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 on 18 November 2014 at HMP Hewell

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 from a ruptured aneurysm, at HMP Hewell on 18 November 2014. He was 73 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 Hewell. The prison cooperated fully with the investigation.

The man had been at Hewell since May 2012. He suffered from many chronic health problems, including an abdominal aortic aneurysm. Healthcare staff frequently reviewed the man, and he was under the care of specialists throughout his time in prison, although he did not always cooperate with his treatment. Healthcare staff had difficulty managing the man's pain, which was made more difficult because he had previously been dependent on opiates.

In the early hours of 18 November 2014, the man's cellmate found the man unresponsive. When a nurse examined him, it was evident that he had died. In line with the man's wishes, the staff did not attempt to resuscitate him.

I am satisfied that the man received a good standard of healthcare at Hewell. While it would not have affected the outcome for the man, the investigation identified some concerns about the operation of the prison's emergency response protocol. I am also concerned that the man was restrained for hospital appointments without fully considered risk assessments, which took account how his health and mobility affected his risk of escape. There are both matters I have raised with the prison before.

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 **May 2015**
Prisons and Probation Ombudsman

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SUMMARY

1. In May 2012, the man was remanded to HMP Hewell, charged with sexual offences committed some years previously. This was the man's first time in prison. Later that month, he was sentenced to 12 years in prison.

2. The man suffered from many chronic health problems, including chronic obstructive pulmonary disease, hypertension, hypotension, peripheral vascular disease and asthma. He also had an abdominal aortic aneurysm (a swollen blood vessel close to the heart). Healthcare staff frequently reviewed the man, and he was under the care of specialists throughout his time in prison. When he attended hospital appointments he was always restrained.

3. The man often changed his mind about his treatment and did not attend hospital appointments or follow the advice of healthcare staff. The man's multiple health problems and historic opiod dependency made it difficult to manage his pain, but healthcare staff frequently reviewed and adjusted his medication.

4. The man harmed himself on a number of occasions, usually when he was in pain or when he did not agree with proposed treatment. Staff supported and monitored the man, and encouraged him to engage with his treatment plans.

5. At around midnight on 17/18 November 2014, his cellmate found the man unresponsive in his chair in the cell. Staff found that the man had no signs of life, and did not attempt to resuscitate him as he had requested. Paramedics attended shortly afterwards, and confirmed that the man had died.

6. We agree with the clinical reviewer that the clinical care the man received at Hewell was at least equivalent to that which he could have expected to receive in the community. Healthcare staff frequently reviewed the man and encouraged him to engage with his health care, although he often refused their advice about managing his health conditions. We are concerned that risk assessments for hospital visits did not fully take into account the man's health and mobility. The investigation also identified that prison staff did not always call an ambulance when an emergency medical code was called as national instructions require. These are issues that we have raised with Hewell before. We make two recommendations.

THE INVESTIGATION PROCESS

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

8. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

9. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. The investigator interviewed the man's cellmate at Hewell in November 2014, and discussed the man's care with prison managers.

10. We informed HM Coroner for Worcestershire 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 family to explain the investigation. The man's son, his nominated next of kin, did not have any specific issues for the investigation to consider.

12. The man's next of kin received a copy of the draft report and raised no factual inaccuracies. The prison also received a copy of the draft report and their response to the recommendations has been added to the end of the report.

HMP HEWELL

13. HMP Hewell comprises two separate sites – a closed local prison and an open prison known as The Grange Resettlement Unit (formerly HMP Hewell Grange). The closed site, where the man lived, takes prisoners from courts in the West Midlands, Warwickshire and Worcestershire and holds up to 1074 men in six houseblocks. Worcestershire Health and Care NHS Trust provides 24 hour health care.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Hewell was in July 2014. The Inspectorate found that there was a good staff skills mix in the health care unit, but there were staff vacancies. Prisoners they surveyed were generally dissatisfied with the quality of health care services, as well as their access to them. Inspectors found the range and quality of most services were good, except that prisoners waited too long to see a GP. All prisoners had adequate health screens when they arrived. Pharmacy services were satisfactory.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers who help ensure that prisoners are treated fairly and decently. In its most recent report, for 2013, the IMB noted that there had been some progress in relation to deficiencies in healthcare identified by the Inspectorate at the 2012 inspection, including dealing with staff vacancies, which it hoped would help resolve problems experienced with GP waiting times.

Previous deaths at Hewell

16. The man was the fourth prisoner to die from natural causes at Hewell since the start of 2014. In previous investigations, we have raised concerns about the prison's emergency response process, and risk assessments for the use of restraints for prisoners being taken to hospital.

