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 September 2011 at HMP Bullingdon

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 of a man who died of a heart attack at HMP Bullingdon on 28 September 2011. He was 41 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 Bullingdon. The prison cooperated fully with the investigation.

After the man's death, Oxford Health, which commissioned health services at Bullingdon at the time, carried out a serious incident review. Two nurses were suspended from duty and no longer work at HMP Bullingdon. The police carried out a criminal investigation which meant my investigation could not proceed for over two years, until the outcome of the police investigation. No criminal charges were brought. I regret the consequent delay in issuing this report.

The man had a history of drug dependency for which he was treated at Bullingdon. He had very little contact with healthcare for any other reason. On the evening of 27 September, the man complained of chest pain and was taken to the prison's healthcare centre. Nurses treated the pain as heartburn or indigestion and the man returned to his wing. The next morning, the man's cell mate found him apparently dead in his bed. The officer who had unlocked his cell did not check on his welfare. Healthcare staff attended, followed shortly afterwards by paramedics, and confirmed that the man had died.

The man's GP records were not requested when he arrived at Bullingdon and he was never asked about any family medical history which would have indicated that he was at risk of heart disease. I am concerned that the nurses on duty did not appear to understand how to respond to sudden onset chest pain and did not follow up to date clinical guidance which should have resulted in a doctor being called or the man being taken to hospital. It is not possible to know whether this would have changed the outcome for the man, but it would have increased his chances of survival.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2014**

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SUMMARY

1. The man arrived at Bullingdon on 2 October 2009 when he was recalled to prison for a breach of licence conditions. He was dependent on drugs for which he was treated with subutex. No other significant health issues were noted although he was noted to have asthma. Throughout 2009 and 2010, the substance misuse team frequently reviewed the man. He continued his drug treatment but also admitted to taking illicit drugs occasionally

2. The man sometimes self-harmed by cutting himself superficially, often related to changes in his drug treatment. He was supported under Prison Service suicide and self-harm prevention procedures whenever he harmed himself.

3. The substance misuse team continued to review the man frequently in relation to his drug treatment, but he had few other health issues apart from treatment for his asthma. There is no record that the man ever complained of chest related pain until 12 August 2011, when he was treated for heartburn.

4. On the evening of 27 September 2011, the man rang his cell bell and told officers that he felt dizzy and had pains in his chest and down his left arm. The officers noted that he was sweating heavily. They contacted a nurse who asked them to bring him to the prison's healthcare centre. A nurse took the man's clinical observations, which were within the normal range. A short while later the man complained that he was still in pain. As his observations had been normal, another nurse gave the man medication for heartburn. He was then taken back to his cell.

5. The officer who unlocked his cell the next morning did not check on his welfare. Shortly afterwards, at 7.50am, the man's cell mate found him unresponsive and cold. Healthcare staff attended immediately, but could find no signs of life. They did not attempt resuscitation as it was apparent that he had died.

6. We agree with the clinical reviewer that the nurses did not respond appropriately to the man's symptoms of chest pain. The man's GP records should have been requested when he arrived at Bullingdon, which would have shown a family history of heart disease. The nurses who dealt with his reported chest pain did not keep full and accurate records. The officer who unlocked the man's cell on the morning he was found dead, did not check on his welfare. We make five recommendations.

THE INVESTIGATION PROCESS

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

8. The investigator obtained copies of the man's prison and prison medical records. He visited Bullingdon on 3 October 2011 and spoke to the man's personal officer and cell mate.

9. In line with our agreement with the police, the Ombudsman's investigation was suspended while the police carried out their own enquiries. On 24 November 2013, we were informed that the Crown Prosecution Service (CPS) had decided not to bring charges in relation to the man's death. This allowed our investigation to begin again.

