Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Stead a prisoner at HMP Dovegate on 21 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 Alan Stead died on 21 January 2016, of heart failure, while a prisoner at HMP Dovegate. He was 49 years old. I offer my condolences to Mr Stead's family and friends.

Mr Stead had been in prison since 2009, but had relatively little contact with healthcare services. In 2010, and again, early in 2015, he reported having heart palpitations. Both times, prison healthcare staff conducted thorough tests, which revealed no significant abnormalities. I am satisfied that Mr Stead received an appropriate standard of care in prison, equivalent to that he could have expected to receive in the community, and that healthcare staff could not have predicted or prevented his death. However, there was a brief delay in the emergency response and Dovegate need to learn from this to improve future response times.

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 **July 2016**

Contents

Summary

Events

1. On 13 February 2009, Mr Alan Stead was sentenced to life imprisonment for murder and sent to HMP Birmingham. On 13 December 2010, Mr Stead told a prison GP that he had occasional palpitations (heartbeats that suddenly become more noticeable) and that he had been told he had an enlarged heart in 2003, after an X-ray. Full blood tests and an ECG revealed nothing significant.

2. In November 2011, Mr Stead transferred to HMP Dovegate. Other than for management of asthma and osteoarthritis, he had little contact with healthcare services at the prison. On 8 December 2015, Mr Stead said he had experienced intermittent palpitations over the previous three weeks. Again, tests indicated no abnormalities.

3. At 11.18pm on 20 January 2016, Mr Stead pressed his cell bell and reported chest pains. A prison manager called for a nurse to assess him and bring equipment for 'code blue symptoms'. (Code blue is an emergency medical code used in circumstances such as when a prisoner has chest pain, is unconscious, or has breathing difficulties.) Three minutes later, while waiting for the nurse to arrive, Mr Stead collapsed and he became unresponsive. The manager then radioed a code blue emergency; the control room called an ambulance in response. Staff began cardiopulmonary resuscitation until paramedics arrived and took over his care. Mr Stead was taken to hospital, but did not recover. Hospital staff recorded his death at 1.10am on 21 January.

Findings

4. Mr Stead had little interaction with prison healthcare services. When he reported palpitations, healthcare staff examined him thoroughly and carried out appropriate tests. They found nothing to warrant further specialist investigation. The clinical reviewer concluded that healthcare staff could not have predicted Mr Stead's heart condition and we are satisfied that he received an appropriate standard of care at the prison.

5. Although there was only a slight delay calling an ambulance, which was done shortly after Mr Stead collapsed, we consider that the prison manager who first spoke to Mr Stead should have used an emergency medical code, as he had identified Mr Stead had 'code blue symptoms'. This would have alerted all staff to the urgency of the situation, and we are concerned that it took the nurse nine minutes to arrive at the cell. Although there is no evidence that this affected the outcome for Mr Stead, such a delay could be critical in future cases.

Recommendation

- The Director should ensure that, when indicated, prison staff use an appropriate medical emergency response code to alert relevant staff to the urgency and to prompt the control room to call an ambulance immediately.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

7. NHS England commissioned a clinical reviewer to review Mr Stead's clinical care at the prison.

8. The investigator obtained copies of relevant extracts from Mr Stead's prison and medical records. He and the clinical reviewer interviewed two members of staff at Dovegate on 23 February 2016.

9. We informed HM Coroner for the South Staffordshire District of the investigation who gave us the post-mortem report. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers wrote to Mr Stead's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked why Mr Stead had to wait six weeks to have a blood test repeated and wanted details of the results. She also asked if staff had answered his cell alarm promptly, his position when he was found and whether prison staff knew he had an enlarged heart.

11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

12. Mr Stead's mother received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Stead's mother also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Dovegate

13. HMP Dovegate is privately run by Serco. The main prison holds around 933 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men.

14. Care UK, who took over from Serco Health in October 2014, provides healthcare services. There is an inpatient unit for 12 prisoners and 24-hour nursing cover. Two GPs provide cover Monday to Friday and Saturday mornings. There is an out of hours GP service at other times.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Dovegate was in January 2015. Inspectors reported that the standard of healthcare was improving, but the facilities were too small for the number of prisoners, the waiting times for routine GP appointments were excessive and too many hospital appointments were rescheduled. There was an appropriate range of primary care services. Prisoners with life-long conditions and complex needs were properly identified and there were relevant clinics, including a weekly GP-led session.