KEY EVENTS

17. On 16 May 2012, the man was sent to HMP Hewell after a conviction for historic sexual offences. This was his first time in prison.

18. During initial health screens, healthcare staff noted that the man had many chronic health problems, including chronic obstructive pulmonary disease, hypertension (high blood pressure), peripheral vascular disease and asthma. He also had an abdominal aortic aneurysm (a swollen blood vessel close to the heart). The man smoked moderately, and had some mobility difficulties.

19. In addition to his physical problems, the man had a history of psychiatric problems and self-harm. He suffered from depression. He had previously been dependent on opioids (strong pain-relieving drugs). A prison GP reviewed the man and re-prescribed his regular medication. The GP decided that the man should be admitted to the prison's healthcare unit for a further review of his health and needs.

20. The man told staff that he wanted to harm himself because of being in prison. Healthcare staff immediately began to manage him under Assessment, Care in Custody and Teamwork procedures - ACCT, the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm.

21. On 25 May, the man was sentenced to 12 years in prison. Over the following days, the man superficially harmed himself a number of times. Staff continued to monitor and support him.

22. The man often complained of experiencing pain, particularly in his hands and legs. Healthcare staff reviewed and adjusted his pain relief medication frequently, but the man still reported pain. Staff found it difficult to manage his pain effectively, and he could not keep some medication in his cell because of his risk of suicide and self-harm. Staff noted that the man often said that his symptoms disappeared immediately after taking pain relief, contrary to the medication's known effects. The man declined help to stop smoking.

23. On 7 June, the man moved to Houseblock 5, a standard residential unit. On 11 June, a mental health nurse reviewed him and noted that he asked for an increase in his pain relief medication, but did not seem to be in pain. The nurse thought that the man was trying to seek additional medication because of his opiod dependency. She encouraged the man to engage in activities to take his mind off his pain, although the records show that the man was often reluctant to do so.

24. During his time at Hewell, the man had a number of mental health assessments to check his capacity to make decisions. The assessments found that he was able to decide about his care and treatment and he did not need additional support from mental health services.

25. On 9 July, a specialist reviewed the man's aneurysm at an outpatient hospital appointment. The specialist told the man that it was 5.9mm in size and

potentially life-threatening. He needed a further consultation and, ideally, treatment.

26. The man remained under the care of specialists for his chronic health problems, including his aneurysm, vascular disease and sight problems. The specialists advised the man he needed a stent (a short wire mesh tube) inserted to treat narrow arteries close to the aneurysm. However, he refused to attend a number of hospital appointments, despite staff encouragement. He often said that he was too tired or in too much pain to attend. Sometimes he complained that the handcuffs officers used were too tight. Specialists and healthcare staff, explained the potential dangers of not engaging with treatment, but the man frequently changed his mind about the treatment he wanted.

27. The man harmed himself again a number of times, usually by cutting himself when he said he was in pain and was often admitted to the healthcare unit for treatment. Staff used ACCT procedures to monitor and support the man, with multidisciplinary input from prison and healthcare staff, although the man sometimes refused to engage with reviews. Staff believed that the man's self-harmed to try to get additional medication. The man often stopped harming himself after healthcare staff reviewed or adjusted his pain relief medication.

28. On 5 October, a nurse reviewed the man's physical health and began a care plan requiring staff to take daily medical observations, and to support the man with his medication regime and other health needs. Healthcare staff continued to develop care plans to support the man during his time at Hewell.

29. As the man's health deteriorated, he said that he did not want to be resuscitated if his heart or breathing stopped. After a discussion with a prison GP on 30 January 2013, the man signed an order formalising this. The GP noted that the man had the mental capacity to make the decision, but she encouraged him to have a discussion with his family about it, which he refused to do. Healthcare staff often reviewed this decision with the man, but he did not change his mind.

30. Over the following months, healthcare staff continued treat the man's pain with morphine, tramadol (opioid painkillers) and paracetamol. Although they reviewed and adjusted his medication, he continued to complain of pain. The man did not always comply with his medication regime or the advice of healthcare staff, and often refused to have his medical observations taken. When the man did agree to medical tests, the results revealed no major concerns. The man was offered help with daily activities as his mobility decreased, but he usually refused any help.

31. Despite the man's reluctance to engage, healthcare staff continued to review him frequently and provide support. On 13 June, the man told a prison GP that he did not want to be in pain anymore and would rather die than have any more treatment. The GP noted that the man had the capacity to make decisions about his treatment, but encouraged him to engage.

