



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Wealstun in February 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 from a heart attack of a man at HMP Wealstun in February 2014. He was 37 years old. I offer my condolences to his family and friends.

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

The man received an indeterminate sentence in November 2012 and arrived at Wealstun in April 2013. He had treatment for sleeping problems and irritable bowel syndrome, and was also given advice to help him give up smoking. No major health concerns were recorded and he had infrequent contact with healthcare services. One morning in February, he told staff he was experiencing chest pains. His condition deteriorated very quickly and he soon stopped breathing. Staff attempted to resuscitate him. Paramedics attended and, after further resuscitation attempts, pronounced him dead.

The clinical reviewer concludes that the man's standard of healthcare in prison was equivalent to that he could have expected to receive in the community. Moreover, staff are to be commended for their efforts to save his life.

However, there are still lessons to be learned by the prison from the man's untimely death. I am concerned that the officer who first found him with chest pain did not continue to monitor his condition until help arrived. While there were sufficient first aid staff on duty on the night that he died, they were unaware of the availability of some emergency medical equipment. I am also concerned that his family was informed of his death by telephone, rather than in person as Prison Service guidance requires.

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

October 2014

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SUMMARY

1. The man was remanded to HMP Leeds in July 2012 and, in November, received an indeterminate sentence for arson. He had a number of previous convictions and had been in prison before. He had a history of drug and alcohol abuse and had suffered from depression and irritable bowel syndrome. No other significant medical problems were recorded.
2. On 5 April 2013, the man transferred to HMP Wealstun. After initial health screenings, he had infrequent contact with healthcare staff apart from to receive medication to help with sleeping problems and irritable bowel syndrome. He also had help to try and give up smoking.
3. On morning in February, the man told an officer that he was experiencing chest pain. The officer radioed for the night manager for help and went back to the wing office. When staff went to his cell around five minutes later, his condition had deteriorated significantly. His breathing was shallow, his colour had changed and they could get no response from him. The night manager radioed an emergency medical code which led to an ambulance being called. He stopped breathing and the staff attempted to resuscitate him. Paramedics arrived with emergency equipment shortly afterwards but were unable to resuscitate him. They pronounced him dead at 5.15am.
4. The clinical reviewer concluded that the care the man received at Wealstun was equivalent to that he could have expected to receive in the community. Once staff realised that his health had deteriorated, a medical emergency code was used correctly and the control room automatically called an ambulance. However, we are concerned that the officer who found him with chest pain failed to monitor him and could have requested help sooner. We are also concerned about current levels of first aid training at the prison and access to emergency medical equipment. His family were not informed of his death in person, contrary to Prison Service guidelines. We make three recommendations.

THE INVESTIGATION PROCESS

5. The investigator issued notices to staff and prisoners at HMP Wealstun informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
6. NHS England commissioned a clinical reviewer to assess the man's clinical care in prison.
7. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. He and the clinical reviewer interviewed six members of staff at Wealstun on 14 April. He wrote to the Governor about the preliminary findings of the investigation.
8. We informed HM Coroner for the County of West Yorkshire (Eastern District) of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report. The West Yorkshire Police were not able to provide toxicology results until 23 June and we could not conclude our investigation until we had these results.
9. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. His mother, his nominated next of kin, did not have any specific issues for the investigation to consider.
10. The family received a copy of the draft report. They were concerned that the man was left alone for a time after he first reported chest pains in February.
11. The service also received a copy of the draft report. Their response to our recommendations and action plan is included.

HMP WEALSTUN

12. HMP Wealstun is a Category C prison in West Yorkshire holding up to 832 prisoners. NHS Leeds provides healthcare services at Wealstun. There is a part-time GP, with an on-call facility outside of normal working hours. There is no inpatient facility.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Wealstun was in August 2011. Inspectors recommended a review of emergency equipment, to ensure sufficient staff were trained to use defibrillators and that equipment was appropriately located.

Independent Monitoring Board

14. 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. The IMB for Wealstun has not produced an annual report for the past five years. We contacted the IMB and they did not have any issues for this investigation to consider.

Previous deaths at Wealstun

15. The man was the first prisoner to die from natural causes at Wealstun since 2010.

KEY EVENTS

16. The man was remanded to HMP Leeds in July 2012 and received an indeterminate sentence for arson in November. He had a number of previous convictions and had been in prison before. He had a history of alcohol and drug abuse and had suffered from depression and irritable bowel syndrome.
17. On 5 April 2013, the man transferred to HMP Wealstun. At his initial health screen, staff recorded that there was some history of heart problems in his family, but his blood pressure was normal. No concerns were recorded.
18. A prison GP reviewed the man on 2 July after he reported stomach and bowel pain. She diagnosed possible inflammatory bowel disease and prescribed medication to relieve his symptoms. She also requested blood tests and an ultrasound scan and staff referred him to hospital that day.
19. On 23 July, another prison GP saw the man after he reported continuing abdominal pain. She told him the results of his previous blood tests were normal. She gave him dietary advice and prescribed medication to treat irritable bowel syndrome. The next day he had a negative test for bacteria in his digestive system.
20. The man attended hospital for an ultrasound scan on 25 September 2013. On 30 September, the hospital wrote to the prison to say that the results of the scan were normal. Over the following months, he saw healthcare staff infrequently for help with anxiety, sleeping problems and irritable bowel syndrome. He received medication to help him give up smoking. No major concerns were recorded.

