

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Usk on
16 November 2014**

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 from a heart attack of a man, at HMP Usk on 16 November 2014. He was 84 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. Healthcare Inspectorate Wales (HIW) reviewed the clinical care the man received in custody. The prison cooperated fully with the investigation.

The man was sentenced to seven years in prison in January 2012, and arrived at Usk in October 2012. Healthcare staff reviewed and treated the man frequently for asthma, oedema and prostate problems, although he was generally reported to be well and active.

On the morning of 16 November, the man's cellmate found him unresponsive in bed. Officers found that the man had no signs of life, and rigor mortis indicated that he had been dead for some time. Paramedics attended shortly afterwards and confirmed that the man had died some hours before.

I share HIW's opinion that the standard of healthcare the man received at Usk was equivalent to that he could have expected to receive in the community. Healthcare staff reviewed the man frequently, and his death could not have been prevented.

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 January 2012, the man was sentenced to seven years in prison. He was 81 years old and this was his first time in prison.
2. The man went first to HMP Parc. He had asthma, but staff recorded no other significant medical problems. At Parc, healthcare staff treated the man frequently for chronic asthma and oedema (fluid retention). He also had high blood pressure, although this reduced over time without medication.
3. In October 2012, the man transferred to HMP Usk. Staff continued to provide frequent support for his medical conditions. Although elderly, the man was active, fully mobile and able to undertake his daily activities independently. In 2014, the man had some prostate problems, but declined full investigation.
4. At around 8.35am on 16 November, the man's cellmate found him unresponsive in bed. Officers found that the man had no signs of life and signs of rigor mortis indicated that he had been dead for some time. Paramedics attended shortly afterwards and confirmed that the man had died some hours before. We are satisfied that officers made an appropriate decision not to try to resuscitate the man.
5. Healthcare Inspectorate Wales concluded that the standard of healthcare the man received at Usk was equivalent to that he would have received in the community. The man had appropriate investigations and frequent support for his medical problems.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Usk informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
7. Healthcare Inspectorate Wales (HIW) reviewed the man's clinical care in prison.
8. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. The investigator and HIW interviewed staff and a prisoner at Usk in January 2015, and informed prison managers of their preliminary findings.
9. We informed HM Coroner for Wales, Gwent District, of the investigation, who provided the cause of death. We have sent the coroner a copy of this investigation report.
10. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. The man's wife, his nominated next of kin, did not have any specific issues for the investigation to consider.
11. The man's family and the prison received a copy of the draft report. The prison identified one factual inaccuracy that has been amended.

HMP USK

12. 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 provides healthcare services at Usk, 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

13. The most recent inspection of HMP Usk was in May 2013. Inspectors found that health services at the prison were generally good, and chronic disease management was starting to develop. However, medicine management and support for older prisoners needed improvement.

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 recent annual report for the year 2013-14, the IMB reported that a change in health care provision at the prison had led to a more effective service. The IMB was concerned that reduced staffing levels at the prison could impact on the management of unforeseen incidents.

Previous deaths at HMP Usk

15. The man was the fourth prisoner to die at Usk since the start of 2013. All these deaths were from natural causes. There were no significant similarities with the circumstances of the man's death.

KEY EVENTS

16. On 20 December 2011, the man was sent to HMP Parc after a conviction for historic sexual offences. He was 81 and this was his first time in prison.
17. At an initial health screen, a nurse noted that the man had asthma and used inhalers. The man told the nurse that he felt well, but was sometimes short of breath. A prison GP reviewed the man the next day and noted that he managed his asthma well. The man told the GP that he had smoked when he was younger, and had also worked in a mine. The GP prescribed the man inhalers for his asthma.
18. On 30 January 2012, the man was sentenced to seven years in prison. A mental health nurse reviewed the man when he returned to Parc. He told the nurse that he understood his sentence, and had support from his wife. The nurse recorded no concerns.
19. On 15 February, another nurse reviewed the man at an elderly person clinic. The nurse recorded that the man was fully mobile, and able to manage his daily activities. Medical observations showed that his blood pressure was slightly raised.
20. In April, healthcare staff noted that the man still had raised blood pressure. They continued to monitor his blood pressure and a prison GP reviewed the man, but took no further action.
21. Over the following months, the man had infrequent contact with healthcare services, apart from collecting his usual medication and having support stockings fitted for oedema (fluid retention).
22. On 9 October, the man transferred to HMP Usk. At an initial health screen, a nurse noted that the man had arrived with medication for asthma. She had no major concerns about the man, although medical observations showed that he had high blood pressure. The man planned to check the man's blood pressure the next week. There is no record that this happened.
23. Over the following months, the man had infrequent contact with healthcare services at Usk, apart from collecting his usual medication and receiving treatment for a blocked ear.
24. On 7 January 2013, the nurse reviewed the man at an elderly person clinic. She recorded that the man was mentally and physically well, apart from some cysts on his upper body. The nurse took the man's medical observations, which showed raised blood pressure. A prison GP reviewed the man. The GP had no concerns about the man's cysts. She did not review his blood pressure.
25. On 26 March, a nurse noted that the man was not collecting the correct medication for his asthma. The next week, she reviewed the man's respiratory care and gave him advice about using his inhalers. Medical

observations showed that the man still had high blood pressure, although it had reduced. The nurse requested a full set of blood tests, and the results were normal. She also requested a spirometry (breathing test), which showed that the man had a restrictive breathing disorder.

