of high demand and arranged another appointment for 9 July. However, on 24 June, the prison cancelled the appointment because the man was due to transfer to HMP Littlehey on 7 July. Prison GP A considered the man fit for transfer and that the appointment for his angiogram was not urgent.

26. On 7 July, the man transferred to Littlehey. Nurse A at Littlehey carried out an initial health screen and recorded that the man had blood pressure problems and had suffered heart attacks in the past (although there is no evidence of this in his medical records). The nurse referred the man to the prison GP.

27. On 9 July, Prison Dr A saw the man and recorded that he had no symptoms of heart problems. The man said he did not have any chest pain or shortness of breath. The doctor recorded that he had missed his angiogram appointment at Kings College Hospital. She queried whether to make a referral to a local cardiac service as he was due to be released in four or five months (a routine referral would take that long), and he did not have any obvious sign of cardiac problems. She told the investigator that in such cases she would normally discuss with a registrar at the hospital before making a referral, but had not done so before the man died.

28. On 23 July, a specialist heart disease nurse reviewed the man. The nurse found no signs of heart problems and took a blood test, which was normal. She arranged a further review in three months.

Events on 2 August

29. At approximately 7.00am on 2 August, Officer A checked that all the prisoners on the man's landing were present in their cells. The officer told us that the man appeared to be sleeping on his back, and he had no concerns about him. At 8.45am, the officer started to unlock the cells.

30. At 8.50am, Officer A opened the man's cell and realised that he had not moved since earlier. He went in and found the man unresponsive and not breathing. The officer radioed a code blue medical emergency, which indicates a prisoner is unconscious or has breathing problems.

31. Officer A called for help from Officer B and Officer C who were on the wing. None of the officers were trained in first aid or basic life support and they did not attempt to resuscitate the man. A supervising officer, A, arrived and asked for an ambulance. At 8.55am, the control room officer called an ambulance.

32. At 8.56am, Nurse A and Nurse B arrived at the cell. The nurses moved the man into a flat position on his bed and started cardiopulmonary resuscitation. They checked for signs of life with a defibrillator (which analyses heart rhythm and delivers electric shocks to restart the heart). The defibrillator did not detect a shockable rhythm and the nurses continued cardiopulmonary resuscitation.

33. The nurses asked a custodial manager, who had also responded to the emergency call, to help with resuscitation. He was the only other person present trained in first aid. Paramedics arrived at the cell at 9.12am. They continued emergency treatment, but, at 9.35am, they pronounced the man dead.

Family liaison

34. The prison appointed a family liaison officer and that afternoon, the family liaison officer and the deputy family liaison officer visited the man's sister, his nominated next of kin, and informed her of his death. The Governor wrote to the man's sister to offer condolences and support. The family liaison officer remained in contact with the man's sister and offered support. The prison organised the man's funeral and contributed to the costs in line with national guidance.

Support for staff and prisoners

35. The duty governor debriefed staff involved in the emergency response before they left the prison. She directed the staff to the available support services if they needed them.

36. A Governor's notice informed staff and prisoners of the man's death and the support available. The prison reviewed prisoners identified as at risk of suicide and self-harm in case the news of the man's death had adversely affected them.

Post-mortem report

37. After a post-mortem examination, the Coroner gave the cause of death as ischaemic heart disease, related to high blood pressure. The report noted that there was no significant underlying coronary artery disease.

ISSUES

Clinical Care

38. The clinical reviewer concluded that the overall standard of care the man received was equivalent to that which he could have expected to receive in the community. Healthcare staff appropriately managed the man's medical records, health needs, conditions and treatments. However, we consider that healthcare staff should have made another referral for an angiogram when he transferred to Littlehey.

39. We recognise that it is unlikely that the man would have received a further appointment before his death, but it is important that prisoners have appropriate continuity of care when they transfer. We are surprised that the man transferred from Brixton just two days before his appointment, for which he had been waiting some months. However, we accept that the reasons for the investigations were not sufficiently urgent as to require a medical hold on his transfer.

40. When Dr A saw the man on 9 July, she recorded that he had missed his angiogram appointment at King's College Hospital. The doctor told us she considered the man's prison medical records, including the latest ECG results from 10 September 2013. She said this gave her sufficient information about the man's healthcare issues and history.

