

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in April 2014,
while in the custody of HMP The Mount**

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 in April 2014, while in the custody of HMP The Mount. The man died from an intestinal obstruction and a diaphragmatic hernia. He was 25 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 The Mount. The prison cooperated fully with the investigation.

In September 2012, the man was sentenced to four years in prison. He transferred to The Mount in May 2013 and healthcare staff did not identify any physical health problems when he arrived,

On 1 April 2014, the man reported feeling unwell with abdominal pain. His condition deteriorated over the next 24 hours and he went to hospital by ambulance on the afternoon of 2 April. The man had a seizure in hospital the next day and went into cardiac arrest. Hospital staff were unable to resuscitate him and he was pronounced dead at 9.35am.

The man's death was sudden and unexpected and I agree with the clinical reviewer that the standard of healthcare he received at The Mount was equivalent to that which he could have expected to receive in the community. However, we have identified some areas for improvement which, while they did not affect the outcome for the man, need to be addressed. These include the need to review emergency procedures, improve risk assessments for prisoners taken to hospital and inform families promptly when a prisoner becomes seriously ill.

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

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SUMMARY

1. In September 2012, the man was sentenced to four years in prison for drugs offences. He was transferred to The Mount in May 2013. He had no physical health concerns when he arrived and healthcare staff did not identify any. The man reported no significant health problems in the following months.
2. On 1 April 2014, the man first reported feeling unwell with stomach cramps, vomiting and reflux symptoms. A nurse saw him that morning and thought he might have food poisoning. She advised him to avoid food and stay hydrated. She gave the man medication to treat his reflux symptoms.
3. The man continued to feel unwell and called an officer to his cell in the early hours of 2 April. He said that he had been sick and was in pain. The officer advised him to go to the prison's healthcare centre in the morning. The next morning, a doctor saw the man who reported cramping pain in his stomach and said that he was constipated. The doctor prescribed medication to alleviate his symptoms and told him to return if he felt worse.
4. On the afternoon of the 2 April, the man's condition deteriorated suddenly. His stomach was visibly swollen and he was in a lot of pain. Nurses assessed the man and called an emergency ambulance. After assessing him, paramedics took the man to hospital.
5. The man arrived at Watford General Hospital at 4.32pm. The hospital admitted him for observations and monitored him throughout the night. At 8.45am on 3 April, the man asked to go to the toilet but had a seizure. One of the escort officers called for medical assistance. Hospital staff took the man back to his bed and he went into cardiac arrest. At 9.35am, a doctor pronounced the man dead. A post-mortem examination found the cause of death to be due to an intestinal obstruction and a diaphragmatic hernia.
6. NHS England found that the standard of healthcare the man received at the Mount was equal to that he could have expected to receive in the community. He did not report any concerns until 1 April and prison healthcare staff ensure he was taken to hospital on 2 April when he needed urgent treatment. While these issues would not have affected the outcome for the man, the investigation had identified a need for some improvements, including in emergency procedures, escort risk assessments and informing prisoners' families when they are seriously ill. We make four recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices informing staff and prisoners at HMP The Mount of the investigation and inviting anyone with relevant information to contact her.
8. The investigator obtained copies of the man's medical records and relevant extracts from his prison records. She interviewed ten members of staff and four prisoners at HMP The Mount in June and July.
9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison. The clinical reviewer joined the investigator for interviews with healthcare staff.
10. We informed HM Coroner for Hertfordshire of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation. The man's sister said that some friends of her brother had told her that he had been complaining of stomach pains from the previous Monday, that his stomach was visibly swollen and that he did not receive the appropriate medication and treatment. The man's sister had the following specific questions:
 - Why was she not contacted when the man was taken to hospital?
 - Who alerted the healthcare staff to go to his cell when his condition got worse on 2 April?
 - What changed in his wellbeing from the morning of 3 April to when he was taken to hospital?
 - Was he well enough to be left alone in his cell?
 - How did he leave his cell? Was he in a wheelchair?
 - What did the G.P check for when the man visited the prison healthcare centre?
 - How many times did he visit the healthcare centre?
 - How was his physical appearance?
12. The man's family received a copy of the draft report. The solicitor representing the man's family wrote to us pointing out a factual inaccuracy in the clinical review report which has been amended accordingly. They also raised a question that does not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. The prison has 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 THE MOUNT