10. After the CPS decision, NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

11. The investigator informed HM Coroner for Oxfordshire of the investigation, who provided the post-mortem report and toxicology results. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's brother, to explain the investigation. The man's brother asked for the investigation to consider the following:

    - What happened the evening prior to the man's death?
    - After complaining of chest pains, what assessment took place and what medication was provided?
    - Was it reasonable, considering the man was in a great deal of pain and sweating profusely at the time, for him to be involved in a long walk, going through a number of doors, from his cell to healthcare?

13. The man's brother received a copy of the draft report. He did not make any comments.

14. The draft report was shared with the service and their action plan in response to the recommendations is included at page 16.

HMP BULLINGDON

15. Bullingdon opened in 1992. It is both a training prison and local prison serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men.

16. At the time of the man's death, Oxfordshire Primary Care Trust (PCT) provided health services at the prison with a minimum of two nurses on duty at all times.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Bullingdon was in July 2012. Inspectors found that prisoners were generally dissatisfied with the overall quality of health services. Shortages of permanent staff had led to disruptions in service, but this was improving. Primary care provision was good but limited and nurse-led clinics needed development. The waiting time to see a GP was too long and there was a high rate of non-attendance at appointments. Nurses reported good access to training and all were up to date with mandatory requirements. However, the Inspectorate noted a clinical supervision policy was not being implemented.

Independent Monitoring Board

18. 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. In its annual report for 2011/12, covering the period of the man's death, the Board said that some progress in healthcare had been made in relation to previously identified serious problems. However they considered that the standard of service remained inadequate and inefficient. The Board noted that there was poor staff morale and problems with recruitment. Issues for prisoners included a four week waiting period to see a GP and missed appointments to outside hospitals. Applications to the IMB relating to healthcare were at an all time high. In its annual report for 2012/13, the IMB noted that some issues raised in the previous three annual reports relating to the poor provision of healthcare were being addressed by the new provider including staff training. However, other issues remained such as staff numbers and low morale. Waiting lists for GPs were still running at three weeks although an extra session had been introduced.

Previous deaths

19. There had been two deaths from natural causes at Bullingdon, in 2010 and 2011, before that of the man and there have been two since he died. There are no similarities arising from these investigations.

KEY EVENTS

20. The man had been released on licence from a prison sentence in August 2009 and was recalled to prison for breaching the terms of his licence conditions on 2 October 2009. He arrived at HMP Bullingdon that day.

21. A nurse carried out a reception health screen and noted that the man had asthma and Tourette's syndrome. The man said he was dependent on drugs and was prescribed subutex (a heroin substitute) as part of his treatment programme. He said he did not drink alcohol or smoke cigarettes. The nurse did not identify any other particular concerns about his physical health and referred him to the doctor and the community drug and alcohol team. A prison GP examined the man that day and noted that the man's heart sounded normal, his chest was clear and his pupils were normal. The doctor did not ask about the man's family history, which included heart disease, and did not ask for his community medical records.

22. On 3 October the community drug and alcohol team saw the man and agreed that he should continue his subutex treatment.

23. In April 2010, he was suspected of trading his subutex. His prescription was changed to suboxone, another heroin substitute, which also contains a drug to reverse the effect of other opiate based medication. The records show that this was prescribed and administered appropriately.

24. Throughout 2009 and 2010, the substance misuse team reviewed the man frequently. He continued to be maintained on suboxone, but admitted he sometimes took other drugs illicitly.

25. The man occasionally self-harmed by cutting himself superficially. He told staff that this was a reaction to stress when his medication was changed or reduced. When the man harmed himself, prison staff managed him under suicide and self-harm prevention procedures.

26. Despite the support of substance misuse specialists, the man continued to report that he injected heroin and used illicitly obtained subutex. His suboxone dose was incrementally increased and, in January 2011, he began to be prescribed methadone instead. The dose of methadone was decreased over time until the man was stabilised on 55mls daily. The substance misuse team continued to monitor the man. Healthcare staff saw him for minor treatment after some incidents of self-harm and treated his asthma and some minor ailments.

27. On 12 August 2011, the man reported having heartburn and a nurse gave him antacid tablets. He was not examined at this time. Until 27 September, he had no further contact with healthcare staff other than for his methadone treatment.

