Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Hayde a prisoner at HMP Thameside on 29 June 2016

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*

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 Anthony Hayde died on 29 June 2016 of a heart attack, caused by heart disease, while in hospital. He was 51 years old. I offer my condolences to Mr Hayde's family and friends.

The investigation found that the clinical care Mr Hayde received at HMP Thameside, or in other prisons (HMPs Brixton, Pentonville, Wormwood Scrubs), was not equivalent to that he could have expected to receive in the community. Healthcare staff failed to monitor his high blood pressure properly, which could have contributed to his heart attack. The emergency response after Mr Hayde collapsed was generally appropriate, although there was a delay in calling an ambulance.

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 **January 2017**

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Summary

Events

1. Mr Anthony Hayde was remanded into prison on 17 August 2015 and, on 7 September, 19 January 2016 and 1 March, sentenced for three separate theft and burglary offences. He received a sentence that totalled 28 months. On 1 March, he transferred to HMP Thameside.

2. Mr Hayde had a history of substance misuse, which healthcare staff treated with methadone replacement therapy; as well as schizophrenia and depression. He suffered from high blood pressure for which he took medication. This remained at a low dose, despite consistently high blood pressure readings. On two occasions when a doctor requested closer monitoring, healthcare staff did not do so. He did not have blood tests to assess his heart at any time while in prison.

3. On 22 June, Mr Hayde became unresponsive in his cell and his cell mate raised the alarm. Staff responded and called an emergency code blue (which indicates that a prisoner is unconscious or not breathing), but the prison did not call an ambulance immediately when officers radioed the code. Healthcare staff responded and resuscitated Mr Hayde. Paramedics arrived and took him as an emergency to hospital. Mr Hayde never regained consciousness and died on 29 June.

Findings

4. The investigation found that the clinical care Mr Hayde received was not equivalent to that he could have expected in the community. This was because his high blood pressure was not appropriately treated or monitored, and no one assessed his cardiovascular risk. This could have contributed to the heart attack that caused his death.

5. We are satisfied that the prison's emergency response was appropriate, as they managed to resuscitate him. However, we are disappointed that the control room did not immediately call an ambulance despite an officer having called a code blue emergency.

6. We are not satisfied that the prison appointed a family liaison officer at the earliest opportunity, denying the family what may have been beneficial support.

Recommendations

- The Heads of Healthcare of HMP Thameside, HMP Brixton, HMP Pentonville and HMP Wormwood Scrubs should ensure that high blood pressure readings are monitored and treated in line with NICE guidance.
- The Heads of Healthcare of HMP Thameside, HMP Brixton, HMP Pentonville and HMP Wormwood Scrubs should ensure reviews of cardiovascular risk are appropriately implemented and that prisoners receive appropriate treatment and advice in line with NICE guidelines.
- The Director of HMP Thameside should ensure that control room staff call an ambulance as soon as a medical code is called, in line with PSI 03/2013.

- The Director of HMP Thameside should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

The Investigation Process

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

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

9. The investigator and clinical reviewer interviewed ten members of staff and one prisoner at Thameside on 11 August 2016.

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

11. One of the Ombudsman's family liaison officers contacted Mr Hayde's brother, to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He had no specific questions, but wanted clarification on what had happened to Mr Hayde.

12. Mr Hayde's family received a copy of the initial report. They did not make any comments.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Thameside

14. HMP Thameside is a local prison in south east London that holds up to 900 men. It is privately run by Serco. The Oxleas NHS Foundation Trust delivers primary health services. Turning Point delivers substance misuse services, and Atrium delivers mental health services. There is 24 hour nursing provision and an 18 bed inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Thameside was in September 2014. Inspectors reported that health care services were being transformed and that all care had improved. There was an appropriate range of clinics, and care plans were in place in line with national guidance.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2015, the IMB reported that healthcare had improved over time but a change in provider had a negative impact. Communication between healthcare staff was good, but needed improving.

Previous deaths at HMP Thameside

17. Mr Hayde was the third person to die of natural causes at Thameside since January 2013. Two people have died since. We have made recommendations about the emergency response before.

