A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man on 25 December 2014 at HMP Doncaster

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 chronic obstructive pulmonary disease on 25 December 2014 at HMP Doncaster. He was 60 years old. I offer my condolences to his family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

In November 2014, the man was recalled to prison for breach of his licence conditions, and had two months to serve. A nurse noted a number of health conditions including chronic obstructive pulmonary disease. The man's blood oxygen levels were low and he was severely underweight. When he arrived, a doctor re-prescribed the medications the man had received in the community, but did not see or examine him. He had mobility problems and spent most of his time in his cell. At 4.30am on Christmas Day, his cellmate found him unresponsive and alerted staff. Nurses attended, but did not attempt resuscitation because the man was clearly dead. An ambulance was called and paramedics pronounced him dead at 4.53am.

The clinical reviewer was concerned about the lack of follow up of the man's low oxygen levels and severe low body weight after he arrived at the prison. There was no coordinated care plan to monitor his serious lung condition and manage his overall health. When the GP saw him on 19 December, he adjusted his medication, but did not examine him or assess the severity of his COPD. The clinical reviewer considered that the standard of healthcare the man received at Doncaster was not equivalent to that he could have expected to receive in the community. I agree.

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 **June 2015**

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SUMMARY

1. The man arrived at HMP Doncaster on 27 November 2014. He had been recalled to prison for breaching his licence conditions from a previous offence. A nurse carried out an initial health screen and noted he had chronic obstructive pulmonary disease (COPD – lung disease). She recorded that he was severely underweight and had low blood oxygen levels. The man took a number of medications for breathing problems, heartburn, prostate issues and pain relief. A prison GP re-prescribed these, but did not see or examine the man.

2. On 15 December, the man told a nurse he had not seen a doctor since he had arrived at the prison and asked for an appointment. On 19 December, a GP saw him and reviewed his medications, but did not assess his COPD or plan to review him again.

3. On 25 December, the man's cellmate woke up at 4.30am. The man was unresponsive and cold so his cellmate rang the cell bell for assistance. An officer responded, and radioed a code blue emergency (which indicates a prisoner is unresponsive or having breathing difficulties). Control room staff immediately called an ambulance. Prison nurses attended and checked him, but did not attempt to resuscitate him, as it was clear that he had died. Paramedics arrived and, at 4.53am, pronounced him dead. A post-mortem examination found that he had died of COPD.

4. We agree with the clinical reviewer that the care the man received was not equivalent to that he could have expected to receive in the community. The clinical reviewer considered that it was possible that the lack of appropriate care in prison contributed to his death. Healthcare staff did not follow up his low blood oxygen levels or his severe low weight. They did not implement care plans or reviews, which was a missed opportunity to assess the severity of the man's condition. After his death, there was no debrief for staff involved in the emergency response. We make two recommendations about these matters.

THE INVESTIGATION PROCESS

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

6. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed three members of staff and one prisoner at Doncaster on 23 January 2015. The investigator gave the Director initial feedback about the investigation.

7. NHS England commissioned a doctor to review the man's clinical care at the prison.

8. We informed HM Coroner for South Yorkshire East District of the investigation, who provided the post-mortem report. We have sent the coroner a copy of this investigation report.

9. One of the Ombudsman's family liaison officers contacted the man's son to explain the investigation. He asked for clarification of when his father went to prison and what happened while he was there

10. The man's family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and raised one factual accuracy which has been amended in this report. The prison also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP DONCASTER

11. HMP Doncaster is a local prison operated by Serco, holding 1,145 remand and sentenced men. There are three houseblocks, each with four wings holding 90-96 prisoners.

12. Nottingham Healthcare NHS Trust provides 24-hour care in a healthcare centre and in the houseblocks.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Doncaster was in April 2014. The Inspectorate found that some aspects of healthcare were good but there were delays in giving out medicines. There were chronic disease clinics, but there were delays in initial access to healthcare services because of a poorly managed application procedure.

Independent Monitoring Board

14. 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 annual report for the year to September 2014, the IMB noted that daily triage clinics continued and there was a new minor illness/ailment clinic run by nurse prescribers. Waiting times to see a GP had reduced.

