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 August 2014, while in the custody of HMP Northumberland

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 stroke on in August 2014, while in the custody of HMP Northumberland. He was 84 years old. I offer my condolences to the man's family and friends.

The investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at Northumberland. The prison cooperated fully with the investigation.

The man had been in prison, serving a life sentence, since March 2000. He had been at HMP Northumberland since 2009. He had several chronic health conditions, including epilepsy, heart disease and high blood pressure.

On Sunday 3 August, an officer unlocking the man's cell could not get a response from him. He did not call an emergency code, but asked a nurse who was on the unit administering medication to assess him. The nurse said that the man appeared to be in a deep sleep and he would reassess him later. He went to check the man's medical records. The officer was not satisfied and asked a manager to call an emergency ambulance, but the manager accepted the nurse's advice that an ambulance was not necessary. In the meantime, the wing senior officer had asked two nurses to reassess the man urgently. They requested an emergency ambulance, which took the man to hospital. The prison informed his next of kin who was with the man when he died in hospital later that day.

The clinical reviewer was satisfied that the man's primary healthcare at the prison was comparable to that he could have expected in the community, but was concerned by the lack of formal care plans for chronic conditions and that the man had missed a number of hospital appointments because of a shortage of staff at the prison. These are issues which the Director and Head of Healthcare will need to address.

It appears that the man suffered an intracranial bleed the night before he was found unresponsive. The nurse, who originally checked him accepts he made a significant error of judgement in not immediately calling an ambulance and I am satisfied that his actions have been subject to an appropriate, separate enquiry. It is commendable that the officer who first found the man persisted in efforts to ensure he got emergency attention. However, the clinical reviewer noted that the man had been treated for high blood pressure for some time and it is unlikely that his death could have been prevented or that the outcome would have been any different if an ambulance had been called earlier. Nevertheless, as we have found in a previous investigation, not all staff were fully aware of emergency procedures and the Director needs to remedy this.

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
Prisons and Probation Ombudsman **February 2015**

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SUMMARY

1. On 31 March 2000, the man received a life sentence for arson with intent to endanger life. He had been at HMP Acklington (later HMP Northumberland) since June 2009.

2. The man had a number of chronic conditions including epilepsy, heart disease and high blood pressure. In 2010, doctors diagnosed postural hypotension (a drop in blood pressure due to a change in posture). In 2011, the man began to have blackouts and was fitted with a device to rule out cardiac syncope, which causes loss of consciousness. In November 2013, the man began to have nosebleeds, which were considered to be related to his high blood pressure. .

3. At 9.30am on 3 August, an officer found the man unresponsive in his cell. He asked a nurse who was already on the unit administering medication to assess the man. The nurse said it looked as if the man was in a deep sleep. He said he would discuss this with colleagues and come back later.

4. Officers were unhappy with the nurse's assessment. Another prisoner, who was a trained nurse, told officers that he thought the man had suffered a stroke. An officer asked the orderly officer in charge of operations in the prison that day, to call an emergency ambulance. The orderly officer first spoke to the nurse who had assessed the man. She said that the nurse told her that he had considered an ambulance was not necessary. In the meantime, other nurses were assessing the man as a senior officer had gone to the healthcare centre and asked someone to reassess the man. The orderly officer therefore declined to request an ambulance. Two nurses examined the man, administered oxygen and requested an emergency ambulance. The ambulance took the man to hospital at 10.45am.

5. At 12.20pm, the prison informed the man's niece, his next of kin, that he was seriously ill in hospital. He died in hospital that evening. His niece was with him at the time.

6. We agree with the clinical reviewer that the man received generally appropriate primary healthcare treatment, including for high blood pressure, equivalent to that he could have expected to receive in the community. However, there was a lack of care plans for his chronic conditions and too many hospital appointments were cancelled because of a lack of staff for escorts. We are also concerned that the initial nurse assessment led to a delay in the man going to hospital as an emergency. While there is no evidence that any of these matters would have affected the outcome for the man, whose death would have been difficult to prevent, the investigation identified a need to ensure that all staff are fully aware of emergency procedures. There is also a need to inform families as soon as possible when a prisoner is seriously ill. We make four recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and inviting anyone with relevant information to contact her. One prisoner responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed a prisoner in August and six members of staff at Northumberland in September and subsequently interviewed four more staff by telephone. The investigator gave the Director initial feedback on the preliminary findings of the investigation.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. We informed HM Coroner for Northumberland 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 niece, his nominated next of kin, on 1 September 2014, to explain the investigation process. The man's niece had a number of questions about the man's care, which we have taken into account in the investigation. These included his understanding of his health problems and whether his medication and appointments were appropriate and timely. She wanted to know more about the emergency response and whether she had been informed of his admission to hospital in a timely manner.

12. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP Northumberland

13. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. The prison can hold more than 1,300 men. Sodexo Justice Services has managed the prison since 1 December 2013. Care UK provides healthcare services.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Northumberland was in June 2012. Inspectors found that the amalgamation of the two prisons had gone well. The Inspectorate assessed the healthcare provision as reasonable and found that the care of patients with lifelong conditions such as asthma, diabetes and heart disease was good. Clinical governance systems were robust and primary care provision was good. However, prisoners missed a significant number of NHS outpatient appointments, mainly because of transport problems.

Independent Monitoring Board

15. 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 most recently published report for year to December 2013, the IMB noted that, at a time of major change in the prison when the contract for health had been up for renewal over a prolonged period, there had been no increase in complaints about healthcare.

Previous deaths at HMP Northumberland

16. The man was the fourth person to die from natural causes at HMP Northumberland since January 2013. We have previously identified the need to call an ambulance as soon as there are serious concerns about the health of a prisoner.

KEY EVENTS

17. On 31 March 2000, the man received a life sentence for arson with intent to endanger life. He had a history of epilepsy, heart disease and had suffered from high blood pressure since 2003.

18. In June 2009, he transferred to HMP Acklington. (Which later became HMP Northumberland.) He continued to receive regular blood pressure checks and medication to help control his high blood pressure. In March 2010, doctors at Wansbeck General Hospital, Ashington, diagnosed the man with postural hypotension. (Where a change in position causes a temporary reduction in blood flow and a shortage of oxygen to the brain. This causes light-headedness and sometimes a blackout.)

19. In December 2011, a specialist cardiac nurse saw the man about his high blood pressure and blackouts, to rule out cardiac syncope attacks, which lead to a loss of consciousness. Tests were inconclusive and, in October 2012, the hospital fitted the man with a cardiac monitor. (This is inserted just beneath the skin in the upper chest area. It continuously monitors the heart to help determine if the cause of unexplained fainting is heart-related.) This required staff to take the man to hospital after each blackout for an assessment and a monitor reading, to rule out cardiac complications.

20. In November 2013, the man began to have nosebleeds, which appear to have been related to his high blood pressure. On 25 November, the man had a prolonged nosebleed. The next day his blood pressure was raised and a prison GP asked for the man to be taken to hospital. However, it appears he did not go, because of a shortage of officers to escort him.

21. A hospital cardiac consultant saw the man by a telemedicine appointment on 18 December 2013, and noted it was difficult to keep the man within the target blood pressure range, despite the medication he took to help control it. The consultant recorded that keeping his blood pressure out of the danger range would be an achievement.

22. On 7 March, 3 April and 14 May 2014, the prison cancelled three hospital appointments to check the man's cardiac monitor. The cancellations were again due to staff shortages. There is no evidence that they were rescheduled

23. At about 9.30 am on Sunday 3 August, an officer was unlocking prisoners on Unit 14. The man did not interact with him as usual and he noted that he was lying fully dressed on top of the bed with one leg hanging off. He did not appear to have slept in the bed. The officer tried to wake the man and was concerned that he was not responding, although he was breathing and his pulse appeared normal. He asked a prisoner to bring a nurse who was administering medication nearby. A second officer joined the first officer in the cell and was also unable to get a response.

24. A nurse and a health care assistant, arrived shortly afterwards. The two officers explained that the man was usually active and up early in the morning. The nurse did not have any medical equipment with him but manually took the man's pulse and checked that he was breathing. The man's pulse was strong and he was breathing independently. The nurse said he decided to go back to the dispensary and check the man's medical record to see whether he was insulin dependent and might be having a hypoglycaemic episode. He intended to consult a healthcare colleague and come back with emergency equipment. The officers said that the nurse had said that the man looked like he was in a deep sleep. When interviewed, the nurse clarified that this was an observation rather than a diagnosis. The health care assistant said that she believed that it was she who had made that observation, not the nurse.

25. The two officers said that they were concerned about the nurse's assessment. The officer agreed to allow a prisoner on the unit, who had been a nurse, to check the man. He believed that the man had suffered a stroke.

26. At 9.50am, the officer phoned the Senior Officer (SO) the orderly officer in charge of the daily operation of the prison that day to inform her of the situation and to ask for an emergency ambulance. The SO said she would call him back after she had spoken to healthcare staff. The SO spoke to a nurse. She said that the nurse had told her that the man was in a deep sleep and did not require an ambulance. She left a message for officer that she could not overrule the healthcare assessment and call an ambulance.