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 September 2015, the IMB reported that Care UK's first year of providing healthcare at the prison had been a success. The transition had been well managed, there was evidence of improvements in services and a clear strategic vision for the future.

Previous deaths at HMP Dovegate

17. Mr Stead was the third prisoner to die from natural causes at Dovegate since the beginning of 2014. There were no significant similarities with the circumstances of the previous deaths.

Key Events

18. On 10 February 2009, Mr Alan Stead was charged with murder and remanded to HMP Birmingham. On 13 February 2009, he was sentenced to life imprisonment with a minimum term to serve of 25 years.

19. At an initial health screen, a nurse noted that Mr Stead had asthma and smoked. (He gave up smoking shortly afterwards.) He disclosed no other medical issues and had no significant contact with healthcare staff over the following months.

20. On 13 December 2010, a prison GP reviewed Mr Stead, who said he had occasional palpitations. He did not report any accompanying chest pain. He told the GP that a hospital doctor had told him he had an enlarged heart, after he had inhaled soot after a fire in 2002. He had had no follow-up appointments or treatment for this. The GP took full blood tests and an ECG test (an electrocardiogram, which checks the heart's rhythm and electrical activity). The GP found no further abnormalities, so took no further action.

21. In 2011, Mr Stead transferred to HMP Gartree but went back to Birmingham several times, for court appearances. He had no significant contact with healthcare services at either prison during this time.

22. On 30 November 2011, Mr Stead transferred to HMP Dovegate. At his initial health screen, he reported he had asthma, but said he had no other health concerns. He was subsequently monitored at the prison's asthma clinic.

23. On 8 December 2015, Mr Stead told an advanced nurse practitioner that for the past three weeks he had occasionally experienced palpitations in his chest and a dull, left-sided pain when breathing in, which lasted for approximately five minutes at a time. He also told her that he had an enlarged heart. She noted that there was no evidence in his medical records that hospital staff had decided he needed any follow-up treatment for this.

24. The nurse examined Mr Stead thoroughly. His blood pressure and pulse were normal and his chest sounded clear. She decided to carry out further tests to establish the cause of the palpitations and gave Mr Stead an ECG. A prison GP reviewed the results, but found nothing significant. The nurse also referred Mr Stead for blood tests to check his thyroid function, vitamin B12 levels (a low vitamin B12 level can lead to abnormally large red blood cells being produced causing a feeling of numbness and tingling) and his ferritin level (a test for iron levels to rule out anaemia). Healthcare staff were unable to obtain a suitable blood sample, so they rebooked the appointment for 11 December, to try again. The nurse told Mr Stead to contact healthcare staff if he experienced any further symptoms in the meantime.

25. The appointment on 11 December did not take place. The reason was not recorded, so we do not know whether Mr Stead decided not to attend or there was some other reason. The appointment was rescheduled for the next available blood testing appointment, on 13 January 2016, which Mr Stead attended. A prison GP reviewed the results the same day. He noted that there were some slight abnormalities, but they were not significant enough to warrant

treatment, or referral to a specialist. The GP told Mr Stead to speak to healthcare staff if there was a recurrence of his symptoms.

26. The nurse and GP told the investigator that they did not consider that Mr Stead's disclosure that he had been told he had an enlarged heart in 2003 needed further investigation, as no action had been taken at the time and there was no evidence of this diagnosis in his medical records. None of the diagnostic tests indicated any cardiac issues. If the tests conducted at the prison had identified any concerns, they would have referred him immediately for further investigation.

27. At 11.18pm on 20 January, Mr Stead pressed his cell bell to call staff. A prison manager responded quickly at 11.19pm. Mr Stead was standing up and told him that he had chest pains and felt unwell. The manager immediately radioed the nurse and asked her to examine Mr Stead and bring appropriate equipment for 'code blue symptoms'. (A code blue indicates circumstances such as when a prisoner has chest pain, difficulty breathing or is unconscious.)

