Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Clemens a prisoner at HMP Guys Marsh on 18 January 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

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*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul Clemens died at HMP Guys Marsh on 18 January 2016, of a pulmonary embolism cause by a deep vein thrombosis (DVT). He was 65 years old. I offer my condolences to those who knew him.

Mr Clemens had a heart condition and type two diabetes, but often refused to take his medication. On 18 January, Mr Clemens complained of chest pain and had breathing difficulties. He had a cardiac arrest and died while paramedics were transferring him to an air ambulance to take him to hospital.

I am satisfied that healthcare staff at Guys Marsh responded quickly when Mr Clemens reported feeling unwell and could not have prevented Mr Clemens' sudden death, although further investigations for possible DVT might have been advisable. There was a delay calling an ambulance, although there is no evidence that this altered the outcome for Mr Clemens, in future emergencies it could be critical.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2016**

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Summary

Events

1. Mr Paul Clemens had been in prison since 2008, serving an indeterminate sentence for public protection. He had been at HMP Guys Marsh since 2012.

2. Before his sentence, Mr Clemens had a history of alcoholism. His medical conditions included type 2 diabetes and heart disease. He had had a heart bypass operation in 2007. He was prescribed medication for his medical conditions, but often refused to take it.

3. In September 2014, Mr Clemens said he had pain in his legs. A GP found nothing of concern but referred him for X-rays, which identified nothing of note. During 2015, Mr Clemens continued to complain of pains in his leg and groin area. Healthcare staff investigated him appropriately and also referred him to hospital for tests. Nothing abnormal was found. Doctors considered the pain was caused by diabetic neuropathy (a complication of diabetes).

4. At 7.50am on 18 January 2016, Mr Clemens rang his cell bell and an officer found him struggling to breathe. The officer phoned healthcare staff and two nurses came to assess him. Mr Clemens was cold, sweaty and clearly unwell. He said he had been experiencing chest pain and breathing difficulties since 7.15am. The nurses gave him oxygen and, at 8.08am, radioed a medical emergency and asked for an emergency ambulance.

5. Paramedics arrived at 8.15am and decided to take Mr Clemens to hospital. As they were moving him to the ambulance, Mr Clemens had a cardiac arrest. The paramedics began to try to resuscitate him and called an air ambulance. Mr Clemens did not respond and, at 9.30am, a paramedic recorded his death. A post-mortem examination found that Mr Clemens had died from a pulmonary embolus (a blockage in the main artery carrying blood from the heart to the lungs) resulting from a deep vein thrombosis in Mr Clemens' left calf muscle.

Findings

6. The prison healthcare team reviewed Mr Clemens' medical conditions frequently and he received appropriate treatment. Each time Mr Clemens complained of leg or groin pain, healthcare and hospital staff carried out appropriate investigations. Overall, the clinical reviewer considered that Mr Clemens received an appropriate standard of care at the prison, but noted that there was no record that hospital staff or prison healthcare staff undertook investigations to rule out the possibility that his leg pain was caused by a deep vein thrombosis.

7. When the officer found Mr Clements had breathing difficulties on the morning of 18 January, we consider he should have called an emergency medical code straight away to alert the control room to call an ambulance immediately.

Recommendations

- The Head of Healthcare should ensure that prisoners with long term conditions, such as diabetes, which increase the risk of deep vein thrombosis (DVT), have appropriate investigations when indicated, to rule out the possibility of DVT.
- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance and that responding staff bring appropriate emergency equipment.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Guys Marsh informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. NHS England commissioned a clinical reviewer to review Mr Clemens' clinical care at the prison.

10. The investigator obtained copies of relevant extracts from Mr Clemens' prison and medical records.

11. We informed HM Coroner for the Dorset District of the investigation who gave us the results of the post-mortem. We have sent the coroner a copy of this report.