27 September

28. At about 8.30pm on 27 September 2013, the man rang his cell bell. Two officers attended. The officers said that the man was sweating profusely. He told them that he felt dizzy and had pains in his chest and down his arm. One officer telephoned the prison healthcare centre and spoke to a nurse who asked the officers to bring him to the healthcare centre.

29. At 8.40pm, the officers took the man to the healthcare centre. The nurse then asked another nurse to take the man's clinical observations. At about 8.45pm, the nurse took the man into one of the healthcare cells accompanied by the two officers. The nurse assessed the man and noted his oxygen saturation was 100%, his pulse was 61, and his blood pressure was 102/80. All his observations were within normal ranges. The nurse noted that his skin colour was normal and his breathing was not compromised. He was sitting up but was slightly sweaty, which the nurse considered might have been due to his hyperactive presentation. The nurse told the man that his observations were fine.

30. According to one if the officers, the man said that the pain eased when his observations were being taken. However, he said that he felt cold yet continued to sweat. At 8.50pm, the nurse discussed her findings with the other nurse. She said that the man was complaining of a pain in his throat which was extending into his arm, although the pain was subsiding.

31. The nurse agreed that she would enter the observations the other nurse had taken on SystmOne (the computerised medical record system) as the nurse was going off duty. The man waited in a healthcare cell until night shift officers could be arranged to take him back to the wing.

32. The nurse said that at 9.30pm, as she passed by the man's cell, he told her that he still had some pain in his upper chest area. She gave the man 15mls of antacid medication to take immediately and 15mls to take back to the wing. The nurse said that she advised the man to call if the symptoms persisted or increased. This advice is not recorded in his medical record. The man told her that he did not want to go back to the wing,

33. The officer gave a different account. He said that the man had told him that the pain was coming back and was really bad, and that his left arm felt like it was on fire. The officer said he had reported this to the nurse but she had said that there were no problems with the man's observations. At 9.40pm, two officers from the night shift took the man back to his wing.

28 September

34. The officer said she began to unlock the cells on the man's wing at 7.45am on 28 September. She said that she had unlocked the man's cell while she was talking to another prisoner. She does not appear to have checked on either occupant's welfare. The man's cell mate said that, shortly after the cell was unlocked at about 7.50am, he spoke to the man but he did not reply. He thought something was wrong so he touched his arm and cheek which were

both cold. The man's cellmate said he immediately thought that he was dead. He went to the cell next door and told the prisoner there. This prisoner came to check on the man and then told the man's cell mate to inform staff.

35. The officer said that, at about 8.00am, a prisoner told him that the man was dead. The officer, a Developing Prison Service Manager (DPSM) and another officer all went to the man's cell. The DPSM checked the man for signs of life and found he was cold and unresponsive, there was no pulse and rigor mortis was present. The officer radioed a 'Level One' emergency. At the time this code was used at Bullingdon for serious emergencies such as severe bleeding, hanging, unconsciousness or cardiac arrest. Healthcare staff were required to attend immediately when such a code was called. An ambulance was called at 8.04am

36. A Health care assistant (HCA) heard the radio call and went to the man's cell, taking with her an emergency bag and a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The HCA could find no signs of life and noted that the man looked grey and his body was cold and stiff. Two senior nurses then arrived.

37. The nurses considered that the man was dead. They used the defibrillator to check he had no heartbeat and did not attempt to resuscitate him. The nurse who was a registered paramedic, verified the man's death at 8.11am. An ambulance arrived at 8.20am and paramedics also confirmed that the man had died.

38. Shortly after the man's death, the prison's care team and members of the chaplaincy went to the wing to offer care and support to the staff involved at the scene and to prisoners who knew the man.

39. A Governor informed the man's brother and niece of his death later that morning. The prison appointed a family liaison officer who advised and supported the man's family. The prison offered a financial contribution towards the funeral in line with national guidance.