13. HMP The Mount is a medium security prison, which holds 770 convicted adult men.
14. The primary care team is nurse led. Hertfordshire Community Services Trust provides nursing services. GP services are commissioned from Pathfinder Practice, South West Hertfordshire Health Centre. There are seven GP sessions a week.

HM Inspectorate of Prisons

15. The most recent inspection of HMP The Mount was in February 2012. Inspectors found that the prisoners generally felt safe and overall that prisoners were well cared for. The standard of health services was assessed as good and there were a wide range of services and clinics. There were concerns about insufficient escorts for external health appointments.

Independent Monitoring Board

16. 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 February 2014, the IMB commented that the healthcare team delivered an effective and relevant service to prisoners. They said that prisoners were satisfied with the standard of healthcare services they received.

Previous deaths at HMP The Mount

17. The man was the first prisoner to die from natural causes at HMP The Mount since 2012.

KEY EVENTS

18. The man was remanded to HMP Thameside on 5 July 2012 and sentenced to four years in prison for drugs offences on 28 September 2012. In May 2013, he was moved from HMP High Down to HMP The Mount.
19. When he arrived at The Mount, a reception health assessment identified no physical health concerns. The man stated that he smoked five cigarettes a day.
20. After his reception assessment, the man's only further contact with healthcare staff was for advice about stopping smoking, medication for a skin condition and treatment for a knee injury after playing football.
21. The man first reported being unwell on 1 April 2014. He went to the triage clinic in the healthcare centre and told a nurse that he was experiencing abdominal pain. He said that he had vomited the previous night and had reflux symptoms. The nurse examined him and found no tenderness in his abdomen and no sign of jaundice. She thought that he might have food poisoning and advised the man to drink plenty of fluids and to avoid food until he felt better. She gave the man antacid medication to relieve his symptoms, and advised him to come back if his symptoms got worse.
22. The nurse told the investigator that when nurses have serious concerns about a patient in the triage clinic they consult the doctor. If the doctor shares the concerns then they usually see the patient in the clinic. The nurse said that the man appeared happy with the outcome of the consultation and she did not refer him to see a doctor.

2 April

23. At 1.50am on 2 April, the man pressed his cell bell and told an officer that he was feeling unwell. The man said that he had been vomiting and had pains in his stomach. He said that he had had these symptoms for three days. The officer told him to try and stay hydrated and to see healthcare staff in the morning. The man pressed his cell bell a second time at around 3am and said that he was still unwell. The officer spoke to the orderly officer who also advised that he should see healthcare staff in the morning. The orderly officer did not suggest that they should call the out of hours service and the officer said that the man's condition did not seem serious at the time.
24. The next morning, the man saw a prison GP about his abdominal pain. He reported cramping pain and that he was constipated. The GP took the man's clinical observations and was satisfied that the results indicated no concerns. The man declined co-codamol (a painkiller) due to a possible risk of worsening constipation. He requested senna medication for constipation, which the GP prescribed, as well as mebeverine (for bowel cramps), and omeprazole (to reduce acid levels relating to reflux). She asked the man to return if his symptoms got worse.
25. The man's condition deteriorated during the morning. That afternoon, an officer noticed that the man was in a lot of pain, and his stomach was very swollen. The man told him that he had seen the doctor that morning.