Previous deaths at HMP Doncaster

15. The man was the third prisoner to die of natural causes at Doncaster since January 2013. We have previously made recommendations about the need to follow national guidelines for managing chronic health conditions.

KEY EVENTS

16. The man was recalled to prison on 27 November 2014 for breaching licence conditions imposed for a previous offence and arrived at HMP Doncaster the same day. His release date was 25 January 2015.

17. A nurse carried out an initial health screen and noted he was severely underweight with a body mass index of 13.57. (Body mass index is a measure of body fat based on height and weight, anything under 18.5 is underweight.) He had chronic obstructive pulmonary disease (COPD – lung disease) and asthma. His oxygen levels were low at between 88-94%. His mobility was poor and he used a wheelchair. He had a history of post-traumatic stress disorder (PTSD). The man had brought with him a nebuliser (a machine that creates a mist of medicine for respiratory problems, which is breathed in through a mask or mouthpiece), a blood pressure monitor and a machine to monitor the level of oxygen in his blood. The nurse noted the man was taking 13 different medications for breathing problems, heartburn, prostate issues and for pain relief. A psychiatrist re-prescribed the medications the same day but did not see or examine the man.

18. On 28 November, a senior mental health nurse, reviewed the man's medical history. He noted the man had not shown symptoms of post-traumatic stress disorder when he had been in prison before and discharged him from the mental health team.

19. On 29 November, the man did not attend a booked secondary health screen. A nurse prescriber saw him on 3 December, and re-prescribed his medications and agreed he could keep a weekly supply in his cell. On 15 December, the man told a nurse that he needed more inhalers. He said that he had not seen a GP since he had arrived at the prison and would like to see one. She made a routine GP appointment for him.

20. On 19 December, a doctor saw the man, arranged a repeat prescription for him, and prescribed additional medication for his breathing problems. He did not examine him physically or assess his COPD.

21. On 23 December, a nurse prescriber prescribed the man a nutritional drink and an inhaler.

Events on 25 December

22. The man's cellmate told us that he and the man had watched television and talked until about 11.30pm on 24 December, when he fell asleep. At 4.30am on 25 December, Christmas Day, he woke up and noticed the television was still on. He lent over the edge of the top bunk and saw the man's legs protruding from the bed below. He thought the man had fallen asleep sitting on his bed. He asked him if he was okay, but he did not respond. He got down from the bed and found that the man's eyes were open and he was slumped over to one side. He shook his knee, which he described it as 'ice cold'. He thought the man was dead and pressed the cell bell.

23. An officer attended and the cellmate told him he thought the man had died. The officer asked him to check the man again, while he radioed a code blue (a medical emergency code to indicate a prisoner is unresponsive or having breathing difficulties). The cellmate put his hand to the man's mouth, but felt no breath. The control room log shows the code blue was radioed at 4.30am and the ambulance was called at 4.31am.

24. Three nurses arrived with the emergency bag. They assessed the man, and noted that he had no pulse, was cold to touch, and his eyes were open and fixed and there were signs of rigor mortis. They did not start cardiopulmonary resuscitation because the man was clearly dead and they considered it would be futile and undignified for him. Paramedics arrived at the prison at 4.41am and at 4.53am, pronounced him dead.

Informing the man's family

25. The man's next of kin was his son, but the prison only had his name and 'the armed forces' as an address, and no telephone number. The prison contacted the police to help find him. This took some days and the police informed him of his father's death. A prison family liaison officer then contacted his son and visited him on 31 December to offer support.

26. The man's funeral was on 29 January 2015. The prison contributed to the cost in line with national guidance.

Support for staff and prisoners

27. The prison issued a notice to inform staff and prisoners of the man's death. The notice directed prisoners affected by his death to seek help from peer supporters and healthcare staff on the wing and said that members of the chaplaincy team would attend the wing to offer support. The cellmate told us he felt well supported after the man died. Staff monitored how he was and told him how to get help if he needed it

28. Managers did not hold a 'hot' debrief for the staff involved in the emergency response and some of the staff said that the potential personal impact on them was not recognised.

