Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Noel Laing a prisoner at HMP Northumberland on 27 March 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

Mr Noel Laing died on 27 March of a brain haemorrhage at HMP Northumberland. He was 71 years old. I offer my condolences to Mr Laing's family and friends.

Mr Laing had a history of high blood pressure, diabetes, lung and heart disease, and other related conditions, which healthcare staff at Northumberland managed appropriately. I agree with the clinical reviewer that the care Mr Laing received at Northumberland was equivalent to that he could have expected in the community. However, I am concerned that night staff did not call the out of hours doctor for advice when Mr Laing complained of being ill in the early hours of 27 March. Although it may not have changed the outcome for Mr Laing, this could be crucial in other cases.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

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Summary

Events

1. On 20 February 2013, Mr Noel Laing was sentenced to eight years in prison. He moved to HMP Northumberland on 10 May 2013. He had a number of serious and chronic conditions, including high blood pressure, diabetes, lung and heart disease. Mr Laing smoked cigarettes and resisted any advice on giving up.

2. Mr Laing also suffered short-term memory loss and some right sided weakness from a stroke and brain haemorrhage that occurred some time before he was sentenced to prison. In August 2013, hospital doctors diagnosed Mr Laing with a mild stroke.

3. Mr Laing took a number of medications, which healthcare staff frequently reviewed. They checked his blood pressure and blood sugar levels regularly but both proved difficult to manage. Staff gave Mr Laing regular advice and encouragement regarding diet, exercise, lifestyle and smoking cessation. Mr Laing frequently ignored the advice given and continued to smoke cigarettes

4. In March 2014, Mr Laing moved to a cell adapted for disabled prisoners and a prisoner carer assisted him with daily living.

5. In April 2015, Mr Laing reported right sided chest pain and a test of his heart function confirmed an abnormal and irregular heartbeat (a pre-existing condition for which he took medication). His blood pressure remained high. Healthcare staff continued to monitor both his blood pressure and blood glucose levels and reviewed his medication as appropriate. GPs reviewed and amended his blood pressure medication frequently.

6. In January 2016, Mr Laing accepted nicotine patches in an effort to give up smoking. However, he continued to smoke and, in February, stopped the patches as he told staff they made him dizzy. Healthcare staff continued to see Mr Laing frequently to monitor his conditions.

7. In the early hours of 27 March, Mr Laing told officers that he had a headache and he did not feel right. There were no healthcare staff on duty at night and the night manager told Mr Laing that prison staff would monitor him and ask a nurse to see him when one came on duty later that morning.

8. An operational support officer checked Mr Laing at least every 30 minutes, during which time she saw him on the floor but breathing. At 5.10am, she found him on the floor of his cell and he appeared to have soiled himself. She informed the night manager, who called an emergency ambulance. Officers entered Mr Laing's cell and found that he was breathing but unresponsive. Paramedics took Mr Laing to hospital but he did not regain consciousness. At 4.50pm, a hospital doctor confirmed he had died.

Findings

9. The clinical reviewer said that healthcare staff at Northumberland looked after Mr Laing's chronic conditions well and concluded that the care he received was equivalent to that he could have expected in the community.

10. We are concerned that night staff did not seek the advice of the out of hours doctor when Mr Laing complained of not feeling right and a headache, especially as this continued for some time.

Recommendation

- The Governor should ensure that night staff obtain advice from the out of hours doctor when a prisoner complains of being unwell.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Laing's prison and medical records.

13. The investigater interviewed four members of staff by telephone on 19, 21 and 26 April 2016.

14. NHS England commissioned a clinical reviewer to review Mr Laing's clinical care at the prison.

15. We informed HM Coroner for Northumberland South of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Laing's niece to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any specific issues for the investigation.

17. Mr Laing's niece received a copy of the initial report. She did not make any comments.

18. We shared the initial report with the Prison Service and there were no factual inaccuracies.

Background Information

HMP Northumberland

19. HMP Northumberland can hold more than 1,300 men. Sodexo Justice Services manages the prison and G4S provide the healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm, Monday to Thursday and from 7.30am to 6.00pm on Friday. At the weekend and on Bank Holidays, healthcare staff are on duty from 8.00am to 6.00pm. Northern Doctors provide an out of hours service at other times.

HM Inspectorate of Prisons

20. 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

21. 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 2015, the IMB noted that despite a challenging year in which the healthcare provider had changed, standards of care had been maintained overall and in some areas improved. Locum arrangements had resulted in some lack of continuity, and lack of familiarity with the protocols in a prison environment and this had an impact on both the patient experience and the wider operation of the prison.

Previous deaths at HMP Northumberland

22. Mr Laing was the ninth person to die from natural causes at Northumberland since January 2014. There were no significant similarities with the circumstances of the previous deaths.

