

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in December
2013 at HMP Preston**

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 heart failure of a man in December 2013 at HMP Preston. He was 67 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at HMP Preston. The prison cooperated fully with the investigation.

The man had been in prison since 1998 and had a history of diabetes and heart problems. On 18 December 2013, the man moved from HMP Kirkham to HMP Preston for 24 hour care after falling and injuring his back. On 26 December, the man had not been well and a prison GP asked nurses to take regular medical observations, including recording his blood pressure. No observations were taken during the night, apparently because the nurse on duty did not want to disturb the man who was asleep. The next morning, prison staff found the man unresponsive in bed and a GP confirmed that he had died.

The investigation found that, overall, the man received a good standard of care at Preston. Although the clinical reviewer concluded that the lack of medical observations did not contribute to his death, I am concerned that nurses did not follow the GP's directions for observations. I am also concerned that the staff did not check on the man's wellbeing when his cell was first unlocked in the morning.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2014

CONTENTS

Summary	5
The investigation process	6
HMP Preston	7
Key events	8
Issues	11
Recommendations	13
Action Plan	14

SUMMARY

1. The man had been in prison since 1998 and was sentenced to life imprisonment in February 1999. He had a history of diabetes and cardiac problems and also suffered from hearing loss. He had spent time in a number of different prisons before he transferred to HMP Kirkham in April 2013. Healthcare staff at Kirkham reviewed him frequently and he was under the care of a consultant cardiologist.
2. On 8 December, the man fell and injured his back. He was admitted to the Royal Preston Hospital and fitted with a back brace. He returned to Kirkham on 17 December, but moved to HMP Preston the next day after healthcare staff decided he needed 24 hour care which was not available at Kirkham.
3. At around 4.00pm on 26 December, a prison GP examined the man after he had vomited and a nurse had recorded that his blood pressure was low. The GP noted that the man's blood pressure was fluctuating and asked nurses to take his medical observations, including blood pressure readings, every two to three hours.
4. Healthcare staff next took the man's medical observations at around 7.20pm when his blood pressure was recorded as low. A nurse noted that further observations should be taken at 12.00am, a longer interval than the doctor had directed. However, no further observations were taken as the nurse on duty that night noted that the man appeared settled and asleep and did not want to disturb him.
5. A care support worker unlocked the man's dormitory cell at 9.00am the next morning, but did not check on his welfare or that of the other two occupants. At around 9.45am, the care worker went to wake the man, but was concerned about his appearance and sought help. Nurses found that the man had no signs of life and apparent rigor mortis indicated that he had been dead for some time. A GP attended and, at 9.55am, pronounced the man dead.
6. The clinical reviewer concluded that the standard of healthcare the man received at Preston was equivalent to that he would have received in the community. However, we are concerned that the GP's instruction for regular medical observations was not followed and that the man's welfare was not checked when his cell was unlocked in the morning. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
8. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.
9. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. He interviewed staff and prisoners at Preston with the clinical reviewer. The investigator gave the Governor initial feedback about the investigation and followed this up in writing.
10. We informed HM Coroner for Blackpool and Fylde of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's partner, his nominated next of kin, to explain the investigation. The man's partner did not have any specific issues for the investigation to consider. The family liaison officer also spoke to the man's son who asked if his father received appropriate care. He said that his father had complained about missed hospital appointments, missing medication and fluctuating blood sugar levels up to 2013. We found no recent evidence of this.
12. The man's family received a copy of the draft report. The solicitor representing the man's family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
13. The service also received a copy of the draft report. Their response to our recommendations and action plan is included at page 14 of this report.

HMP PRESTON

14. HMP Preston is a local prison holding up to 842 adult men. Health services are provided by Lancashire Care Foundation Trust. There is an inpatient unit for up to 30 prisoners which is used as a regional facility. Inpatients who transfer from other prisons remain the responsibility of their original prison for all aspects of their management except healthcare.
15. There is a full-time doctor covering the inpatient unit and primary healthcare between 9.00am and 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor in the prison's reception area. At night and weekends there is on-call cover.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Preston was in April 2012. Inspectors found that an appropriate range of health services were provided. Primary care services had improved and inpatient services were satisfactory.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who ensure that prisoners are treated fairly and decently. In its most recent annual report for 2013, the IMB concluded that the healthcare department at Preston appeared very effective.

Previous deaths at HMP Preston

18. The man was the eighth prisoner to die of natural causes at Preston since the beginning of 2011. We have made a recommendation before about the failure effectively to carry out directions from the doctor.

