Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Northumberland in February 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
This is the investigation report into the death of a man, who died of heart disease in February 2015, at HMP Northumberland. I offer my condolences to his family and friends.

One of my investigators carried out the investigation. A clinical reviewer was appointed to review the clinical care the man received at Northumberland. The prison cooperated fully with the investigation.

The man had been in prison since 1980, serving a life sentence and had been at HMP Northumberland since 2007. He suffered from high blood pressure, osteo-arthritis, ulcerative colitis and gastritis. Healthcare staff monitored his conditions and tested his blood pressure routinely.

On the morning of the man's death, the man had a Parole Board hearing and went back to his cell at 1.30pm. About 15 minutes later, a prisoner who had looked into his cell told an officer that he thought that the man was dead. The officer found the man lying unresponsive on his bed and radioed an emergency. Officers and nurses were unable to resuscitate him. Paramedics took over emergency treatment when they arrived but, shortly afterwards, pronounced him dead.

I agree with the clinical reviewer that the care the man received at Northumberland was equivalent to that he could have expected to receive in the community. Although it was not possible to revive the man, the emergency response was swift and professional. I am satisfied that the prison could not have predicted or prevented his sudden death.

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 **September 2015**

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Summary

Events

1. On 30 January 1980, the man was sentenced to life imprisonment. The Parole Board had never considered him as suitable for release. He had been at HMP Northumberland since 2007. He suffered from osteo-arthritis, gastritis (inflammation of the stomach lining), ulcerative colitis (inflammation of the large bowel) and high blood pressure. Healthcare staff regularly reviewed his medication and routinely monitored his blood pressure.

2. On the morning of the man's death he attended a Parole Board hearing. During the hearing, he became angry and frustrated so the panel agreed to a short break. When the hearing resumed, the man remained calm. At 1.30pm, the hearing concluded and the panel told him they would write to him with the result. An officer took him back to his cell.

3. At about 1.45pm, a prisoner looked through the observation panel in the man's cell door. He thought the man looked dead and alerted an officer. The officer went into the cell and found the man lying on his bed. He was unresponsive. She radioed a medical emergency code and two officers responded. They began cardiopulmonary resuscitation and shortly afterwards nurses arrived with emergency equipment. The nurses used an automatic defibrillator, which administered one shock, but the man did not respond. At 2.20pm, paramedics arrived and took over the man's emergency treatment. At 2.43pm, a paramedic pronounced the man dead.

4. We agree with the clinical reviewer that the care the man received at Northumberland was equivalent to that he could have expected to receive in the community. Despite a quick and professional emergency response, the man could not be saved.

The Investigation Process

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

6. The investigator obtained and reviewed copies of the man's prison medical records and relevant extracts from his prison records.

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

8. We informed HM Coroner for North Northumberland of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

9. One of the Ombudsman's family liaison officers spoke to the man's next of kin, his niece, about our investigation. She did not have any issues about the man's death for the investigation to consider.

10. The draft report was shared with the Prison Service. The Prison Service found one factual inaccuracy and this report has been amended accordingly.

11. The man's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Northumberland

12. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. The prison can hold more than 1,300 men. Sodexo Justice Services has managed the prison since 1 December 2013. Care UK provided the healthcare services at the time of the man's death. However, from April 2015, those services are provided by G4S.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Northumberland was in September 2014. The report was critical of many aspects of the prison but found that the quality of healthcare was generally good and appreciated by prisoners. There was an appropriate range of clinics to meet prisoners' needs.

Independent Monitoring Board

14. Each prison 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 year to December 2014, the IMB noted that health services were good overall and they were broadly satisfied that the healthcare and mental health responsibilities at the prison were met.

Previous deaths at HMP Northumberland

15. The man was the eighth person to die from natural causes at HMP Northumberland since January 2014. There were no significant similarities with the circumstances of the previous deaths.

Key Events

16. On 30 January 1980, the man was sentenced to life imprisonment with a minimum period to serve of eleven years before he could be considered for release. The Parole Board had never considered him suitable for release. The man had osteo-arthritis, gastritis, ulcerative colitis and high blood pressure. Healthcare staff regularly reviewed his medications and routinely monitored his blood pressure.