12. Mr Clemens had not named anyone as his next of kin and enquiries after his death did not identify any family.

13. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Guys Marsh

14. Guys Marsh is a medium security prison that holds up to 579 men. Dorset University Healthcare Foundation Trust provides primary and secondary mental healthcare and has commissioned another agency, EDP, to provide integrated substance misuse services. Healthcare is open at weekdays and weekends from 8.30am to 6.00pm and there a doctor is on duty on Saturday mornings.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Guys Marsh was in November 2014. Inspectors were very critical of many aspects of the prison but found that healthcare services were reasonably good. Partnership working and clinical governance were effective. Prisoners had access to an appropriate range of primary care services, although chronic disease management needed improvement.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2015, the IMB noted that a number of prisoners became anxious when their medication was changed but time constraints made it difficult for GPs to discuss and explain changes to prisoners. Prisoners were involved in a prisoner health forum and had identified that improvements were needed to the patient waiting area, which was intimidating for some prisoners and did not support good patient care. Some improvements had been made by the introduction of a dedicated time slot for each wing, reducing the number of prisoners waiting at any one time.

Previous deaths at HMP Guys Marsh

17. Mr Clemens was the third prisoner to die from natural causes at Guys Marsh since January 2012. There were no significant similarities with the circumstances of the other deaths but we identified the need for staff to use an emergency medical code in another recent investigation.

Key Events

18. On 29 July 2008, Mr Paul Clemens was remanded to HMP Nottingham charged with threats to kill. On 1 October 2008, he received an indeterminate sentence for public protection with a minimum term to serve of nearly two years before he could be considered for release. Mr Clemens spent time in various prisons before transferring to HMP Guys Marsh in December 2012. The Parole Board had never considered Mr Clemens' risk had reduced enough to direct release.

19. At an initial health screen in July 2008, a nurse noted that, in the previous October, doctors had diagnosed Mr Clemens with ischaemic heart disease and he had had heart bypass surgery. Mr Clemens' community GP confirmed there was no follow up care planned. The nurse noted that Mr Clemens had type 2 diabetes and that he had been drinking large amounts of alcohol every day.

20. In prison, Mr Clemens received care from specialist clinics for his diabetes and alcohol dependence. Healthcare staff reviewed him regularly and doctors prescribed medication for his heart condition and diabetes. Mr Clemens often refused to take his medication, sometimes as a form of protest when he did not get what he wanted. To monitor his compliance, healthcare staff stopped giving him supplies of medication but he often refused to attend the healthcare unit to collect it. Nurses referred him to the mental health in-reach team (MHIRT), who continued to see Mr Clemens until his death.

21. On 11 December 2012, Mr Clemens was moved to Guys Marsh. Over the following years he attended the prison healthcare centre frequently for a range of minor conditions. He was noted to be difficult and demanding and often did not take his medication as prescribed. Healthcare staff frequently impressed on Mr Clemens the importance of taking his medication correctly and the consequences if he did not.

22. On 17 September 2014, a prison GP examined Mr Clemens after he had complained of pain in his legs, particularly his right leg. The GP found nothing concerning and referred him for pelvic X-rays. The results of the X-rays, taken on 21 October, revealed nothing of note.

23. On 4 December, a nurse referred Mr Clemens for a Doppler test (an ultrasound test used to estimate the blood flow through the veins) after he complained of pain in his right leg again. A prison GP reviewed the results of the test. She found nothing of note and prescribed pain relief.

24. On 19 February 2015, a prison GP suspected a hernia when Mr Clemens complained of pain in the right side of his groin. The GP referred him to hospital for tests. On 8 May, a hospital doctor found no evidence of a hernia and diagnosed muscle strain.

25. Mr Clemens continued to complain of pain in the right side of his groin. On 15 May, the prison GP examined him again, suspected a hip impingement and referred him to hospital for further examination. There is nothing in the records to show the outcome. As Mr Clemens had also complained of chest pain, the GP carried out an electrocardiogram (ECG), which did not indicate anything of

concern. Mr Clemens told the GP that, regardless of the results, he would not take any heart medication.