41. Dr A was aware that the man was going to be in prison for another four to five months. As he presented without heart disease symptoms, she concluded that the angiogram was not urgent. The doctor said that she would have organised an urgent referral to hospital if the man had displayed any symptoms of heart disease, but a routine appointment would take some months to arrange and even an urgent appointment would take weeks. She had intended to discuss this with a registrar at the hospital but had not done so before the man died. A specialist heart disease nurse had examined the man the week before he died but found no cause for concern.

42. The clinical reviewer said that the man's death was not foreseeable but it is not possible to say with certainty if it was preventable, even if he had had the angiogram before 2 August. The post-mortem examination showed that the man did not have any significant underlying artery disease with only minor narrowing of the arteries. Even if he had undergone a procedure to alter coronary circulation, there is little evidence that such a procedure would have prevented his death from ischaemic heart disease.

43. However, the clinical reviewer considered that it would have been appropriate for healthcare staff at Littlehey to re-refer the man to local cardiology services. Prison Service Order (PSO) 3050, Continuity of Healthcare, requires that every prison should ensure appropriate continuity of care when prisoners transfer. We agree with the clinical reviewer that any prisoner who has missed important appointments due to a prison transfer should routinely have another referral. We make the following recommendation:

The Head of Healthcare should ensure that referrals for important hospital appointments are routinely re-arranged when a prisoner transfers to Littlehey,

Emergency Response

44. 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 communication room calls an ambulance automatically, as soon as a member of staff calls an emergency code.

45. Littlehey has a comprehensive local medical emergency response protocol reflecting PSI 03/2013. We are satisfied that the officer who responded to the man understood the code system and used it appropriately. However, the control room did not call an ambulance for another five minutes, after a supervising officer one.

46. The communication room officers, Officer D and Officer E agreed that there had been a delay. They told the investigator that they wanted to gather as much information as possible for the ambulance service before calling them. Officer D said he had searched the prisoner's records, and then called a supervising officer present at the scene for more information. He did not call an ambulance until five minutes after Officer A radioed the emergency code, and only after the supervising officer had confirmed that one was required.

47. 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". Although it is unlikely that the failure to call an ambulance earlier would have affected the outcome for the man, in other circumstances it could be crucial. It is possible for control room staff to update the ambulance service with further details once the ambulance is on its way. We make the following recommendation:

    The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is received.

First Aid Training

48. After Officer A raised the alarm when he found the man unresponsive, Officer C and Officer B joined him quickly. None of the officers attempted to resuscitate the man, but waited for the nurses to arrive. Only one member of the prison staff, a custodial manager, was first aid trained. The custodial manager arrived at the man's cell after the healthcare team and helped the nurses with chest compressions.

49. The custodial manager told us that when he arrived at the man's cell, he noticed that the officers present were upset because they had not known what to do to help the man. The officers stood at the cell door but did not help the

nurses. Officer A told us that he had not received any first aid training at Littlehey and he was concerned that he could have been personally liable if he had made a mistake when helping the man.

50. The man lived on I wing, which is for older prisoners. We found that the officers working on I wing were concerned about their lack of first aid training but the prison has not implemented any training plan.

51. The clinical reviewer noted that it is not possible to say whether the outcome would have been different for the man if officers had begun cardiopulmonary resuscitation immediately. Outcomes for people needing cardiopulmonary resuscitation in all settings are often not successful, but to be effective it needs to begin quickly. The clinical reviewer shares our concern that there are not sufficient staff with the necessary training to start potentially life-saving treatment before healthcare staff arrive. This is particularly important as Littlehey has an ageing population and does not have 24-hour health cover. We make the following recommendation:

    The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that referrals for important hospital appointments are routinely re-arranged when a prisoner transfers to Littlehey,

2. The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is received.

3. The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency.

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ACTION PLAN: Mr The man – HMP Littlehey

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that referrals for important hospital appointments are routinely re-arranged when a prisoner transfers to Littlehey.	Accepted	Staff will ensure that appropriate systems are in place so that referrals for important hospital appointments are routinely rearranged when required.	February 2015 Healthcare / Senior Clinician
2	The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is received.	Accepted	Reminders have been issued to all staff highlighting the emergency medical codes protocol and this information has been displayed within the communications room.	Complete Safer Custody
3	The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency.	Accepted	HMP Littlehey will continue to meet the requirements of the national PSI with regards to the number of sufficiently trained first aid staff on duty in the prison. A local training plan has been put in place to ensure that additional staff on I Wing receive first aid training.	Complete Health and Safety