26. At around 2.15pm, the officer called the healthcare centre to ask someone to come to the wing to review the man. An administrator said that the man should put in an application for an appointment. The officer was unhappy with this response and spoke to the orderly officer (in charge of the daily operation of the prison) who advised him to contact the healthcare centre again and note this in the wing observation book if they refused to see the man again. Another prisoner stayed with the man while the officer contacted healthcare staff.
27. The officer contacted the healthcare centre again and asked to speak directly to a nurse. He told the investigator that he had a lengthy conversation with a nurse and she agreed that the man could go to see her. As the officer went to pass this news on to the man, the prisoner came to the office and said that the man had fainted. The prisoner told the investigator that the man had not actually fainted, but he had said this to try and get a nurse to come and see him straight away.
28. The officer called out to another officer and asked him to contact healthcare centre to say that the man had fainted. The officer went to the man's cell and found him awake and conscious. He said that the man was in a lot of pain and struggled to speak. The officer told the investigator that he did not call a code blue medical emergency (which indicates a prisoner is unconscious or not breathing) as the man was awake and responsive when he arrived at his cell. The officer said that it took the nurse between five and ten minutes to arrive.
29. A nurse arrived first and examined the man. After about 10 minutes, the senior nurse arrived at the cell. The man told the senior nurse that he had vomited and the pain was increasing. He had a distended abdomen and was sweating. The senior nurse contacted her colleague, another senior nurse to check the man's notes and to discuss his symptoms. They agreed that they should request an emergency ambulance. The prison called an ambulance at 2.55pm.
30. The nurse left the wing and another nurse arrived with the man's medical notes for the hospital. The nurses continued to monitor the man. Shortly afterwards, the man suddenly deteriorated further and the nurses found it difficult to read his pulse. The senior nurse asked an officer to contact the healthcare centre and bring emergency equipment. The senior nurse gave the man oxygen and put a coat around his shoulders to try and stop him from shaking. She said that he appeared to be in shock.
31. The ambulance arrived at the prison at 3.20pm. The paramedics assessed the man in his cell and decided to take him to hospital. The man was taken in a wheelchair from his cell to the ambulance. Two officers escorted the man to hospital. He was handcuffed to one of the officers.
32. Ambulance service records show that the ambulance left the wing at 3.57pm, but the prison records show that the ambulance did not leave the prison until 4.07pm. An operational manager said that it would take around ten minutes for the ambulance to get from the man's wing to leave the prison through the gates.

33. The man arrived at Watford General Hospital at 4.32pm. He was assessed in Accident & Emergency and had an X-ray. He moved to a ward at 8.50pm and medical observations continued overnight. He was handcuffed to an officer with an escort chain (a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer).

3 April

34. At 8.45am, the man asked to go to the toilet and one of the escorting officers took him. The officer told the investigator that the man had a seizure while sitting on the toilet. He immediately called for help and hospital staff took the man, in a wheelchair, back to his bed. He then stopped breathing and the hospital staff gave him oxygen. The man went into cardiac arrest and the staff began to attempt resuscitation at 9.05am. Sadly this was unsuccessful and, at 9.35am, a doctor pronounced the man dead.
35. The officer told the investigator that, when the man first collapsed in the toilet area, the man kept trying to stand up and he was unsure how unwell he was. The officer said that when they got him back to his bed and the situation became more serious, he immediately removed the escort chain.

Liaison with the man's family

36. The hospital contacted healthcare staff at the prison during the resuscitation attempt to see if they had any further information about his medical history. The Head of Healthcare then contacted one of the chaplains, the Reverend, a family liaison officer at The Mount, to ask him to let the man's next of kin know that he was seriously ill in hospital.
37. The man had nominated his sister as his next of kin. The family liaison officer was unable to get hold of the man's sister but found a number for his girlfriend. The family liaison officer explained to her that he was trying to get hold of the man's sister to let her know that the man was seriously ill in hospital. His girlfriend said that she would try to contact the man's sister. A few minutes later, the family liaison officer received another call from the head of healthcare with the news that the man had died. Immediately afterwards, the family liaison officer received a call from the man's girlfriend to say that she was coming to the hospital. He felt that he had no choice but to let her know that the man had died. The man's girlfriend asked to speak to a manager at the prison and an operational manager, then spoke to her and confirmed that the man had died.
38. Shortly afterwards, the man's sister telephoned the family liaison officer. He explained what had happened and offered to visit her at her home. She said that she would like to go to the hospital. The family liaison officer and another family liaison officer met her there. The man was a Muslim and the prison's Muslim chaplain went to the hospital as soon as he heard that the man had died.
39. The family liaison officer remained in contact with the man's family and arranged for his family to visit the prison to see where the man had lived. In line with national guidance, the prison contributed to the funeral costs.