February 2014

21. At around 4.20am one morning in February, an officer support grade (OSG) responded to the man's cell bell and opened the observation panel. He was standing with his hand on his chest, and told the OSG that he was experiencing chest pain. The OSG said he did not appear distressed or agitated. He radioed a custodial manager, the night orderly officer in charge of the prison, for help. He did not stay with the man but went back to the wing office to wait for the manager.
22. Around five minutes later, the manager arrived and went with the OSG to the man's cell. The OSG looked through the observation panel and saw him lying on his bed. He called out, but he did not respond. The manager unlocked the cell and they went in. The OSG said that the man's breathing was shallow and the colour in his face had changed. The manager was unable to rouse him by shouting his name or shaking him. He radioed a code blue emergency call (which indicates when a prisoner is unconscious or has respiratory problems). Control room staff called an ambulance at 4.31am.
23. Two officers arrived to help, shortly afterwards. At around 4.35am, Officer A and the manager went to the wing office to take telephone instructions from

the ambulance service about the man's emergency treatment. The ambulance service advised that they should lie him on the floor and clear his airway. The manager relayed this message to the officers. Two minutes later he went to the prison gate area to escort a paramedic to the wing. Officer A remained in the wing office and passed information between the ambulance service and the officers in the cell.

24. At 4.40am, Officer B radioed Officer A to say that the man had stopped breathing. Officer A relayed this to the ambulance service, who advised that they should begin cardiopulmonary resuscitation (CPR). Officer A told Officer B and the OSG to start CPR, and went to the cell to help them. Shortly afterwards, the paramedic and another officer arrived and assisted. The paramedic asked the officers to move him into the corridor, where treatment continued.
25. At around 4.55am, a second ambulance arrived and prison staff escorted the paramedics to the wing. The paramedics took over CPR and used a defibrillator (which analyses heart rhythm and can deliver electric shocks to restart the heart). The defibrillator did not detect a shockable rhythm and the paramedics continued CPR until 5.15am, when they pronounced the man dead.
26. The duty governor arrived shortly after the man's death. He telephoned the man's family at 7.55am to inform them. Later that day, the duty governor visited the family with the prison's family liaison officer and the prison chaplain.
27. The duty governor debriefed the staff involved in the emergency response before they left the prison and ensured they were offered support. Prisoners on the wing where the man lived were also offered support. Prisoners being monitored as at risk of suicide and self-harm were reviewed in case they had been adversely affected by the news of his death.
28. The family liaison officer continued contact with the family after his death. In line with national guidance, the prison contributed to the funeral costs. A memorial service was held at the prison.

Post-mortem

29. After a post-mortem examination, the Coroner gave the cause of death as 1 (a) an acute myocardial infarct; due to 1 (b) thrombosis of left main coronary artery; due to 1 (c) coronary artery atheroma. Toxicology results from West Yorkshire police were negative.

ISSUES

Clinical Care

30. The man arrived at Wealstun in April 2013 and had timely health assessments. Although he had infrequent contact with healthcare staff, he was seen promptly and supported when he required treatment. The clinical reviewer concludes that his standard of healthcare in prison was equal to that he could have expected to receive in the community.
31. Before the events on 22 February, the man did not complain of chest pains or any other symptoms of heart problems. His blood pressure was in the normal range when recorded, and a number of medical tests during his time at Wealstun did not reveal any underlying health problems. The clinical reviewer says that, given his age and the absence of any symptoms of heart disease, there was little reason for healthcare staff to suspect the presence of underlying heart problems.
32. The clinical reviewer notes that, when the man arrived at Wealstun, he told staff that there was some history of heart problems in his family. He also had other risk factors such as smoking and misuse of alcohol. The clinical reviewer found that there was little active health promotion and no screening for prisoners who are at risk of heart disease at Wealstun. He recognises that as he was a young man, healthcare staff might not have been expected to identify him as at risk of significant coronary heart disease. However, the National Institute for Clinical Excellence (NICE) best practice guidelines advises screening all patients for risk of heart disease and that if the patient has an increased risk, they should be monitored regularly.
33. We agree with the clinical reviewer's assessment that the man's received care at the prison equivalent to that in the community and we are satisfied that he received appropriate support for his known health problems. While it would have been very difficult to identify his coronary heart disease, we consider the prison should introduce screening for cardiac risk factors in line with best practice. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are screened for cardiac risk factors and monitored accordingly, in line with NICE best practice guidelines.