27. The nurse said that when the SO rang him he had explained that he had not called an ambulance but that colleagues were about to reassess him. The nurse said that after he had looked at the man's records he had phoned another nurse who had said he was aware of the situation and was going to assess him. It is not clear whether he had phoned the officer before he spoke to the SO or not.

28. The officer had asked the unit manager, a SO, to look at the man. The SO then went to the healthcare centre and came back with two nurses. One nurse examined the man and took his observations, which seemed reasonable. The nurse then went to get the emergency bag and oxygen. As his oxygen saturation levels were a little low she administered oxygen and placed the man in the recovery position. She then asked the SO to call an ambulance. The nurse continued to administer oxygen until paramedics arrived at 10.16 am.

29. The ambulance took the man to Wansbeck General Hospital. The man died at 7.18pm later that day.

Notifying the man's next of kin

30. At 10.45am, the man was taken to Wansbeck General Hospital. An officer acted as the prison's family liaison officer and at 12.20pm telephoned the man's niece, his nominated next of kin, to inform her he had been taken to hospital and was seriously ill. The man's niece arrived at the hospital at 4.50pm and was with the man when he died at 7.18pm.

31. The man's funeral took place on 18 August. In line with national guidance, the prison contributed to the funeral costs.

Support for prisoners and staff

32. The prison issued notices to prisoners and staff informing them of the man's death and offering support to anyone affected. The day after he died, a manager debriefed the staff involved in the man's care and the emergency response and offered them support and reassurance. The prison held a memorial service in the chapel on 13 August.

Cause of Death

33. A doctor at Wansbeck General Hospital certified the man's cause of death as intracranial haemorrhage (a bleed from one of the blood vessels in the brain into a space within the skull) with underlying hypertension (high blood pressure).

ISSUES

Clinical Care

34. The man had a number of medical conditions, for which he was receiving medical treatment. Healthcare staff at the prison and hospital doctors found it difficult to manage and lower the man's high blood pressure. Investigations into recurrent blackouts and nosebleeds were ongoing at the time of his death. The clinical reviewer noted that prison GPs frequently reviewed the man's medication but his high blood pressure was resistant to treatment. In this respect, the management of the man's high blood pressure was equivalent to the care he could have expected to receive in the community.

35. The clinical reviewer was satisfied that a GP monitored the man's chronic medical condition and he received appropriate medication and blood tests as necessary. She was also satisfied that the man had the mental capacity, to understand and make decisions about his health.

36. However, the clinical reviewer noted that there were no formal written care plans to manage the man's chronic conditions. As an example, the man was supposed to have weekly blood pressure checks, but there was no evidence of a care plan to ensure that this was done, who was responsible or when this should be reviewed. He was underweight with no corresponding weight management plan and there was no care plan about his heart monitoring device and the need to refer him to the hospital cardiology department after a faint or fit. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with chronic diseases have appropriate management plans that are communicated effectively to healthcare and relevant prison staff.

37. The clinical reviewer noted that the man missed some hospital appointments to check his heart monitor. On one occasion, he was not taken to hospital, after a doctor had requested this, when he had a prolonged nose bleed and raised blood pressure. This appears to have been because of a shortage of officers for hospital escorts and there is no evidence that the cancelled appointments were rescheduled. We make the following recommendation:

    The Director and Head of Healthcare should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

Emergency response

38. Prison Service Instruction (PSI) 3/2013, which covers emergency medical response codes, contains mandatory instructions and guidance to prisons about the management of medical emergencies. It notes that an NHS Ambulance guide for use in the community states that "an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking,

fitting or concussion, severe allergic reactions or a suspected stroke. This must also be the case for prisoners and therefore, in these situations when the medical emergency is called over the radio network, an ambulance must be called immediately." Prisons are expected to use an emergency code blue for such circumstances, which should lead to the control room calling an ambulance immediately. (A code red should be used for blood injuries.)

39. The PSI also notes that local protocols should "Inform staff that if they are in any doubt about the nature of the injury, they must call an ambulance. It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required."

40. At 9.30am, when the officer found the man unresponsive, he did not call an emergency code blue, even though he considered that the man was unconscious at the time. Instead, he asked a prisoner to alert a nearby nurse to assess the man. While this was understandable, we consider he should have radioed an emergency code immediately. The officer said that at the time his understanding was that a code blue should be used only for someone who was not breathing. He believed that many of the staff thought that and there was a need for the prison to tell them otherwise.