26. On 24 September, Mr Clemens told another GP that he felt better, but still had pain in his right leg, despite taking pain relief. On 12 November, the GP examined Mr Clemens after he complained of pain in his left groin. She considered the pain to be musculoskeletal and prescribed a pain relieving gel.

27. On 26 December, a prison manager began prison suicide and self-harm prevention procedures when Mr Clemens indicated he was unhappy that hospital staff and prison healthcare staff could not diagnose the cause of his pain. He noted that Mr Clemens had been deliberately missing meals and monitoring would help ensure his safety.

28. On 27 December, Mr Clemens told a nurse he had been unable to get out of bed for the previous two days due to groin pain and that he was not eating. The nurse referred him to a GP, who arranged full blood tests and a urine test. She noted the results were satisfactory. She considered his symptoms were due to his own poor management of his diabetes and arranged for a further review a week later.

29. On 30 December, Mr Clemens was taken to hospital after he told officers he had swallowed a number of drawing pins and a razor blade. He told hospital staff that he thought he had cancer and they carried out blood tests, a CT scan and X-rays. The X-ray showed a metal object, which was not causing any danger, so doctors decided surgery was not necessary. Hospital staff reassured Mr Clemens that he did not have cancer and admitted him overnight for pain relief. They investigated Mr Clemens' leg pain and recommended regular checks for peripheral neuropathy (nerve damage due to diabetes). Mr Clemens said that he felt happier after this hospital admission.

30. A prison GP examined Mr Clemens, on 4 January 2016, and noted that while he still had pain in his right leg, there was no sign of a deep vein thrombosis (DVT – a blood clot). He suspected that the pain was diabetic neuropathy, as Mr Clemens was ignoring advice and not taking his diabetic medication correctly. He adjusted Mr Clemens' medication in an attempt to reduce his symptoms.

31. On 8 January, a nurse examined Mr Clemens' legs after he said that he had been unable to get out of bed due to pain in his left calf muscle. She noted he had a strong pulse in his feet, no redness, swelling or abnormalities in either calf and was able to stand and bear his weight on both legs. His blood pressure and pulse were both within normal limits.

32. On 13 January, the prison manager reviewed Mr Clemens, who said he still felt healthcare staff were not taking the pain in his leg seriously, despite all the investigations he had had. He told him he had no intention of harming himself so the manager ended the suicide and self-harm monitoring. That day, a nurse reviewed Mr Clemens and emphasised the need to take his diabetic medication correctly in case the pain was caused by diabetic neuropathy.

18 January 2016

33. At 7.50am on 18 January, an officer responded to Mr Clemens' ringing his emergency cell bell and found him sitting on the end of the bed, struggling to breathe. The officer went to the wing office, phoned healthcare staff and asked them to come. Healthcare records show this was at 8.00am.

34. At approximately 8.05am, two nurses arrived. One nurse noted that Mr Clemens was lying on the bed, pale, cold and sweating. He was alert and understood what she was saying to him. He told her he had been experiencing pain in the centre of his chest and shortness of breath since 7.15am, but had not told anyone earlier. She checked his oxygen saturation level, which was within normal range but gave him oxygen to try to reduce the pain.

35. At 8.08am, the nurse radioed a code blue medical emergency (used when an emergency ambulance is needed such as when a prisoner has breathing difficulties or is unresponsive). She asked a member of the healthcare team to bring a defibrillator and the control room to call an ambulance immediately. They arrived at the cell at 8.12am with the defibrillator. The defibrillator found no shockable heart rhythm and a nurse continued to administer oxygen. He noted that Mr Clemens was still alert and responsive.

36. At 8.15am, paramedics arrived and assessed Mr Clemens. They decided he needed to go to hospital immediately and started to take him to the ambulance in a wheelchair. A nurse noted that although he was in pain, Mr Clemens was still alert and responding to questions.

37. At 8.45am, while moving Mr Clemens out of the wing, he suffered a cardiac arrest. Staff began cardiopulmonary resuscitation while one of the paramedics inserted a device to open his airway. The other paramedic requested an air ambulance.