Post-mortem

29. A post-mortem examination found that the man died of chronic obstructive pulmonary disease.

ISSUES

Clinical care

30. The clinical reviewer concluded the level of care the man received was not equivalent to that he could have expected to receive in the community. Healthcare staff at Doncaster did not act on his low oxygen levels and severely low weight when he arrived at the prison and did not manage his COPD appropriately. The clinical reviewer considered that this could have contributed to the man's death. He has made some detailed recommendations, which the Head of Healthcare will need to address. Because of the concerns identified about the poor standard of care the man received, NHS England is taking forward separate action with the prison, to improve the care provided.

Management of the man's chronic conditions

31. The man came to prison with known COPD, and a nurse noted he had low oxygen levels (88-94%) and was severely underweight. The clinical reviewer said that both of these could be signs of respiratory distress and severe COPD. Healthcare staff did not make any care plans or arrange to review him despite having this information. The nurse in reception also noted he spent most of his time in bed or in his wheelchair, but there is no further reference to his poor mobility after the initial health screen. A doctor did not see him until 19 December, and only after the man had asked for an appointment.

32. A doctor told us that when he saw him on 19 December, the man was only concerned about getting his medication prescribed. He said that the man did not appear out of breath, so he did not examine him. He assumed his low weight was long standing as doctors in the community had prescribed him nutritional drinks. The doctor did not consider setting up a care plan or arranging a review of the man's COPD.

33. The clinical reviewer considered it would have been reasonable to consider whether the man needed palliative care because his medications, medical documentation and lack of mobility suggested he had advanced, severe COPD. There is no evidence that healthcare staff fully considered his complex medical needs. They should have reviewed him and implemented care plans in line with the National Institute for Health and Care Excellence (NICE) guidelines on the management of COPD, but this was not done. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with COPD and other chronic conditions have detailed care plans and are managed and reviewed in line with NICE guidelines and any deterioration in their condition is closely monitored.

Support for staff

34. Prison Service Instruction 64/2011 –Safer Custody, states that ‘in line with PSI 08/2010 Post Incident Care a ‘Hot Debrief’ must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited’. An early debrief is an opportunity to discuss what happened, learn lessons and receive support and we consider it is good practice to offer support to staff in this way after all deaths. Staff told us there was no debrief for those involved in the emergency response for the man, and some said they did not feel appropriately recognised or supported. We make the following recommendation:

The Director should ensure that a manager debriefs all relevant staff shortly after a death at the prison and that all staff involved receive appropriate support.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with COPD and other chronic conditions have detailed care plans and are managed and reviewed in line with NICE guidelines and any deterioration in their condition is closely monitored.

2. The Director should ensure that a manager debriefs all relevant staff shortly after a death at the prison and that all staff involved receive appropriate support.

ACTION PLAN: A man – HMP Doncaster

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that prisoners with COPD and other chronic conditions have detailed care plans and are managed and reviewed in line with NICE guidelines and any deterioration in their condition is closely monitored.	Accepted	HMP Doncaster are currently developing the workforce capability to undertake annual reviews of patients with long term respiratory disease including Asthma and Chronic Obstructive Pulmonary Disease (COPD). Training has commenced to have two registered nurses trained in diagnostic spirometry and healthcare assistants trained to undertake recording of spirometry. Spirometry training is being undertaken to the Association for Respiratory Technology and Physiology (ARTP) validation standards and competency will be reviewed and revalidated every three years through submission of spirometry data and interpretation to an approved ARTP provider. Care plan templates for long term conditions have been installed on SystmOne, the training incorporates the use of the templates that all clinicians are competant to use. The care plans will be reviewed by the PrimaryCare Clinical Matron monthly. The Trust will complete annual audit of compliance Annual reviews will meet the requirements of the quality outcomes framework (QOF) and embed best practice as identified in NICE COPD and Asthma pathway clinical guidelines and quality standards.	31 May 2015 Head of Healthcare

2	The Director should ensure that a manager debriefs all relevant staff shortly after a death at the prison and that all staff involved receive appropriate support.	Accepted	An instruction has been issued to all Manager grades reminding them of the necessity to carry out a hot debrief immediately post incident, and before staff involved leave the establishment. Managers have been reminded of their responsibilities in terms of their duty of care to each other and their staff. The care team lead has also been advised to review their processes to ensure that all staff affected are contacted and offered assistance. The Business Services manager has refreshed the information to staff on the company assistance scheme (Unum Lifeworks)	Completed Director