Support for staff and prisoners

40. The Governor issued a notice informing staff and prisoners of the man's death and reminding them of the support available. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been affected by the man's death. A special prayer service was held for prisoners on 4 April, which was well attended.
41. The duty governor held a hot-debrief for the escort staff who had been with the man at Watford General Hospital.

Post-mortem

42. A post-mortem examination found that the cause of death was an intestinal obstruction and a diaphragmatic hernia. The report found that the man died from natural causes.

ISSUES

Clinical Care

43. The man did not report feeling unwell until the morning of 1 April 2014 and a nurse examined him that morning. The man continued to feel unwell, was in pain and sick during the early hours of 2 April and staff referred him to the doctor first thing the next morning. A doctor examined him that morning and prescribed medication for his symptoms. The clinical reviewer concluded that the diagnosis, care and management of the man's condition was appropriate and timely and that when his condition deteriorated the response was prompt and appropriate.
44. The clinical reviewer was satisfied that the man's clinical care in prison was at least equivalent to that which he could have expected to receive in the community. The clinical reviewer concludes that the man's death was not foreseeable and there was nothing staff at The Mount could have done to prevent it. Once the man's condition became a concern, they arranged for him to go to hospital by emergency ambulance. Before that, there was no sign that he needed treatment in hospital. After the man went to hospital, his care was solely the responsibility of the hospital. The hospital did not immediately diagnose his serious condition, but hospital care is outside the scope of this investigation. We agree with the clinical reviewer's assessment that the man received an appropriate standard of clinical care at the prison.
45. Although it did not affect the outcome for the man, or the standard of his clinical care, we are concerned about the apparent initial reluctance of healthcare staff to examine the man on 2 April. The officer became aware on the afternoon of 2 April that the man was feeling very unwell. He told the investigator that he made two telephone calls asking for a nurse to visit the man, but found it difficult to get medical assistance.
46. When the prisoner came to the office and told the officer that the man had fainted, the officer immediately went to the man's cell and asked a colleague to let healthcare staff know. He did not use an emergency code blue which would have resulted in an ambulance being called immediately. The officer said this was because the man was alert and awake when he arrived at the cell. We are satisfied that this was appropriate. After healthcare staff heard that the man had fainted, they agreed to come and examine him. The clinical reviewer concluded that, with the information available, their response time was not unreasonable. We accept that, but we are concerned about the initial response, earlier that afternoon.
47. The officer was evidently worried about the man's condition and first called the healthcare centre at 2.15pm. At first, a healthcare administrator told him to make an appointment. When he called again, the nurse asked that the man should come to the healthcare centre. It was not until the prisoner pretended that the man had fainted, that a nurse agreed to come and examine him. Although the officer did not consider it was a medical emergency requiring the immediate calling of an ambulance, he had serious concerns about the man's state of health and considered a healthcare professional needed to examine him urgently. His judgement was correct and we do not consider that

healthcare staff responded appropriately until they were told that the man had fainted. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff examine prisoners promptly when prison staff contact them with serious concerns about their health.

Emergency Response

48. There was a ten minute delay between the ambulance being ready to leave the prison and when it actually left the prison gates. An operational manager agreed that it took ten minutes for the ambulance to get to the prison gate, because of the location of the wing. Although this did not affect the outcome for the man, whose condition was stable when he reached the hospital, we consider this was too long. In other medical emergencies such a delay could have serious consequences. Prison Service Instruction 3/2013, dealing with medical emergencies, requires prisons to have protocols which ensure there are no delays in calling, directing or discharging ambulances. The Mount needs to have contingency plans to allow ambulances to leave the prison quickly in an emergency. We make the following recommendation:

The Governor should ensure that there are no delays in getting an ambulance out of the prison in a medical emergency.

