



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in
December 2014 at HMP Usk**

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 heart disease on December 2014 at HMP Usk. I offer my condolences to his family and friends.

On of my investigator and the Health Inspectorate Wales (HIW) reviewed the clinical care the man received at HMP Usk. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 1982. Between 2002 and 2005, he suffered a number of heart attacks and doctors fitted stents to widen the arteries in his heart. In 2012, he moved to Usk. He continued to suffer from angina, but had no further heart attacks.

On the afternoon of 1 December 2014, the man was playing the drums in a concert for staff and other prisoners when he collapsed. An officer put the man in the recovery position and radioed an emergency code, indicating a life-threatening situation, but the control room did not call an ambulance until healthcare staff arrived and requested one. Prison and healthcare staff carried out cardiopulmonary resuscitation for over 20 minutes until paramedics arrived. After further attempts at resuscitation, the paramedics pronounced the man dead.

Despite his previous heart problems, the man's death was sudden and unexpected. I agree with the clinical reviewer that that the standard of care the man received at Usk was at least equivalent to that he could have expected to receive in the community. The investigation identified a need for Usk to improve its emergency response procedures to ensure there is no delay in calling an ambulance in future, but I am satisfied that this did not affect the outcome for the man.

The 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

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SUMMARY

1. In July 1982, the man was sentenced to life imprisonment. Between August 2002 and February 2005, he had four heart attacks. Doctors treated him with medication and inserted stents to widen his arteries.
2. From 2005, the man frequently experienced angina (muscle pain in the heart) and was occasionally admitted to hospital for treatment. He used a GTN spray to ease angina pain.
3. In November 2013, healthcare staff noted that the man had slightly raised blood pressure, which they began to monitor. In February 2014, a GP prescribed medication to reduce his blood pressure and, by March 2014, it had returned to normal. For the next nine months there nothing significant was recorded in the man's healthcare records.
4. On 1 December, the man was playing the drums in a concert for staff and prisoners. At approximately 2.55pm, he collapsed to the floor. An officer put him in the recovery position and radioed an emergency code blue (which indicates a prisoner has severe breathing difficulties or is unresponsive). Another officer ran to the healthcare department to get assistance. The control room did not call an ambulance immediately, as should happen once an emergency code is broadcast.
5. When the man collapsed, a prisoner went to his cell to get his GTN spray as he knew the man used the same medication as he did. When he came back, he administered a dose to the man.
6. Immediately after this, a nurse and a healthcare assistant arrived with an emergency bag and defibrillator. The nurse radioed the control room and the staff called an ambulance at this point.
7. The nurse checked the man for signs of life and was unable to find a pulse. The nurse and her colleague started cardiopulmonary resuscitation and used the defibrillator, which administered a shock. Afterwards, the nurses and officers continued with resuscitation.
8. At approximately 3.20pm, paramedics arrived and took over the resuscitation attempt. They continued for approximately 20 minutes and then pronounced the man dead.
9. HIW concluded that the standard of healthcare the man received at Usk was at least equivalent to that he could have expected to receive in the community. We make one recommendation about calling ambulances immediately in an emergency, but do not consider that the delay in this case affected the outcome for the man.

THE INVESTIGATION PROCESS

10. The investigator issued notices to staff and prisoners at HMP Usk informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed seven members of staff at Usk on 15 January 2015 and subsequently informed the prison of the preliminary findings of the investigation.
12. Health Inspectorate Wales (HIW) reviewed the man's clinical care at the prison.
13. We informed HM Coroner for Wales, Gwent District, of the investigation, who provided the post-mortem report. We have sent the coroner a copy of this investigation report.
14. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. They were concerned that he had not attended hospital for an important scan.
15. The man's family received a copy of the draft report. They pointed out a factual inaccuracy. This report has been amended accordingly.
16. The prison also considered our draft report and raised some factual inaccuracies which have also been amended. They submitted an action plan addressing our recommendations which is at the end of this report.

HMP USK

17. HMP Usk holds up to 273 men convicted of sexual offences. The prison is managed jointly with nearby HMP Prescoed. The Aneurin Bevan Health Board delivers healthcare services, which are available between Monday and Friday from 8.00am to 4.30pm. There is a GP surgery every weekday morning and doctors from the practice are on call until 6.30pm each weekday.

HM Inspectorate of Prisons

18. The most recent inspection of Usk was in May 2013. The Inspectorate found that health services at the prison were generally good and chronic disease management was starting to develop. However, medicine management needed improvement.