Post-mortem and toxicology

40. A doctor carried out a post-mortem examination on 29 September. He found that the man had severe narrowing of a number of the arteries supplying blood to his heart (coronary artery atherosclerosis) as well as damage to the heart muscle itself as a result of this (ischaemic heart disease). The doctor concluded that 'the severity of the ischaemic heart disease is such that it could have caused death in its own right at any time'.

41. An initial toxicology report had found that there was methadone present in the man's blood which was "at a concentration that is higher than would normally be expected following use of a dose of 55ml daily. Methadone may therefore have played a role in the man's death…"

42. However, the doctor concluded, “Whilst it is possible that he [the man] had taken more than his prescribed dose and that this could have contributed to his death, it should be noted that there is considerable overlap between reported therapeutic levels of this drug at fatal levels. The interpretation of blood levels is also made problematic by the potential for redistribution of the drug after death (although the effects of this would be reduced by the sampling of peripheral venous blood as was the case here). Thus whilst I could not exclude this drug having contributed to death, I do not believe that it has played a major part in this case. In my opinion death may reasonably be attributed to natural causes”

ISSUES

Clinical care

43. A serious incident review carried out by NHS Oxford Health concluded that the man was not given the treatment he would have received in the community in relation to his chest pain.

44. The clinical reviewer found that the general standard of the man's healthcare at the prison was appropriate. However, he notes that the prison did not request the man's community medical records which would have shown that the man had a significant family history of ischaemic heart disease. This should then have been viewed as a risk factor. Nor is there any record that anyone asked the man about his family medical history.

45. Prison Service Order (PSO) 3050 - Continuity of Healthcare states that efforts should be made to obtain any information required from the prisoner's GP or other relevant service. In the week after first reception prisons are required to offer a general heath assessment which is equivalent to a primary care assessment when registering with a new practice in the community. Such community assessments include taking a family medical history and we would expect the same to happen in prisons. We make the following recommendations:

    The Head of Healthcare should ensure that GP records are routinely requested for newly arrived prisoners and that prisoners are asked about their family medical history during initial health screens.

    The Head of Healthcare should ensure that secondary health screens include an assessment of risk factors for cardiovascular disease, particularly for prisoners most at risk, including those who have a family medical history of heart disease, history of smoking heavily and misuse of drugs or alcohol.

Responding to chest pain

46. At 8.30pm on 27 September, the man complained of chest pain and that the pain was travelling down his left arm. He was sweating and felt dizzy. These are well known symptoms of a heart attack, even to a lay person. The officer contacted the prison's healthcare centre and spoke to the nurse who asked them to bring the man to see her. We would have expected the nurse to attend the wing immediately, instead of requiring the man to walk to the healthcare centre.

47. The nurse took the man's clinical observations and noted they were all within normal range. However, the clinical reviewer points out that with the symptoms the man was presenting, ischaemic heart disease should have been excluded and examination adds very little to this. He notes that in the event of ischaemic chest pain, the respiratory rate may not be raised and blood pressure, oxygen levels and pulse can all appear normal. He says that it appears a great deal of weight was placed on the observations being normal, whereas the correct course of action would have been to take a thorough history. The clinical reviewer states that at the

very least, the on call doctor should have been called who was likely to have advised that the man needed to be sent to hospital urgently.

48. The clinical reviewer found that the nurses failed to recognise that the man might have ischaemic chest pain and that the focus on observations rather than history demonstrated that they were inadequately trained. After the man's death the nurses were suspended and they are no longer employed at Bullingdon. One was an agency nurse whose agency was asked to refer her to the Nursing and Midwifery Council (NMC – the regulatory body for nurses.) Oxford Health referred the other nurse directly to the NMC. The outcomes are not yet known.