26. On 2 May, a prison GP examined the man for signs of chronic obstructive pulmonary disease (COPD - lung disease). The GP recorded no major concerns, but gave the man advice to help him use his inhalers effectively. Over the following months, the man continued to collect regular medication for his asthma, but otherwise had infrequent contact with healthcare staff.
27. On 21 February 2014, a nurse reviewed the man after he reported feeling unwell with a chest cough. The nurse noted that the man was short of breath, although other medical observations, including his blood pressure, were normal. A prison GP reviewed the man later that day. She prescribed amoxicillin to help clear the man's chest, and recommended a chest X-ray if his symptoms continued.
28. Healthcare staff reviewed the man more frequently, and he received treatment for blocked ears and oedema in his legs. Medical observations showed that his blood pressure had reduced.
29. A prison GP reviewed the man on 7 April as he had swollen legs. The GP gave the man advice on managing his oedema with a compression stocking (to reduce swelling). The results of full blood tests suggested a problem with the man's prostate gland. The GP discussed the results with the man, but he did not want the doctor to examine him.
30. Over the following months, healthcare staff monitored the man's oedema and gave him his regular medication. A prison GP repeated prostate gland tests on 24 July. The results were still abnormal, but the man said he had no symptoms and again refused to let the doctor examine him. The GP planned a further review three months later.
31. On 12 September, a nurse noted that the man was struggling to manage his asthma. He was not using his inhalers effectively, so the nurse gave him advice.
32. On 13 October, the man told a nurse that he had been unwell with flu symptoms for two days. Medical observations, including blood pressure, were normal. The nurse gave the man paracetamol to treat his cold, and told him to return if his symptoms continued.
33. A prison GP repeated prostate gland tests on 28 October. The results showed that the man had improved prostate function. This was not reviewed again before his death.
34. On Saturday 15 November, the man's cellmate put an application form in the wing healthcare appointment box asking for a medical appointment for the man. He wrote that the man was struggling to breathe and had difficulty

moving around. Healthcare staff did not receive the form until after the man's death, as the unit was not open that day. The man's cellmate and the man did not report any concerns to prison staff.

35. The man's cellmate told us that the man was unwell and seemed confused in the morning, but had recovered by the afternoon and walked around the prison. At around 10.30pm, the man's cellmate and the man spoke briefly before they went to bed. The man's cellmate had no concerns about the man at the time.

Sunday 16 November

36. At around 8.35am, the man's cellmate got out of bed to make a drink and tried to wake the man, but he did not respond. As prisoners were still locked in their cells, the man's cellmate pressed the cell bell to alert prison staff.
37. An officer was collecting another prisoner for work from a nearby cell. He responded to the cell bell immediately and opened the observation panel. The officer saw the man lying still in bed with his hands fixed on his chest. His false teeth had fallen into the back of his mouth and his skin had no colour. The officer told us that it was apparent to him that the man had been dead from some time.
38. The officer reassured the man's cellmate that he would be back very quickly and took the other prisoner away. He came back to the cell immediately with another officer and a senior officer (SO) from the wing office. The first officer took the man's cellmate from the cell and the other officer and the SO checked the man for signs of life. They were unable to find a pulse, and noted that there were signs of rigor mortis. The officers did not attempt resuscitation as they believed that it was evident that the man had died.
39. The SO went to the wing office to call an ambulance and update the duty governor. Officers sealed the cell. Paramedics arrived at around 9.00am. They could not find any signs of activity in the man's heart, and confirmed his death. The paramedics considered that the man had been dead for some hours.
40. The duty governor debriefed the staff involved in the emergency response and offered them support. The staff offered prisoners on the wing support. Officers moved the man's cellmate to a cell with Listeners (volunteer prisoners trained by the Samaritans to support other prisoners).
41. Prison managers asked a trained family liaison officer to act as the prison's family liaison officer. At around 2.00pm, the family liaison officer and the duty governor visited the man's family and informed them that he had died.
42. The family liaison officer continued to support the man's family after his death. In line with national guidance, the prison contributed to the funeral costs.

Post-mortem

43. After a post-mortem examination, the coroner gave the cause of death as a myocardial infarction (heart attack), coronary thrombosis (a blood clot) and coronary artery atheroma (narrowed arteries).

ISSUES

Clinical care

44. HIW concluded that the man's care in prison was equivalent to that he could have expected to receive in the community. They noted that the man's health problems, such as his chest condition and swelling of his leg, were appropriately investigated, monitored and treated. HIW considered that the man's death was not preventable or foreseeable.
45. Although the man's raised blood pressure was not always followed up earlier in his sentence, monitoring increased during his time at Usk and his blood pressure reduced without medication. HIW noted that, in general, his blood pressure monitoring was appropriate and, as it had reduced, it had no bearing on his death. The man had no symptoms, such as chest pains or frequent breathlessness, that would indicate he had ischaemic heart disease. 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.

Staff response

46. Prison Service Instruction (PSI) 03/2013 says that a code blue emergency call should be used for respiratory issues or if a prisoner is found unconscious. It directs that there should be no delay in summoning an ambulance when there are serious concerns about the health of a prisoner and an ambulance should be called by the control room as soon as an emergency medical code is called. Usk has a suitable emergency protocol in place, reflecting current Prison Service requirements
47. The officers who found the man said that he was cold, without a pulse and displaying signs of rigor mortis. They did not call an ambulance immediately as the man's appearance indicated that he had been dead for some hours, and did not attempt to resuscitate him. We are satisfied that the officers' actions were appropriate in the circumstances. Emergency first aid would not have changed the outcome, as the man had suffered a heart attack and it was apparent that he had died hours earlier.