32. On 6 September, another prison GP reviewed the man after he reported having chest pain during the night. The man refused to go to hospital, or to be admitted to the healthcare unit for observation. He told the GP that he did not want hospital treatment or resuscitation if his health deteriorated significantly, although he did want to have treatment for his aneurysm and eye problems. After discussions with a number of healthcare staff, the man signed an Advance Decision to Refuse Treatment form to document his wishes about future life-saving treatment. The man told the GP that he did not want to discuss this decision with his family.

33. The man's condition fluctuated and he often had to use a stick to get around. He also suffered from incontinence. He did not always take his medication and still sometimes refused to have his medical observations taken. He continued to change his mind about treatment for his chronic health problems, and refused to attend a number of hospital appointments.

34. In early 2014, the man had a number of blood tests after he reported feeling unwell. The results were normal. As his health deteriorated, staff discussed the possibility of the man moving to the healthcare unit. On 29 April, a nurse reviewed the man after he experienced chest pain. The results of an electrocardiogram (ECG) to assess heart activity were abnormal, but the man refused any treatment. He told the nurse that he was frightened of dying in hospital, and wanted to stay on the wing with his friends.

35. Over the following months, the man's health continued to deteriorate. He suffered chest pain a number of times, but continued to refuse treatment. A multidisciplinary team of staff met frequently to review the man's care, but were unable to determine if the man's constant reported pain resulted from his chronic diseases, or his opiod dependency. Against advice, the man decided not to have treatment for his vascular problems. On 19 September, a prison GP noted that the man refused to go to hospital in handcuffs, as he said they hurt him. The GP questioned the need to use restraints at a multidisciplinary meeting on 2 October, but security staff said that the man could not go to hospital unrestrained.

36. On 29 October, the man asked to see a heart specialist after having chest pains. The GP referred the man to a cardiologist, and healthcare staff started a care plan to monitor and treat his heart problems. (The man did not see the specialist before he died.)

37. On the morning of 14 November, the man's regular medication was delayed as the prescription had expired. The GP re-wrote the prescription later that day. At around 9.00pm, a nurse reviewed the man in his cell and the man asked for more pain relief. The nurse told him he would overdose, if he took any more morphine. The man threatened to harm himself, so staff decided to open an ACCT to monitor and support him.

38. The next morning, the man's cellmate alerted staff after he found the man had cut his legs. The man initially refused treatment, but then let a nurse treat his wounds. The nurse noted that the man had bought paracetamol from the

canteen in addition to his usual prescription from healthcare. That afternoon, a prison GP reviewed the man and noted that he was stockpiling paracetamol. The GP asked staff to note this in the ACCT plan.

39. On the morning of 17 November, the man refused to have medical observations taken, and refused to take his prescribed isosorbide mononitrate (a drug to help the heart pump blood). Staff recorded no further concerns that day. The man's cellmate told us that the man seemed well; he spoke to friends on the wing and watched TV. The man's cellmate last spoke to the man at around 9.45pm, and fell asleep while they were both watching television in their cell.

18 November

40. At about midnight on the night of 17/18 November, the man's cellmate woke up to go to the toilet. He spoke to the man, but he did not respond. The man's cellmate noticed that the man was sitting in his chair, and was slumped to one side in a strange position. He shook the man and shouted to him, but he still did not respond. The man's cellmate immediately pressed the cell bell to call for help.

41. At 12.01am, officers attended and radioed a code blue emergency (to indicate a prisoner is unconscious or has difficulty breathing). Shortly afterwards, a rapid response team arrived from the healthcare unit. A nurse checked the man for signs of life, but found none. The staff did not attempt resuscitation, as it was evident that the man had died, and he had indicated that he did not want to be resuscitated.

42. Prison staff moved the man's cellmate to another cell. At around 12.30am, the nurse asked the control room to call paramedics to attend. They arrived at around 12.50am, and confirmed the man's death.

43. Shortly after the man's death, the police, who the prison had informed of his death as required, told the prison that they had told some of the man's relatives of his death. A prison manager telephoned the man's son, his nominated next of kin, to inform him of the man's death and offer condolences. Two prison managers visited the man's son the next day.

44. A supervising officer acted as the prison's family liaison officer and offered support to the man's family after his death. In line with national guidance, the prison contributed to the funeral costs.

45. The prison issued notices to prisoners and staff informing them of the man's death and offering support to those who might have been affected. Staff gave the man's cellmate additional support.