49. Nurses on the frontline need to be fully trained to recognise potentially serious conditions and know what to do, including when to refer to a doctor or the emergency services. The National Institute for Clinical Guidance (NICE) Clinical Guideline 95 provides information on recent onset chest pain. It advises clinicians to assess patients for signs of and risk factors for cardiovascular disease and indicates that a person with chest pain of suspected cardiac origin should be referred to hospital for same day or urgent assessment and treatment. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff are aware of current clinical guidance for managing chest pain and that prisoners presenting with such symptoms are assessed urgently, in line with NICE guidelines on the diagnosis of chest pain and where indicated referred to hospital for emergency treatment

Record keeping

50. The clinical reviewer noted that the nurses did not keep full and accurate records, including why referrals were not made. The nurse did not make her own notes when she took the man's clinical observations. The clinical reviewer comments that the task of completing notes should not be passed on to someone else or completed at a later time. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council.

Unlock procedures

51. The officer was responsible for unlocking cells on the morning of 28 September. She said in her statement that while she unlocked the man's cell she was talking to another prisoner. She does not appear to have tried to get a response from the man or his cellmate. As the man was found dead a few minutes later, it is seems he was dead at the time she unlocked the cell.

8. For their own safety, officers are supposed to make contact with a prisoner through the observation hatch before opening a locked cell door. When

unlocking a cell they should take active steps to check on a prisoner's wellbeing. 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 make the following recommendation:

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

Emergency response

52. The clinical review found that the actions taken by staff when the man was found were appropriate. We are satisfied that both prison and healthcare staff acted professionally and appropriately. The correct emergency code (at the time) was called, ensuring the healthcare staff arrived swiftly and with the correct equipment and there was no delay in calling an ambulance.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that GP records are routinely requested for newly arrived prisoners and that prisoners are asked about their family medical history during initial health screens.

2. The Head of Healthcare should ensure that secondary health screens include an assessment of risk factors for cardiovascular disease, particularly for prisoners most at risk, including those who have a family medical history of heart disease, history of smoking heavily and misuse of drugs or alcohol.

3. The Head of Healthcare should ensure that all healthcare staff are aware of current clinical guidance for managing chest pain and that prisoners presenting with such symptoms are assessed urgently, in line with NICE guidelines on the diagnosis of chest pain and where indicated referred to hospital for emergency treatment

4. The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council.

5. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety 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 GP records are routinely requested for newly arrived prisoners and that prisoners are asked about their family medical history during initial health screens.	Accepted	Nursing staff now request information about each prisoner's family medical history and seek their consent to request information from their GP (and other relevant medical agencies). This information is recorded on SystmOne.	Completed and ongoing Head of Healthcare	
2	The Head of Healthcare should ensure that secondary health screens include an assessment of risk factors for cardiovascular disease, particularly for prisoners most at risk, including those who have a family medical history of heart disease, history of smoking heavily and misuse of drugs or alcohol.	Accepted	A health promotion strategy and additional health checks have now been introduced. Following assessments actions are agreed with the prisoner to reduce their risk, including a referral to the gym, smoking cessation and healthy life advice. Prisoners identified as being at risk are put on a chronic risk register and monitored in line with national frameworks.	Completed and ongoing Head of Healthcare	
3	The Head of Healthcare should ensure that all healthcare staff are aware of current clinical guidance for managing chest pain and that prisoners presenting with such symptoms are assessed urgently, in line	Accepted	Healthcare staff have received further training with regards to the treatment of prisoners presenting symptoms of chest pain. Further guidelines to enforce this are currently being developed.	June 2014 Head of Healthcare	

	with NICE guidelines on the diagnosis of chest pain and where indicated referred to hospital for emergency treatment				
4	The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council.	Accepted	All healthcare staff have completed the mandatory annual information governance training and been reminded of the importance of contemporaneous record keeping in line with the General Medical Council and Nursing and Midwifery Council guidelines. A medical records audit is now completed on an annual basis to monitor delivery against the standards set by the General Medical Council and Nursing and Midwifery Council.	Completed and ongoing Head of Healthcare	
5	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	This has been reinforced via Bullingdon's Safer Custody training and a notice to staff will be published at least every six months to remind them of their responsibilities when unlocking cells.	Completed and Ongoing Safer Custody	