Independent Monitoring Board

19. Each prison in England and Wales 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 the year 2013-14, the IMB noted that a change in healthcare provision at the prison had led to a more effective service. The IMB was concerned that reduced staffing at the prison could impact on the management of unforeseen incidents.

Previous deaths at HMP USK

20. The man was the fifth prisoner to die at Usk since the start of 2013. All five deaths were from natural causes. We have recommended that the prison revise its emergency response procedures before.

KEY EVENTS

21. In July 1982, the man was sentenced to life imprisonment. Between August 2002 and February 2005, the man suffered four heart attacks. Doctors treated him with medication and inserted stents to widen his arteries.
22. Between June 2006 and February 2013, the man was admitted to hospital with angina several times. Doctors prescribed a number of medications including GTN spray (glyceryl trinitrate – a short acting preparation to ease angina), atenolol (to reduce blood pressure) and simvastatin (to reduce cholesterol).
23. After spending time at a number of prisons, the man transferred to Usk from HMP Lincoln on 14 August 2012. At an initial health screen, Nurse A noted his cardiac history and listed and dispensed his medications.
24. On 15 August, a prison GP, Dr A, saw the man and recorded that he should not do any heavy lifting but that he was fit for remedial exercise such as walking. He noted that, following an exercise test earlier in August, at Pilgrim Hospital in Lincolnshire, staff had advised the man to have a myocardial perfusion scan (a procedure which uses radioactive chemicals to track how well blood is flowing to the heart's muscles). On 15 August, the day after he arrived at Usk, Nurse A referred the man to Neville Hall Hospital cardiology unit.
25. On 13 February 2013, the man went to hospital with chest pain. Doctors discharged him the same day with a diagnosis of angina.
26. On 26 June, the man moved to HMP Leyhill as part of his sentence progression. A healthcare assistant carried out a comprehensive initial screen and noted that the man had a cardiology appointment for a scan on 2 July. She noted that he might need another referral because his prison move meant he was now in a different NHS area. In fact, the man's move to Leyhill was not successful and he returned to Usk the next day.
27. On 26 July, the prison received a letter from a consultant cardiologist, Dr B, saying that the man had not attended his appointment for a scan on 2 July and that he did not intend to see him again as he believed he had changed prisons and was now in a different NHS area. On 14 August, a prison GP, Dr C, referred the man back to Dr B.
28. On 8 November, Nurse B took the man's blood pressure as he had said he felt stressed. The readings were 140/90 and 130/80 (both within normal range). On 22 November, Nurse C re-checked the man's blood pressure and noted it was slightly raised (141/97). Nurses checked his blood pressure frequently over the next two months, and records show it fluctuated. On 6 February 2014, Nurse D referred him to the GP to review his blood pressure.

29. Dr C saw the man the next day. He considered the man's history and changed his blood pressure medication. Blood pressure checks in March and May showed it had returned to normal levels.
30. On 9 May 2014, Dr B, the consultant cardiologist, reviewed the man and noted that his angina was stable. He decided that the man did not need the scan that Pilgrim Hospital had recommended in 2012.
31. On 28 August, Healthcare Support Worker A carried out the man's annual coronary heart disease review. She assessed him using the QRisk2 tool – a cardiovascular risk factor calculator looking at an individual's profile (lifestyle, history, physical factors etc). She concluded his cardiovascular health risk was at the very bottom end of the moderate risk group and no further action was needed at the time.
32. The last time a member of healthcare staff saw the man before he died, was on 27 November, when the pharmacy technician gave him his usual medication. She did not note any concerns about him.

Monday 1 December

33. On 1 December, as part of World Aids Day, the man played the drums in a band at a concert for staff and prisoners in the prison gym. At approximately 2.55pm, the man fell from his stool and collapsed on the floor. Officer A put him in the recovery position and radioed a code blue (which indicates a prisoner has severe breathing difficulties or is unresponsive). The control room did not call an ambulance immediately as Prison Service instructions require. Officer B ran to the healthcare centre (one or two minutes away) and called for nurses to help.
34. In the meantime, another prisoner ran to his cell (which was closer than the man's) to get his GTN spray as he knew that he and the man used the same medication. He returned and administered the spray to the man (under his tongue), just before Nurse E and a healthcare assistant, B, arrived with an emergency bag and a defibrillator.
35. When Nurse E saw the man on the floor, she immediately radioed the control room and asked them to call an ambulance. She checked for signs of life and noted he had no pulse. She started chest compressions and the healthcare assist attached an ambu-bag (a device to help deliver rescue breaths). After one round of compressions, the nurse applied the defibrillator which advised a shock. After this, the healthcare assistant, Officer C and a custodial manager took it in turns to do chest compressions.
36. An operational support grade called the ambulance from the communications room at 3.00pm. The emergency services operator asked the operational support grade a number of questions that she was unable to answer so she put the call through to an operational manager, who was close to the scene.