Key Events

23. On 20 February 2013, Mr Noel Laing was sentenced to eight years in prison for sexual offences and was sent to HMP Holme House. He moved to HMP Northumberland on 10 May 2013.

24. At his initial health screen at Northumberland, Mr Laing told a nurse he had a history of lung disease and angina. He had smoked cigarettes for many years and did not want help to stop. The nurse referred him to the practice nurse and the elderly prisoner service.

25. On 22 May, at a follow up appointment, Mr Laing told a nurse he had suffered a brain haemorrhage and stroke in 1993 and, as a result, suffered short-term memory loss. He also had diabetes, high blood pressure and an irregular heartbeat for which he took medication. Mr Laing could walk short distances with the aid of a stick but otherwise needed and had access to a wheelchair. Healthcare staff saw Mr Laing regularly to check his blood pressure and blood glucose levels.

26. Healthcare staff regularly monitored Mr Laing’s chronic conditions. He suffered a minor stroke in August 2013, but continued to smoke cigarettes despite advice.

27. In March 2014, staff moved Mr Laing to a disabled cell and arranged for a prisoner carer to assist him with his daily living. They also provided a personal alarm and a dosette box to help arrange his daily medication, as they were concerned he had not been taking it correctly. Healthcare staff monitored his compliance with his medication and took daily blood pressure readings.

28. On 21 March, a prison GP reviewed Mr Laing and prescribed rivaroxaban (an anticoagulant) for his atrial fibrillation (an abnormal and irregular heartbeat) and high blood pressure. Prison GPs frequently reviewed and amended Mr Laing’s blood pressure medication.

29. Throughout the rest of 2014, healthcare staff continued to monitor Mr Laing whose condition remained relatively stable. In June, a nurse noted he spent most of his time in his cell but could manage his daily activities. She advised him on the use of his inhaler, which it appeared he did not use correctly. Mr Laing continued to smoke despite advice.

30. In December 2014, Mr Laing began to suffer light-headedness and dizzy spells. Doctors considered this was because of high blood sugar levels and reviewed his diabetic medication. In March 2015, after specialist advice, doctors prescribed insulin to help manage his diabetes. Nurses continued to monitor Mr Laing’s blood pressure, which was persistently high. Doctors prescribed various medications to try and control it, with limited success.

31. On 1 April 2015, a nurse examined Mr Laing after he reported right sided chest pain. He described the pain as sharp and intermittent. She noted a strong smell of cigarette smoke in the cell and advised him about the risks of smoking. Mr Laing had high blood pressure (156/98) but otherwise appeared well. She referred him to the GP and a GP saw him the next day. She arranged for him to

have an electrocardiogram (ECG), to test the function of his heart. Mr Laing's blood pressure remained high (169/90)

32. The ECG confirmed atrial fibrillation, a pre-existing condition, for which Mr Laing took medication. On 5 April, a nurse recorded Mr Laing's blood pressure as 140/90, still high.

33. Healthcare staff continued to see Mr Laing regularly, particularly to monitor his blood glucose levels, which remained difficult to manage despite the use of insulin. He often reported feeling dizzy

34. A prison GP reviewed Mr Laing's treatment and medication on 17 August. He told her he regularly felt dizzy and confused and that this affected his memory. Mr Laing said that this was particularly bad when his blood glucose levels were at his target levels and he felt much better when they were higher.

35. Healthcare staff continued to monitor Mr Laing for the next five months, including his diabetes medication and treatment in consultation with the specialist diabetic nurse. In January 2016, after speaking to the smoking cessation nurse, Mr Laing agreed to try to stop smoking and started using nicotine patches. However, he continued to smoke.

36. On 6 February, a nurse examined Mr Laing at the request of wing staff. The nurse described his complexion as ashen. Mr Laing told the nurse that, after collecting his meal, he became very dizzy, unsteady on his feet and needed wing staff to help him back to his cell. He believed the nicotine patches caused his dizzy spells. Wing staff confirmed that Mr Laing continued to smoke cigarettes.

37. On 8 February, a nurse reviewed Mr Laing and recorded his blood pressure had improved (138/86). Mr Laing said he had stopped using nicotine patches and had not fainted since. He said he still wanted to stop smoking and asked about alternatives. On 10 February, Mr Laing told a nurse he no longer wanted to continue with the smoking cessation programme. Healthcare staff continued to see Mr Laing frequently.

27 March 2016

38. At 2.45am on 27 March, an operational support officer (OSG) responded to Mr Laing's cell bell. He was pacing the floor and told her "there's something not right". She spent about ten minutes talking to Mr Laing from outside his cell but he could not explain anything more just saying something was wrong. She telephoned a Senior Officer (SO), the night manager, for advice, who told her to check on Mr Laing every 30 minutes.