28. At 11.22pm, while waiting for the nurse to arrive, Mr Stead fell onto the bed and became unresponsive. The prison manager then radioed a code blue emergency and asked the nurse to attend the cell immediately. He went into the cell and began cardiopulmonary resuscitation (CPR). At 11.24pm, the prison control room called an emergency ambulance.

29. The nurse arrived at Mr Stead's cell at 11.28pm. She checked his pulse and discovered he was not breathing. She and the prison manager continued CPR. She attached a defibrillator, but it found no shockable heart rhythm so they continued CPR.

30. At 11.40pm, an emergency ambulance arrived at the prison. A second ambulance arrived shortly afterwards. The paramedics reached Mr Stead's cell about five minutes later and took over emergency treatment. At 12.35am, they took Mr Stead to hospital. Two prison officers accompanied him, but did not use restraints.

31. Hospital staff continued emergency treatment but Mr Stead did not respond. At 1.10am on 21 January, Mr Stead was pronounced dead.

Contact with Mr Stead's family

32. At 8.15am, two officers from the prison's family liaison team arrived at Mr Stead's parents' home and informed them of his death. They explained what had happened and offered condolences and support.

33. On 22 January, both officers accompanied Mr Stead's family to see Mr Stead in the hospital's chapel of rest. On 25 January, they arranged for Mr Stead's mother, father, son and his three daughters to visit the prison to see where he lived. They remained in contact with Mr Stead's family for support.

34. Mr Stead's funeral was on 8 February. The prison offered a contribution to the costs, in line with national policy, but Mr Stead's family declined the offer.

Support for prisoners and staff

35. After Mr Stead's death, the prison care team offered prison and healthcare staff support.

36. The prison posted notices informing staff and prisoners of Mr Stead's 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 Stead's death.

Post-mortem report

37. A post-mortem examination found that the cause of death was 1a) haemopericardium, 1b) thoracic aortic dissection and 1c) ruptured atheromatous plaque. (Bleeding from the aorta into the sac surrounding the heart resulting in death.)

Findings

Clinical care

38. The clinical reviewer noted that Mr Stead's contact with healthcare staff was mainly limited to the management of his asthma at a specialist clinic at the prison, and treatment for joint pain caused by osteoarthritis.

39. The clinical reviewer considered that the nurse's assessment of Mr Stead on 8 December 2015 was thorough and that she had explored his symptoms fully. He noted that she had carried out a number of tests in an attempt to identify the underlying problem and had asked a prison GP to review the results. Given those results, the clinical reviewer considered that the prison's healthcare staff could not have predicted death.

40. We are satisfied that Mr Stead received an appropriate standard of healthcare at Dovegate, equivalent to that he could have expected to receive in the community and there was nothing staff could have done to prevent his sudden death.

Emergency response

41. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which alerts all relevant staff and ensures an ambulance is called automatically in a life-threatening emergency. It states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. It requires staff to call an emergency code blue when prisoners have specified symptoms – the first two of which are listed as chest pain and difficulty in breathing.

42. When Mr Stead reported chest pains, a prison manager asked a nurse to assess him and noted that he had 'code blue symptoms'. He asked a member of staff to observe his breathing, suggesting he had some concerns. Three minutes later, at 11.22pm, Mr Stead became unresponsive. The manager then called a code blue and asked the nurse to attend urgently. The control room quickly called an ambulance. The nurse arrived nine minutes after Mr Stead first reported his symptoms and six minutes after the code blue call.

43. We recognise that the prison manager had to make a judgement about the severity of Mr Stead's symptoms. However, as he asked the nurse to being equipment for code blue symptoms, we consider he should have radioed a code blue at the outset. The PSI states, "It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required". There is no evidence that the outcome would have been different if the code blue had been called sooner, and we note that there was only a slight delay as the manager radioed a code blue as soon as Mr Stead collapsed, three minutes later. He also began CPR immediately. However, in future cases, any delay could be critical. It is preferable to call an emergency code when there is any doubt, to allow the quickest possible medical intervention. We make the following recommendation:

The Director should ensure that, when indicated, prison staff use an appropriate medical emergency response code to alert relevant staff to the urgency and to prompt the control room to call an ambulance immediately.

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