41. Once the nurse decided not to call an ambulance immediately, the officer was in a difficult position as calling an ambulance would have meant overriding the assessment of a trained nurse. The orderly officer for the day was unwilling to countermand the nurse's assessment. Like the officer, the orderly officer also believed it was not a code blue emergency as the man was breathing. The orderly officer indicated that when healthcare staff were on duty it was their responsibility to decide whether an ambulance should be called. Nevertheless, the officer commendably persisted in his attempt to get the man emergency medical care.

42. As no emergency code had been called, the nurse did not take an emergency bag when he went to see the man, as he believed he was simply being asked to review a prisoner who officers were concerned about. He said he had intended to return to reassess the man, after checking his medical record and speaking to another nurse . However, when he spoke to the other nurse he learnt that the situation was being dealt with. When discussing his actions, the nurse fully accepted that he had made an error of judgement and should have requested an ambulance. There was an internal enquiry and the nurse has subsequently resigned.

43. While there was a delay in calling an ambulance on the morning of 3 August, we are satisfied that this delay did not affect the outcome for the man. The man died from a stroke caused by his high blood pressure and the evidence suggests that this happened the night before officers found him unresponsive. There is little to suggest that his death could have been prevented or the outcome changed, if the ambulance had arrived an hour earlier.

44. However, we are concerned that interviews with staff indicated that there was a lack of understanding at the prison of the mandatory instructions in PSI

3/2013 and the local emergency protocol. It is important that the prison ensures that all staff understand what is required in an emergency and act accordingly. We have raised this matter with the prison before. In its response to a previous recommendation after a death at the prison in December 2012, the prison said that they had implemented PSI 3/2013 and issued new guidance. It is evident that this guidance is not well understood and the prison needs to take more active steps to ensure staff understand and follow it. We make the following recommendation:

The Director should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during medical emergencies. In particular, staff should use an emergency medical code whenever there are serious concerns about the immediate health of a prisoner and call an ambulance without waiting for healthcare staff to attend.

Contacting the man's family

45. When the man went to Wansbeck General Hospital at 10.45am, he was unconscious. At 12.10pm, hospital staff told the orderly officer that the man had suffered a bleed to the brain and was unlikely to live for more than 24 hours. The family liaison officer, discussed the man's diagnosis and prognosis with his manager. At 12.20pm, the family liaison officer telephoned the man's niece to inform her of his condition. The man's niece arrived at the hospital at 4.50pm and was with the man when he died at 7.18pm. His niece, who lived some distance away, considered she should have been informed earlier.

46. Prison Rule 22(1) states:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

47. While we are pleased that the prison informed the man's in time to enable his niece to spend time with him before he died, it is clear that he was seriously ill when he went to hospital. There was no need to wait for further information from the hospital. In some cases, this would mean families would be informed too late. We consider that the prison should have contacted the man's niece immediately when he went to hospital. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with chronic diseases have appropriate management plans that are communicated effectively to healthcare and relevant prison staff.

2. The Director and Head of Healthcare should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

3. The Director should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during medical emergencies. In particular, staff should use an emergency medical code whenever there are serious concerns about the immediate health of a prisoner and call an ambulance without waiting for healthcare staff to attend.

4. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that prisoners with chronic diseases have appropriate management plans that are communicated effectively to healthcare and relevant prison staff.	Accepted	It is recognised that lessons can be learnt from this case and improvements will be implemented to ensure that prisoners with chronic diseases have an appropriate management plan in place in the future and plans are communicated effectively.	**31 January 2015** **Head of Healthcare**
2	The Director and Head of Healthcare should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.	Accepted	All hospital appointments are booked via healthcare and the prison is committed to providing staff for two escorts each morning and each afternoon. The exception to this would be if there was an emergency escort, which would always be accommodated. Healthcare staff will ensure that the reasons for missed appointments are recorded and new appointments are rescheduled.	**31 January 2015** **Head of Healthcare**
3	The Director should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during medical emergencies. In particular, staff should use an emergency medical code whenever there are serious concerns about the immediate health of a	Accepted	Notices to staff will be re-issued to ensure that staff are aware of their responsibilities.	**31 January 2015** **Head of Safer Custody**

	prisoner and call an ambulance without waiting for healthcare staff to attend.			
4	The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.	Accepted	All orderly officers and duty governors will be reminded of the importance of contacting seriously ill prisoners' next of kin (NOK) as soon as possible, and this should not wait until there is a diagnosis from the doctor at the hospital. If the prisoner is conscious they will be asked whether they would like their family/NOK contacted. If the offer is declined, this will be recorded.	**31 January 2015** **Head of Residence**