Restraints, security and escorts

49. When prisoners have to travel outside prison to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints. The man was assessed as a medium risk to the public (on a scale of low, medium, high) and a low risk of escape. The assessment concluded that the man should be accompanied by two officers and restrained by a single cuff (the prisoner is handcuffed to a prison officer).
50. In the risk assessment there is a section for a medical professional to advise on how the medical condition of the prisoner affects risk. The nurse recorded no objections to the use of restraints, but did not give any information about how his medical condition impacted his risk. The nurse told the investigator that this is how they routinely complete risk assessments. However, a judgement in the High Court in 2007 made it clear that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process when considering using restraints. It is not sufficient simply to say there are no objections.
51. The Prison Service's principal responsibility is protection of the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances which must be fully considered. It is likely that, in the man's circumstances, a fully considered risk assessment would have reached the same conclusion about restraints. However, we are concerned that healthcare staff at The Mount do not complete this assessment in the way the court judgement and subsequent Prison Service guidance requires. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

52. When the man was taken to hospital on 2 April, the risk assessment indicated that no phone calls or visitors should be allowed. The acting Head of Security, told the investigator that this was standard practice until a manager re-assessed the situation within 24 hours. The man was at hospital for less than 24 hours and there was no management check during this time.
53. Prison Rule 22 requires that a prisoner's family is informed if they become seriously ill. Although the man's condition was initially undiagnosed and his death was sudden, he had been taken to hospital by emergency ambulance which, by definition, would indicate serious concerns about his health. The prison did not consider notifying his family that he had been admitted to hospital. We consider they should have done. This might have allowed his family to visit him on the evening before he died. 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 and that they are able to visit them in hospital without delay.

54. When prison healthcare staff were aware that the man's health had deteriorated the Head of Healthcare asked one of the family liaison officers to contact the man's family to let them know. The family liaison officer was unable to contact with the man's nominated next of kin, his sister, and instead spoke to his girlfriend. Unfortunately, when his girlfriend phoned back the man had died and the family liaison officer felt that he had to break the news of his death over the phone. Prison Service policy usually requires that prison staff inform families in person of a prisoner's death, but we are satisfied that this was a reasonable decision in the circumstances.
55. The family liaison officer continued contact with the man's family after his death. In line with national guidance, The Mount offered a contribution to the funeral costs. We are satisfied that the prison made appropriate contact with the man's family.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff examine prisoners promptly when prison staff contact them with serious concerns about their health.
2. The Governor should ensure that there are no delays in getting an ambulance out of the prison in a medical emergency.
3. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
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 and that they are able to visit them in hospital without delay.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that healthcare staff examine prisoners promptly when prison staff contact them with serious concerns about their health.	Accepted	A new system is now in place which ensures that a nurse is available to respond promptly to any urgent request for medical assistance without delay.	Completed and ongoing Head of Healthcare
2	The Governor should ensure that there are no delays in getting an ambulance out of the prison in a medical emergency.	Accepted	Local systems have now been established to ensure that ambulances are able to exit the prison in an appropriate timeframe for all emergency and non-emergency incidents.	31 December 2014 Head of Security and Intelligence
3	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	Healthcare staff are now being briefed about their responsibilities when making assessments. Operational managers will also be briefed accordingly. Assessments will take into account the health of the prisoner at the time, so that an informed decision can be taken on the level of restraints to be used. The risk assessment will also be based on the overall security risk the prisoner poses at the time of the risk assessment.	31 December 2014 Head of Security and Intelligence
4	The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon	Accepted	All senior managers have been reminded of the need to contact the next of kin in the event of a prisoner being taken to hospital with a serious illness.	Completed and ongoing Deputy

	as possible and that they are able to visit them in hospital without delay.			Governor
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