KEY EVENTS

19. The man had been in prison since 1998 and received a mandatory life sentence for murder in February 1999. He had a history of cardiac problems, including ischaemic heart disease, angina and an irregular heartbeat. He also suffered from diabetes and hearing loss.
20. The man had spent time in a number of prisons before he transferred to HMP Kirkham in April 2013. Initial health screens recorded his existing medical conditions, but noted that otherwise he appeared fit and well. The man had frequent diabetic and cardiology reviews at Kirkham. Records show that he received his required medication regularly.
21. On 13 May, a nurse reviewed the man after he reported feeling unwell. An electrocardiogram (ECG, which measures the electrical activity of the heart) highlighted his irregular heartbeat. He was admitted to Blackpool Victoria Hospital but, after further medical investigations, was discharged later that day.
22. Healthcare staff reviewed the man every day after he returned to the prison. His blood pressure remained in the normal to pre-high range. On 23 May, a prison GP reviewed the man and requested blood tests and weekly blood pressure checks. The results of the blood tests were normal. His medical observations continued to be taken weekly as directed by the doctor. No concerns were recorded.
23. On 2 August, a consultant in acute and general internal medicine, at Blackpool Victoria Hospital, reviewed the man. The consultant requested a scan to determine the extent of the man's heart disease and referred him to a consultant cardiologist, to consider treatment for his irregular heartbeat.
24. On 19 September, the man had further blood tests at Kirkham. The results of the blood test were recorded as normal and no further action was required.
25. The man remained under the care of cardiologists and, on 7 November a specialist registrar, confirmed that scans had shown no significant heart disease. The registrar recorded that the consultant would continue to review the man.
26. On 8 December, the man fell in his room at Kirkham. He was taken to Royal Preston Hospital and diagnosed with a fracture to his back. The man remained in hospital until 17 December, when he was discharged back to Kirkham wearing a back brace. Healthcare staff assessed the man's care needs and decided he needed the level of help available at the inpatient unit at HMP Preston, where he could receive 24-hour care and help with daily activities. The man transferred to Preston the next day, 18 December.
27. The nurse assessed the man's care needs when he arrived at Preston and arranged for his medication to be prescribed. The next day, healthcare staff reviewed the man and drew up care plans to help manage his mobility, diabetes and cardiac problems. He was allocated a dormitory cell with two other prisoners in the inpatient unit.

28. Nurses at Preston saw the man every day for observations and to administer his medication. No major concerns were recorded, but he occasionally experienced some nausea and his blood pressure levels fluctuated.

26 December

29. On 26 December, a nurse asked a GP to review the man as his blood pressure had dropped in the morning and he had vomited that afternoon. At about 4.00pm, a prison GP examined the man and recorded that he had no symptoms at the time, but his blood pressure was fluctuating. The GP thought the man could have had a vasovagal (fainting) episode. He requested blood tests and, because of the man's medical history, he asked nurses to take medical observations every two to three hours. (Despite this, a nurse subsequently wrote in the healthcare diary that observations should be taken at 7.00pm and 12.00am.) The GP asked nurses to contact him if they were concerned about the man.
30. At around 7.00pm, the nurse handed over to another nurse. He told her that observations should be taken at 7.00pm and 12.00am as noted in the healthcare diary. The nurse took the man's observations at around 7.20pm and recorded that his blood pressure was in the low range.
31. The nurse handed over to another nurse at around 8.00pm and told him that the man had been experiencing vomiting and loose stools. She explained the earlier observations and asked for further observations to be taken at 12.00am, as noted in the healthcare diary.
32. The nurse said that the man vomited at around 9.30pm and then went to sleep. He had looked into the man's cell at around 11.40pm and said he appeared settled and asleep, lying on his back with his chest moving. In a written statement, the nurse said he decided not to wake the man and took no further observations.

27 December

33. At around 2.00am, the nurse looked into the man's dormitory cell from the door observation hatch. He saw that the man was lying on his left side facing the door and thought he was sleeping. He wrote in the unit observation book that the man had experienced no episodes of vomiting or loose stools during the night.
34. At 9.00am, a care support worker unlocked the man's dormitory cell, but he did not look in or check on his welfare or that of the other occupants. At around 9.45am, he went back to wake the man for treatments. He was concerned by the man's appearance and called for help. He then moved the other two prisoners from the cell.
35. The inpatient manager at Preston, heard the support worker call for help and went to the cell to assist. She saw the man lying in bed in on his side facing the door and said he appeared to be asleep. The inpatient manager checked the man and saw that his skin was drained of colour. She was unable to find a pulse, noted he was cold and that there were signs of rigor mortis.

36. The inpatient manager called to a nurse for help. She went to the nearby nursing station and radioed the communications room at 9.47am requesting immediate assistance. She asked the support worker to call a doctor. She did not call an emergency medical code as she believed that it was evident that the man had died.
37. The inpatient manager and nurse returned to the man's cell with a defibrillator, which analyses heart rhythm and delivers electric shocks to victims of cardiac arrest to restore a heart beat. The nurse attached the defibrillator, but the machine did not detect a shockable heart rhythm. A prison GP, arrived shortly afterwards, noted that rigor mortis had set in and said that any resuscitation attempts would be futile. He pronounced the man dead at 9.55am.
38. Notices were issued to prisoners and staff at Preston and Kirkham, informing them of the man's death and offering support to those who might have been affected by his death. A debrief meeting was held for the staff involved at Preston.
39. The Governor at Kirkham, visited the man's partner, his nominated next of kin, later that day to inform her of his death and offer support.
40. The prison's family liaison officer continued contact with the man's partner and his son after his death. In line with national guidance, the prison contributed to the funeral costs.
41. The Coroner gave the cause of death as acute left ventricular failure due to coronary artery atherosclerosis and systemic hypertension. The Coroner said the cause of death was not related to the man's fall on 8 December.