Cause of death

46. The coroner confirmed that the man died from a ruptured abdominal aortic atheromatous aneurysm.

ISSUES

Clinical care

47. When the man arrived at Hewell, he already had significant health problems and suffered from multiple chronic diseases. The clinical reviewer concluded that the man's care in prison was at least equivalent to that which he could have expected to receive in the community. Although staff often had difficulty managing the man's pain, the clinical reviewer found that the man's health conditions and medication were managed in line with NICE (National Institute for Health and Care Excellence) guidance. He noted that healthcare staff provided appropriate treatment in relation to the man's aneurysm, his most significant physical condition, and his vascular disease, although the man was reluctant to engage with the treatment recommended by specialists. He commended healthcare staff for their management and ongoing review of the man decision not to be resuscitated.

48. We agree with the clinical reviewer's assessment of the standard of the man's care in prison, and we are satisfied that he received appropriate support. The man's treatment was complex because of his multiple health problems, and his reluctance to take the advice of medical staff or engage with treatment. However, healthcare staff reviewed the man daily and provided him with ongoing support as his health deteriorated.

Restraints, security and escorts

49. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility.

50. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and that risk should be reviewed when circumstances changed.

51. The man attended a number of hospital appointments while in prison, for both outpatient and emergency treatment. We have reviewed the risk assessments for a number of these. Prison security staff assessed the man was either a medium or high risk to the public based on his offences, and a low risk of escape. Prison managers always directed the use of restraints and usually recommended double handcuffs. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for

moving category A or category B prisoners in good health.) They sometimes allowed officers to use an escort chain because of the man's health problems (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Two prison officers usually accompanied the man to hospital.

52. Healthcare staff gave no medical objections to the use of restraints in their input to the risk assessment. They noted the man's limited mobility, but did not comment on how or whether his medical condition or lack of mobility affected his risk of escape, as required by the 2007 High Court Judgement and it does not appear that this was taken into account.

53. The man did not attend at least 12 hospital appointments, some of which were because he said that handcuffs were painful. The man's fluctuating condition and reluctance to have treatment made it difficult for staff to accurately assess his state of health. However, towards the end of his life, the man was clearly unwell and his mobility was poor. Healthcare staff were concerned that the use of restraints was discouraging the man from attending hospital for treatment, but seemed to be unaware that they could, and should, have influenced the risk assessment process. A GP raised concerns about the use of restraints at a multidisciplinary meeting in October, but his concerns were discounted.

54. Ultimately, it is the Governor's responsibility to ensure that the risk assessment process is managed properly. However, the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities, and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners attending 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.

Emergency response

55. Prison Service Instruction (PSI) 03/2013 requires the control room to call an ambulance as soon as an emergency medical code is called. Hewell has a suitable written emergency protocol, dated 19 April 2013, reflecting current Prison Service requirements. However, we are concerned that staff at the prison do not follow the protocol as required.

56. The staff who found the man unresponsive on 18 November correctly called a code blue over the radio immediately they found the man unresponsive, but the control room did not call an ambulance automatically, contrary to local and national instructions. (A nurse appropriately decided that the man should not be resuscitated, in line with his wishes. At that stage the control room should have stood the emergency ambulance down, in line with the procedures in the instructions.) We found that the failure to call an ambulance automatically

was not an isolated incident. Staff radioed a code blue emergency a number of times when the man was unwell, but it appears that the code was often used to summon healthcare staff quickly rather than for an emergency requiring an ambulance.

57. While the failure to immediately call an ambulance did not affect the outcome for the man, in other emergencies any delay could be crucial. We have made a number of previous recommendations to Hewell about their emergency response procedure, and it is important that prison managers convey the importance of this procedure to prison staff. We repeat a previous recommendation:

The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.

Family contact

58. A prison manager telephoned the man's son, his nominated next of kin, on the morning of 18 November to inform him of his death. Two prison managers went to see the man's son at his home the next day to offer condolences and support.

59. Prison Service instructions require prisons, where possible, to inform the next of kin in person, when a prisoner dies. Prison managers told us that they decided it would be appropriate to telephone the man's son to break the news of his death, as the police had already broken the news of his death to other members of his family. Prison staff were concerned that the man's son would find out about his death from another source, and were also aware that he was away from home with work. While it is preferable to inform the next of kin in person, we accept that this was a reasonable decision.

Recommendations

1. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners attending 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.

2. The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.

ACTION PLAN: The man – HMP Hewell

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners attending 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	The hospital bed watch risk assessment has been updated and includes guidance to ensure that the decision maker fully considers the health of the prisoner, current risk of escape as well as public protection in terms of reoffending particularly in relation to harm to others.	Completed The Governor and Head of Healthcare
2	The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.	Accepted	Systems are now in place to ensure that codes blue and red are called appropriately and in line with PSI 03/2013.	Completed The Governor