Key Events

18. Mr Anthony Hayde was remanded into HMP Thameside on 17 August 2015. He spent time at HMP Thameside, HMP Wormwood Scrubs, HMP Brixton and HMP Pentonville. He was sentenced for three different offences of burglary and theft on 7 September 2015, 19 January 2016 and 1 March, to a total of 28 months imprisonment. He was sent to Thameside for the final time on 1 March 2016.

19. At Mr Hayde's initial health screening on 1 March, a nurse noted that he took methadone (for opiate dependency), and had a history of schizophrenia and depression. He also had high blood pressure, which healthcare staff treated with a five milligram dose of lisinopril. The nurse measured Mr Hayde's blood pressure at 152/66 (a reading is high if it is over 140/90). The nurse also referred Mr Hayde to the substance misuse service. Mr Hayde engaged with the substance misuse services and there was evidence that he engaged well.

20. The following day, a mental health nurse measured Mr Hayde's blood pressure at 157/104. On 3 March, a prison GP saw Mr Hayde, measured his blood pressure at 163/98 and prescribed an increased dose of lisinopril (to ten milligrams).

21. From March 2016, healthcare staff frequently recorded Mr Hayde's blood pressure. Several readings showed it was high, though some were in the normal range. On 4 May, Mr Hayde attended his brother's funeral and, on return to prison, saw a prison GP. The GP measured his blood pressure, which was significantly high at 178/105, and asked for staff to measure Mr Hayde's blood pressure daily for one week. There was no record that healthcare staff took a daily reading.

22. On 24 May, a prison GP saw Mr Hayde, who was struggling to come to terms with the death of his brother. The doctor measured his blood pressure, which was high at 169/103, and, again, asked for staff to measure his blood pressure daily for a week. Again, there was no record that healthcare staff took a daily reading.

22 June 2016

23. At about 7.00pm on 22 June, Mr Hayde's cell mate was talking to Mr Hayde when he began to fit. He pressed the cell intercom (recorded at 7.03pm) and reported that Mr Hayde seemed to be having a fit. Mr Hayde's face turned red and his cell mate realised he was not breathing. He pressed the cell intercom again (recorded at 7.05pm) to tell this to staff, and started cardiopulmonary resuscitation (CPR).

24. An officer answered the intercom call both times. She was asking her colleagues to go to Mr Hayde's cell when the second call came in.

25. All three officers went to the cell together and CCTV footage shows they arrived at 7.04pm. Officer A got to the cell first and looked through the observation hatch in the door. He saw Mr Hayde's cell mate performing CPR so all of the officers entered the cell. They checked Mr Hayde and could find no pulse so, at 7.07pm, Officer A called an emergency code blue (which indicates that a prisoner is

unconscious or not breathing) over the radio. The three officers began CPR and the cell mate left the cell after two minutes. A second code blue was called at 7.08pm. Officer A and a colleague both radioed the control room to ensure healthcare staff were on their way.

26. Two nurses responded to the code blue. Nurse A collected the emergency bag, and Nurse B went on to the cell first, to direct CPR. She arrived in the cell at 7.08pm and Nurse B arrived two minutes later. The nurses attached the defibrillator, which administered shocks, and gave Mr Hayde oxygen. The ambulance call log records that the prison called an ambulance at 7.10pm.

27. The first paramedics arrived at 7.19pm. They performed CPR with prison healthcare staff. They took Mr Hayde to hospital at around 8.20pm.

28. Healthcare staff contacted the hospital for updates on Mr Hayde's condition. While in hospital, Mr Hayde had heart surgery. He remained on a life support machine in a critical condition, and did not regain consciousness. Mr Hayde had a heart attack on 29 June, and end of life care processes were started. He died later that day.