ISSUES

Clinical Care

42. The man had frequent diabetic and cardiac reviews while in prison and was under the care of a cardiologist. When he transferred to Preston in December 2013, healthcare staff updated the man's prescriptions and implemented care plans to help manage his health problems. The clinical reviewer concluded that the man's standard of health care in prison was equivalent to that he could have expected to receive in the community.
43. We agree with the clinical reviewer's assessment of the standard of the man's healthcare in prison, but share her concern that directed medical observations were not taken in the hours before his death. The GP told us he gave nursing staff verbal directions to take regular observations, every two to three hours, after his consultation with the man on 26 December. He also recorded this in the SystmOne, the computerised medical record. However, a nurse wrote in the healthcare diary (used to record clinical issues for staff handovers) that observations should be taken at 7.00pm and 12.00am. This was contrary to the GP's instruction. The nurse told us that she did not refer to the SystmOne record when she handed over to the other nurse that evening.
44. While the clinical reviewer concluded that the failure to take further observations did not contribute to the man's death, she was concerned that these clinical instructions were overlooked. The GP told us that he had expected the man's observations to continue as directed until he was next seen by a GP. Nurses did not accurately record this in the healthcare diary and did not refer to the SystmOne record during their handovers. It appears that the nurse decided not to disturb the man to take observations while he was sleeping. It has not been possible to interview the nurse due to his ill health.
45. We are concerned by the failure to take directed observations and, while we cannot conclude that this contributed to the man's death, it meant that nurses missed opportunities to check on the man's wellbeing. It is important that any clinical directions are followed and that decisions to deviate from them are justified and recorded. We make the following recommendation:

The Head of Healthcare should ensure that nurses carry out required observations in line with clinical instructions. If a decision is taken not to follow them then the reasons should be fully documented in the patient's medical record.

Unlock procedures

46. Staff first became concerned about the man's wellbeing at around 9.45am on 27 December, after the support worker raised the alarm. However, his dormitory cell was unlocked at around 9.00am and there is no evidence that staff checked on him or the other occupants at that time.
47. The inpatient manager told us there is no protocol for checking the wellbeing of inpatients in the healthcare unit at unlock times. She said that prisoners usually leave their cells after unlock to collect their medication and staff take

medication to those who are unable attend. She said it was not unusual for the man not to collect his medication in person as he was immobile.

48. Prison officers on standard prison wings are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead". We consider it is all the more important that checks are made in a healthcare unit where a number of the inpatients have serious health problems. We make the following recommendation:

The Governor and Head of Healthcare should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

49. Prison Service Instruction (PSI) 03/2013 says that a code blue emergency call should be used for respiratory issues or if a prisoner is unconscious. It directs that there should be no delay in summoning an ambulance when there are serious concerns about the health of a prisoner and an ambulance should be called by the control room as soon as an emergency medical code is called.
50. When the inpatient manager found the man, she recorded that he was cold, without a pulse and displaying signs of rigor mortis. She thought a code blue emergency call was not applicable as the man's appearance indicated he had been dead for some hours. We are satisfied that the inpatient manager's actions were appropriate in the circumstances. When interviewed, she displayed a good awareness of the code system and told us that all staff on the unit were aware of it. We are satisfied that Preston has a suitable emergency protocol reflecting current Prison Service requirements.
51. The nurse attached a defibrillator to the man, but the machine did not detect a heartbeat. The GP attended shortly afterwards and agreed that resuscitation would be futile as it was apparent that the man had died. We agree that this decision was appropriate. The investigator and clinical reviewer discussed expectations for resuscitation with the Head of Healthcare, and are satisfied that staff have been given guidance about the circumstances in which resuscitation is inappropriate.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that nurses carry out required observations in line with clinical instructions. If a decision is taken not to follow them then the reasons should be fully documented in the patient's medical record.
2. The Governor and Head of Healthcare should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that nurses carry out required observations in line with clinical instructions. If a decision is taken not to follow them then the reasons should be fully documented in the patient's medical record.	Accepted	All staff will be made aware of the importance of following clinical instructions and documentation. If for some reason clinical instructions are not followed, this will be documented clearly with the reasons noted on the medical record.	June 2014 Head of Healthcare	
2	The Governor and Head of Healthcare should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	The prison's core day has been implemented in the Healthcare Department and the wellbeing of prisoners in Healthcare will now be checked by the person unlocking them. Any prisoner requiring immediate assistance will be offered appropriate support by staff on the unit.	Completed and ongoing The Governor and Head of Healthcare	