39. The OSG returned to Mr Laing's cell at 3.10am. She did not enter but asked Mr Laing if he was all right. At this point, Mr Laing touched his head, lowered himself onto the floor and rolled over onto his back. Mr Laing did not say he was unwell but she considered his behaviour strange. She telephoned the SO, who agreed to attend. The SO arrived a few minutes later with two officers. They entered Mr Laing's cell and he told them that he was "wrong and had a headache". He told the SO that he regularly suffered from headaches, and confirmed that he had taken his medication that day.

40. The SO asked Mr Laing if he had any other symptoms and he repeated that he had a headache and did not feel right. The officers helped Mr Laing back into bed and the SO told him they would monitor him throughout the night and get a member of the healthcare staff to see him as soon as they came on duty.

41. A short time later, the OSG checked Mr Laing, and saw him lying on his bed. At around 4.00am she saw him on the floor, lying on his back. She could see that his eyes were open and that he was breathing. She telephoned the SO, who said to continue to monitor Mr Laing.

42. The OSG checked Mr Laing a short time later and could see he had not moved from the floor but was breathing and his legs had moved. At 5.10am, she checked Mr Laing again and saw a wet patch on his trousers. She telephoned the SO, who immediately contacted the control room and told them to call an emergency ambulance. She also told two officers to return to the cell.

43. Both officers arrived at approximately 5.20am and the SO Proctor moments later. They entered Mr Laing's cell and found he was unresponsive but breathing heavily. The officers put him into the recovery position while they waited for paramedics to arrive.

44. Paramedics arrived at about 6.00am and took Mr Laing to Northumbria Specialist Emergency Care Hospital. Two officers accompanied him to hospital but did not restrain him. A CT scan showed a massive brain haemorrhage. Mr Laing did not regain consciousness. At 4.50pm, a hospital doctor confirmed he had died.

Contact with Mr Laing's family

45. Northumberland appointed two officers as the prison's family liaison officers. When Mr Laing was taken to hospital on 27 March, one officer repeatedly tried to contact his niece, his nominated next of kin, but she could not reach her.

46. A senior prison manager informed the officer that Mr Laing had died shortly after 5.00pm and a hospital nurse confirmed that a hospital doctor had informed Mr Laing's niece that he had died.

47. The officer tried several times to contact Mr Laing's niece, eventually speaking to her on 29 March, when she offered her condolences and support.

48. Mr Laing's funeral was on14 April. The prison contributed to the costs in line with national instructions.

Support for prisoners and staff

49. After Mr Laing's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. A member of the staff care team was also available to offer support.

50. The prison posted notices informing staff and prisoners of Mr Laing's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Laing's death.

Cause of death

51. The Coroner recorded that Mr Laing died from acute intracerebral haemorrhage (a type of stroke caused by bleeding within the brain). He also had diabetes and high blood pressure.

Findings

Clinical care

52. The clinical reviewer was satisfied that the care Mr Laing received at Northumberland was equivalent to that he could have expected in the community. Mr Laing had high blood pressure, which healthcare staff monitored regularly and doctors tried to regulate. Medication and treatment were appropriate and timely.

53. Healthcare staff also tried hard to manage Mr Laing's diabetes, seeking to help him control his blood sugar levels and keep his treatment stable, often without much co-operation on Mr Laing's part. The transition to insulin treatment was appropriate and staff taught Mr Laing how to monitor his blood sugar levels and administer his medication. Healthcare staff managed all of Mr Laing's health conditions in line with national guidance.

54. The clinical reviewer notes that Mr Laing's lifestyle choices, particularly cigarette smoking, put him at higher risk of high blood pressure and stroke. She was satisfied that healthcare staff regularly advised Mr Laing of the risks involved and encouraged him to give up smoking.

Emergency response

55. There are no healthcare staff on duty overnight at Northumberland, but there is an out of hours doctors service available. When Mr Laing reported feeling unwell in the early hours of 27 March, the OSG, the staff member on duty, considered his behaviour odd and called the night manager for advice who asked her to monitor Mr Laing every 30 minutes. The next time she saw Mr Laing, he lowered himself to the floor. Officers entered the cell and he twice told them he had a headache and did not feel right, they put him back to bed and she continued to monitor him. She noted he was back on the floor again and just over half an hour later noted he had been incontinent of urine. It was at this time that the SO requested an ambulance.

56. We consider that prison staff should have sought advice from the out of hours doctor when Mr Laing reported being unwell. Prison staff are not clinicians and should always seek advice when a prisoner reports being unwell. Mr Laing's odd behaviour and complaints of a headache should have prompted staff to obtain advice. Although it may not have changed the outcome for Mr Laing, this could be crucial in other cases. We make the following recommendation :

    The Governor should ensure that night staff obtain advice from the out of hours doctor when a prisoner complains of being unwell.

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