Emergency response

34. Prison Service Instruction (PSI) 03/2013 says that a code blue emergency call should be used in a medical emergency, including when a prisoner has chest pain, has difficulty breathing or is unconscious. It directs that medical emergency is called over the radio network, an ambulance must be called immediately.
35. When the man first reported chest pains, he was standing up and speaking normally. He was not in distress or agitated and his appearance did not

suggest he required immediate medical help. The OSG's decision to seek advice from a senior member of staff appears reasonable in the circumstances. However, we are concerned that he did not stay with the man to monitor and reassure him, but went back to the wing office to wait for the manager to arrive. The manager called a code blue immediately after he got to the cell and found him unresponsive. This ensured that an emergency ambulance was called automatically and arrived quickly. While it is unlikely to have made a difference to the outcome for him, it is possible that the OSG might have called a code blue slightly earlier, if he had stayed to monitor his condition.

36. The prison's protocol states that, on discovery of an incident at night, staff should remain at the scene if possible and continue to observe. We consider this is appropriate guidance. We make the following recommendation:

The Governor should ensure that, where possible, a member of staff remains with a prisoner who reports ill at night, until additional help arrives.

37. The clinical reviewer concluded that prison staff's resuscitation efforts were appropriate. He commends the actions of those involved, and the communication between staff and the ambulance service. We consider that the emergency treatment was appropriate. While there were sufficient trained staff available at that time (two had up to date CPR training), but we were not assured that this would always be the case.

38. Prison Service Instruction (PSI) 01/2014 –First Aid, requires prisons to have an adequate number of trained staff and the necessary emergency equipment to provide first aid to prisoners. In line with the PSI, the prison has recognised a need for more trained staff and is working to get the numbers up to the level they have identified they need by October 2014. Although there was a defibrillator in the healthcare wing close to the man's cell, the custodial manager was the only member of staff able to access this at night. Staff we interviewed did not know there was a defibrillator available, and had not received training to use it. They said they would have used a defibrillator if it had been accessible. We make the following recommendation:

The Governor should ensure that there are sufficient first aid trained staff on duty at all times with access to defibrillators and other emergency equipment which they understand how to use them.

Family contact

39. The duty governor telephoned the man's parents at 7.55am to inform them of his death. The man's father answered and put the telephone down on hearing the news. Later that morning, the duty governor spoke to the man's brothers and agreed to visit his family. At around 3.45pm, he, the prison's family liaison officer and the prison chaplain went to see the family at their home to offer condolences and support.

40. PSI 64/2011 Safer Custody states “Wherever possible, the FLO (Family Liaison Officer) and another member of staff must visit in person the next of kin or nominated person to break the news of the death”. Prison Service Order 1400 ‘Incident Management’ states that the prison should try to deliver the news themselves or at the very least via prison staff from a prison local to the next of kin.
41. The duty governor told us that he decided to telephone the man’s parents as he wanted to arrange a suitable time for staff to visit them in person. He also wanted to confirm the next of kin details, as the PNOMIS (electronic) record had contact details for both the man’s parents and his partner.
42. We are not persuaded by the duty governor’s reasons and do not consider that it was appropriate to telephone the man’s father in this case. Indeed, contacting him to confirm next of kin details was insensitive. There was no justification for not informing the family in person, particularly as his death was unexpected. The man’s parents lived around 40 minutes away from the prison, so it would have been easy to visit their home to break the news. We make the following recommendation:

The Governor should ensure that in the event of a death, prisoners’ families are informed in person by a member of Prison Service staff, in line with national guidance.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners are screened for cardiac risk factors and monitored accordingly, in line with NICE best practice guidelines.
2. The Governor should ensure that, where possible, a member of staff remains with a prisoner who reports ill at night, until additional help arrives.
3. The Governor should ensure that there are sufficient first aid trained staff on duty at all times with access to defibrillators and other emergency equipment which they understand how to use them.
4. The Governor should ensure that in the event of a death, prisoners' families are informed in person by a member of Prison Service staff, in line with national guidance.

ACTION PLAN

No	Recommendation	Accepted /Not Accepted	Response	Target date for completion and <u>function responsible</u>
1	The Head of Healthcare should ensure that prisoners are screened for cardiac risk factors and monitored accordingly, in line with NICE best practice guidelines.	Accepted	Existing screening for cardiac risk factors will be reviewed and amended in order to comply with NICE best practice guidelines.	November 2014 Head of Healthcare
2	The Governor should ensure that, where possible, a member of staff remains with a prisoner who reports ill at night, until additional help arrives.	Accepted	<i>Know Your Job</i> sheets and night procedures will be amended to reflect the need to stay with prisoners who fall ill until additional help arrives.	September 2014 Head of Operations
3	The Governor should ensure that there are sufficient first aid trained staff on duty at all times with access to defibrillators and other emergency equipment which they understand how to use them.	Accepted	Additional first aid training is currently underway at the prison and defibrillator training is planned over the following months.	January 2015 Head of Healthcare and Head of Residence and Safety
4	The Governor should ensure that in the event of a death, prisoners' families are informed in person by a member of Prison Service staff, in line with national guidance.	Accepted	All Governor grade staff will be advised of the correct procedure and the national guidance will be reinforced.	August 2014 Governor