17. On 14 November 2012, the man had a cardiac risk assessment, offered for men over 40. Dr A prescribed simvastatin (a drug that reduces the level of cholesterol in the blood).

18. On 25 March 2013, Nurse A reviewed the man and recorded his ten-year cardiovascular risk score as 38.99%. This score suggested that he was at high risk of having a cardiovascular event in the next ten years. The nurse advised him to improve his diet, to exercise and to stop smoking to lessen this risk.

19. On 31 March 2014, the man told Nurse B that he had right sided chest pain radiating down his right arm. The nurse recorded his pulse as ‘irregularly irregular’ and referred him for a blood test. There is no record of the results. She booked a GP appointment for 2 April, which the man did not attend. There is no record of why he did not attend. On 23 April, a nurse saw him and noted he said he was well and not short of breath.

20. On 19 February 2015, Nurse C, a mental health nurse, saw the man and he said that he was hopeful that his Parole Board hearing on 23 February would go in his favour.

21. At around 10.00am on the day of the man’s death, he went to his Parole Board hearing. At 10.30am, while hearing evidence about his suitability for release he became angry and frustrated, and his speech was incoherent. After a short break, the hearing continued. The man remained calm and the panel told him that they would write to him with the outcome of the review.

22. Officer A took the man back to his houseblock, at about 1.30pm. The man collected his lunch and the officer locked him in his cell.

23. At around 1.45pm, Officer B began to unlock prisoners after lunch. After he was unlocked from his cell, prisoner A looked through the observation panel in the man’s door and told Officer B that he thought the man was dead. Officer B went in and found the man lying on his bed. His face was grey and his eyes and mouth were slightly open. She called his name but he did not respond.

24. Officer B radioed a code blue medical emergency (indicating a prisoner is not breathing or unresponsive) at 1.49pm. The communications room called for an emergency ambulance shortly afterwards.

25. Officer D and Officer A arrived in response to the emergency code and began cardiopulmonary resuscitation. At 1.55pm, Nurse B and Nurse D arrived with a defibrillator. Together with Officer A, the nurses continued to attempt resuscitation. The nurses inserted an airway and attached the defibrillator, which

administered one shock. At 2.20pm, paramedics arrived and took over emergency treatment. At 2.43pm, a paramedic pronounced the man dead.

Informing next of kin

26. Officer E was the prison's family liaison officer and, at 6.05pm, he and Officer F went to the home of the man's niece, his next of kin, to tell her that he had died. They offered condolences and support. On 27 February, the man's niece and her daughter visited the prison.

27. The man's funeral was on 24 March. The prison contributed to the costs in line with Prison Service guidance.

Support for prisoners and staff

28. A Director's notice informed staff and prisoners of the man's death. One of the prison manager debriefed the staff involved in the emergency response and offered them the support of the prison's care team.

29. A team of Listeners supported prisoners on the man's houseblock. (Listeners are prisoners trained by the Samaritans to support other prisoners.)

Cause of death

30. The Senior Coroner for North Northumberland recorded that the man died from ischaemic heart disease due to coronary artery atheroma (hardening of the arteries).

Findings

Clinical care

31. The clinical reviewer noted that there was potentially one missed opportunity to detect the man’s ischaemic heart disease - almost a year before, on 31 March 2014, when he told Nurse B that he had chest pain. The nurse took blood tests and arranged a GP appointment but there is no record of the outcome of the tests and he did not attend the doctor’s appointment. However, shortly afterwards, he told a nurse that he was well and reported no further pain. The clinical reviewer also noted that, in the weeks leading up to his death, there was nothing to indicate he was feeling unwell or had any problems. We do not consider that the prison could have predicted or prevented the man’s sudden death. The clinical reviewer has made a recommendation in her review about the need to follow up blood tests and other matters, which the Head of Healthcare will need to address.

32. We agree with the clinical reviewer that the standard of healthcare the man received in prison was equivalent to that he could have expected to receive in the community. He received appropriate treatment for his health conditions and had regular reviews of his medication and high blood pressure. When the man was found unresponsive, the emergency response was of a good standard.

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