37. At approximately 3.20pm, the ambulance arrived at the prison. Paramedics spent approximately twenty minutes trying to resuscitate the man, but, at 3.45pm, they pronounced him dead.

Contact with the family

38. Senior Officer A acted as the prison's family liaison officer and she and the duty governor went to the man's parents' home and informed them of his death.
39. SO A continued to support the man's family after his death. The man's funeral was on 19 December. The prison contributed to the costs in line with national guidance.

Support for staff and prisoners

40. Officers visited every prisoner on the man's wing individually to inform them of his death and gave them details of available support, including from Listeners (prisoners trained by the Samaritans to give support and counselling to other prisoners).
41. The Governor emailed all staff to inform them that the man had died and offered appropriate support. A senior manager debriefed all the staff involved in the emergency response.

Post-mortem

42. A post-mortem examination found that the man had died from ischaemic heart disease (a reduced supply of blood to the heart) and coronary artery atheroma (narrowed arteries).

ISSUES

Clinical care

43. HIW concluded that the man's care in prison was at least equivalent to that he could have expected to receive in the community. HIW noted that healthcare staff monitored his conditions (high blood pressure and cholesterol) appropriately. Although the man missed an appointment for a scan, because of confusion when he moved briefly to another prison, the cardiologist concluded, when he saw the man, that a scan was not necessary. His collapse on 1 December was sudden and unexpected and could not have been prevented. Healthcare staff and officers administered cardiopulmonary resuscitation appropriately to try to save the man. A prisoner administered GTN, but HIW noted that this would have had no effect.
44. We agree with HIW's assessment of the standard of the man's care in prison, and we are satisfied that he received appropriate support and treatment.

Emergency Response

45. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, issued in February 2013, says that prisons should have a local protocol which gives guidance on efficiently communicating the nature of any medical emergency. A code blue emergency call should be used for respiratory issues or if a prisoner is unconscious. This should ensure that staff take the right equipment to an incident and that the control room staff call an ambulance automatically. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies and that it should not be necessary to wait for a member of healthcare staff or a manager to attend before calling an ambulance.
46. At the time of the man's collapse, Usk's protocol directed nurses to identify the need for an emergency ambulance and inform the control room. It did not clearly set out the responsibilities of prison staff in an emergency. There was no requirement for staff to use emergency codes which specify the nature of the emergency, or guidance about the correct equipment to bring.
47. Officer A did use an emergency code to relay the nature of the emergency to other staff on duty but the operational support grade did not call an ambulance immediately, when she heard the code blue. Instead, she waited for nurses to attend the scene and advise her if they needed paramedics. She told us she had always been instructed to wait until a nurse or prison manager told her to call an ambulance.
48. We are concerned that emergency procedures at the prison did not reflect current Prison Service requirements or set out the responsibilities of staff in an emergency. HIW noted that that a more rapid response would not have changed the outcome for the man, but, in other circumstances, such a delay could be crucial. We understand that Usk are working to amend their

emergency response procedures to address the issues that this and another recent investigation into a death at the prison in August 2014, has raised. We repeat the recommendation we made in the previous case:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Usk has a medical emergency response code protocol based on the PSI which ensures:

- **staff efficiently communicate the nature of a medical emergency;**
- **relevant emergency equipment is brought, and**
- **that there are no delays in calling, directing or discharging ambulances**

RECOMMENDATION

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Usk has a medical emergency response code protocol based on the PSI ensures:

- staff efficiently communicate the nature of a medical emergency;
- relevant emergency equipment is brought; and
- that there are no delays in calling, directing or discharging ambulances

ACTION PLAN: The man– HMP Usk

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	<p>The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Usk has a medical emergency response code protocol based on the PSI ensures:</p> <ul style="list-style-type: none"> • staff efficiently communicate the nature of a medical emergency; • relevant emergency equipment is brought; and • that there are no delays in calling, directing or discharging ambulances 	Accepted	<p>Staff have been reminded via staff meetings, Governor's blogs and formal notices to staff of the requirements of PSI 03/2013 and their responsibilities during medical emergencies.</p> <p>Medical emergency response codes have been implemented and communicated to all staff. Further communication of these response codes will be issued quarterly and included in local staff training events.</p> <p>The content of monthly staff training days will be amended to reflect suitable training for all staff in relation to duty of care, response codes, calling of ambulances and out of hours healthcare advice and support.</p>	31 August 2015