Contact with Mr Hayde's family

29. The details of the prison's liaison with Mr Hayde's family were unclear, though it was evident that his family knew, from at least 23 June, that Mr Hayde was in hospital as there are records that his brothers visited him that day. The prison formally appointed a chaplain as a family liaison officer on 28 June, six days after Mr Hayde collapsed. On the same day, the chaplain and an imam met Mr Hayde's mother and brother at the hospital. Mr Hayde's family were with him when he died.

30. The chaplain next contacted Mr Hayde's brother on 4 July, via telephone. The imam organised for the family to come to the prison, on 29 July, to see Mr Hayde's cell and to meet his cellmate.

31. Mr Hayde's funeral was held on 12 July. The prison contributed to the funeral expenses in line with national policy.

Support for prisoners and staff

32. After Mr Hayde's death the operational healthcare manager debriefed the healthcare staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

33. There was no formal debrief for the officers involved in the emergency response, though managers later contacted them to offer support and ensure they knew how to access the staff care team.

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

Post-mortem report

35. The post-mortem report concluded that Mr Hayde died of a heart attack caused by blocked arteries. High blood pressure also contributed to his death.

Findings

Clinical care

36. Throughout his sentence, Mr Hayde suffered from high, poorly controlled blood pressure for which he took lisinopril. The clinical reviewer concluded that the dose of ten milligrams was low, and that doctors could have increased the dose to at least 20 milligrams. We are concerned that none of the prisons Mr Hayde spent time in monitored or treated his high blood pressure appropriately, and that healthcare staff at Thameside ignored the prison GP's plan to take a daily reading of Mr Hayde's blood pressure on two occasions. Regular readings would have provided more scope for doctors to consider an increase to his dosage of lisinopril.

37. Further to this, he had no kidney function blood tests while in prison, which would be normal practice for someone taking medication for high blood pressure. He also had no cardiovascular risk assessment, as would be expected. This could have contributed to his heart attack. For this reason, the clinical reviewer concluded that the clinical care Mr Hayde received was not equivalent to that he could have expected in the community. We make the following recommendations.

    The Heads of Healthcare of HMP Thameside, HMP Brixton, HMP Pentonville and HMP Wormwood Scrubs should ensure that high blood pressure readings are monitored and treated in line with NICE guidance.

    The Heads of Healthcare of HMP Thameside, HMP Brixton, HMP Pentonville and HMP Wormwood Scrubs should ensure reviews of cardiovascular risk are appropriately implemented and that prisoners receive appropriate treatment and advice in line with NICE guidelines.

Emergency response

38. The emergency response was appropriate, including the CPR administered by the cellmate, and it was successful in resuscitating Mr Hayde.

39. However, while officers called emergency code blues, at 7.07pm and 7.08pm, the ambulance records show that the prison's control room called for an ambulance at 7.10pm.

40. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, states that, when a medical emergency is called, the control room should call an ambulance immediately and there should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed. Thameside has a local protocol in line with PSI 03/2013.

41. While the ambulance arrived quickly to attend to Mr Hayde, we are concerned that the control room did not immediately call for one when the code blue had been called. In this instance, the delay did not affect the outcome for Mr Hayde, however it could make a difference in the future. We make the following recommendation:

The Director of HMP Thameside should ensure the control room call an ambulance as soon as a medical code is called, in line with PSI 03/2013.

Family liaison

42. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". In addition, Prison Service Instruction (PSI) 64/2011, about safer custody, states that where prisoners suffer a rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner and engaging with their next of kin. It also says that following the death of a prisoner, that their next of kin must be notified promptly.

43. While it was clear that Mr Hayde's brothers knew that he was in hospital, because they visited him on 23 June, there was no record that the prison had appointed someone to support Mr Hayde and his family until the chaplain's appointment on 28 June. We are concerned that the prison appears not to have appointed a family liaison officer sooner in line with the Prison Rule 22 and PSI 64/2011.

44. We are also concerned that there was no record that the family liaison officer, or other appropriate person, spoke to Mr Hayde's family on the day of his death to offer their condolences and support. The chaplain did not contact Mr Hayde's family until 4 July, five days after his death. We make the following recommendation:

The Director of HMP Thameside should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

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