38. The nurses and paramedics continued to try to resuscitate Mr Clemens until the air ambulance arrived at approximately 9.00am. The air ambulance crew took over emergency treatment but Mr Clemens did not respond. At 9.30am, a paramedic recorded that Mr Clemens had died.

Contact with Mr Clemens' family

39. A prison manager acted as the prison's family liaison officer and noted that Mr Clemens had not named anyone as his next of kin. She checked his prison records and found that he had not telephoned anyone, or received any visits while he was in prison. Checks with Mr Clemens' solicitor and his probation officer established that they had no details of a next of kin. As no family could be found the prison arranged and paid for Mr Clemens' funeral.

Support for prisoners and staff

40. After Mr Clemens' death, the prison care team offered support to the prison and healthcare staff involved in the emergency response.

41. The prison posted notices informing staff and prisoners of Mr Clemens' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Clemens' death.

Post-mortem report

42. A post-mortem examination found that the cause of death was a pulmonary embolus (a blockage in the main artery carrying blood from the heart to the lungs) resulting from a deep vein thrombosis in Mr Clemens' left calf muscle, with a background of heart disease and type two diabetes.

Findings

Clinical care

43. Prison healthcare staff saw Mr Clemens frequently throughout his time in prison. Sometimes Mr Clemens would cooperate with staff but more often he did not take his medication as prescribed, despite advice from healthcare staff of the dangers. The clinical reviewer noted that it was apparent that Mr Clemens' lifestyle choices over a number of years had contributed to his poor health, and subsequent cardiac arrest. Overall, the clinical reviewer considered that Mr Clemens received an appropriate standard of care at the prison, equivalent to that he could have expected to receive in the community.

44. Prison healthcare and hospital staff had both investigated Mr Clemens' frequent complaints of leg pain and found nothing abnormal. Doctors eventually considered it was caused by diabetic neuropathy. However, the clinical reviewer considered that it was likely that the leg pain Mr Clemens experienced was caused by an undiagnosed deep vein thrombosis (which was found in the post-mortem examination). On 4 January 2016, a prison GP noted that Mr Clemens showed no signs of DVT. While it appears there were no obvious signs of DVT, the clinical reviewer considered that investigations to rule out the possibility of DVT would be of benefit for patients such as Mr Clemens, who have long-term conditions, such as diabetes, which places them at higher risk. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with long term conditions, such as diabetes, which increase the risk of deep vein thrombosis (DVT), have appropriate investigations when indicated, to rule out the possibility of DVT.

Emergency response

45. Prison Service Instruction (PSI) 3/2013 requires prisons to have a medical emergency response code protocol, which makes it clear that control room staff should call an ambulance immediately when an emergency code is used. In line with the national instructions, Guys Marsh has a local protocol, which states that a code blue should be used if a prisoner is unconscious or not breathing, has chest pain, difficulty breathing, or there are signs of a stroke. This should indicate to responding staff, the type of emergency equipment to bring.

46. When the officer initially responded to Mr Clemens' cell bell at 7.50am, Mr Clemens had difficulty breathing but he did not use an emergency code, as the protocol requires. When the nurse arrived at 8.05am, she did not bring a defibrillator, as she had not been aware it was an emergency. She radioed a code blue at 8.08, which meant that there a delay of 18 minutes between the officer first finding Mr Clemens with breathing difficulties and an ambulance being called. We are satisfied that healthcare staff responded quickly and Mr Clemens received appropriate emergency treatment. However, while there is no evidence that calling an ambulance immediately would have altered the outcome for Mr Clemens, it is important that there is no avoidable delay in any emergency. In another recent investigation into a death at the prison (which reported after Mr Clemens' death) we found a similar failure to use an emergency medical code.

The Governor needs to ensure that all relevant staff understand and follow the emergency procedures. We repeat our previous recommendation:

The Governor should ensure that all prison staff understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance and that responding staff bring appropriate emergency equipment.

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