Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Ingram a prisoner at HMP Hewell on 29 January 2017

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 Graham Ingram died from a heart attack in hospital on 29 January 2017, while a prisoner at HMP Hewell. Mr Ingram was 74 years old. I offer my condolences to Mr Ingram's family and friends.

I am satisfied that Mr Ingram received a good standard of care at Hewell, equivalent to that he could have expected to receive in the community.

However, I am concerned that a prison manager did not debrief staff or offer appropriate support after Mr Ingram's death.

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 **July 2017**

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Summary

Events

1. On 13 April 2012, Mr Graham Ingram was sentenced to ten years in prison for sexual offences and sent to HMP Hewell. In 2013, he was convicted of further sexual offences and received a ten year concurrent sentence. Mr Ingram moved prisons a number of times but returned to Hewell on 15 January 2016.

2. Mr Ingram had a number of chronic medical conditions, the most serious of which was heart failure. In November 2015, a heart specialist gave him a life expectancy of six to twelve months. Staff at HMP Stafford, his prison at that time, started an application for his early release on compassionate grounds.

3. After his return to Hewell in January 2016, Mr Ingram lived in the prison's inpatient unit. Healthcare staff introduced appropriate care plans to manage and monitor his various conditions. They saw him daily and Worcestershire social care provided staff to assist with his personal hygiene and social care. Mr Ingram was aware of the seriousness of his condition and agreed that he did not want staff to attempt to resuscitate him if his heart or breathing stopped.

4. In early February 2016, the Secretary of State rejected Mr Ingram's application for early release. Hewell did not consider a second application.

5. Mr Ingram's health gradually deteriorated. In September, a chest X-ray identified a build up of fluid around his lungs and the suspicion of lung cancer. A prison doctor referred him to a specialist as an urgent case and he underwent further tests. These investigations were ongoing when Mr Ingram died.

6. On 23 January 2017, Mr Ingram returned from a visit with his wife and told a nurse he did not feel well. His condition worsened and he became more breathless. A nurse examined him shortly after 7.00pm and noted his earlobes, lips, fingers and toes were blue. The nurse gave him oxygen but he did not improve. Staff called an ambulance and he went to hospital for further assessment. Two prison officers went with him and restrained him using an escort chain.

7. Mr Ingram was admitted to hospital but his condition continued to deteriorate and he died on 29 January from congestive heart failure.

Findings

8. Overall, we consider that Mr Ingram received a good standard of care at the prison. The clinical reviewer was satisfied that the care he received at Hewell was equivalent to that he could have expected in the community.

9. However, we are concerned that the prison did not hold a debrief after Mr Ingram's death or offer staff appropriate support.

Recommendation

- The Governor should ensure that a debrief takes place following a death in the prison and that staff involved are appropriately supported.

The Investigation Process

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

11. The investigator visited Hewell on 7 February 2017. He obtained copies of relevant extracts from Mr Ingram's prison and medical records.

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

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

14. One of the Ombudsman's family liaison officers contacted Mr Ingram's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked to see a copy of the report.

15. Mr Ingram's wife received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

16. We shared the initial report with the Prison Service who clarified an issue that we had raised. This report has been amended accordingly.

Background Information

HMP Hewell

17. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr Ingram was at the Blakenhurst site, which comprises six houseblocks, holding around 1,100 men. Care UK took over the provision of primary care services from Worcestershire Care Trust in April 2016. There is an 18 bed inpatient unit.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported that the prison had many challenges and areas of serious concern. Inspectors acknowledged that Care UK had inherited a poor service but while they had made some improvement, significant work was still needed. Staff shortages had significantly affected service delivery. Areas in healthcare, including the inpatient area, were dirty and poorly ventilated. The waiting area for vulnerable prisoners had prominent racist and violent graffiti and, what appeared to be, blood on the walls. The high rate of 'failure to attend' healthcare appointments had shown recent improvement.

19. Emergency resuscitation equipment bags were in poor condition, as they did not contain any emergency medication and some items were missing or had passed their use by date. Monitoring was not effective. Too few custody staff had received first aid or automated external defibrillator (AED) training and had no access to AEDs.

Independent Monitoring Board

20. 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 September 2016, the Board was concerned that the newly appointed healthcare providers had not been able to provide the promised, acceptable standard of care. Late provision of regular medication on the house blocks had caused considerable disruption and the use of a large number of agency nurses had led to a lack of continuity in patient care.

Previous deaths at HMP Hewell

21. Mr Ingram was the third prisoner to die from natural causes at Hewell since January 2015. There has been one subsequent death. There were no significant similarities with the circumstances of the previous deaths.

Key Events

22. On 13 April 2012, Mr Graham Ingram was sentenced to ten years in prison for sexual offences and was taken to HMP Hewell. On 9 August 2013, while still at Hewell, Mr Ingram was convicted of further sexual offences and given a concurrent ten year sentence. He spent time at a number of prisons and was moved to HMP Stafford in April 2015.

23. Mr Ingram had arthritis (inflammation in the joints) and hypertension (high blood pressure). In June 2013, he was diagnosed with cardiovascular disease (heart disease) and in August 2015, he was diagnosed with chronic kidney disease. His main problem was congestive heart failure (where the heart is unable to pump blood around the body properly). His prognosis was poor and, in November 2015, his consultant cardiologist estimated he had between six to twelve months to live.

24. On 9 December 2015, a nurse examined Mr Ingram, as he was breathless, had an enlarged stomach and his ankles were red and swollen. Staff called an ambulance and Mr Ingram was admitted to hospital. The prison appointed a family liaison officer who informed Mr Ingram's family and arranged for his wife and son to visit him. Staff at Stafford started an application for Mr Ingram's early release on compassionate grounds, due to his ill health.

25. On 14 December, a nurse visited Mr Ingram in hospital. She noted that Mr Ingram had agreed with hospital staff that they would not attempt to resuscitate him if his heart or breathing stopped. The nurse suggested that when Mr Ingram was discharged from hospital, they should consider moving him to a prison with a 24 hour healthcare facilities and she recommended Hewell, a prison close to Mr Ingram's family.

26. On 15 January 2016, Mr Ingram was discharged from hospital to the inpatient unit at Hewell. Healthcare staff did a verbal handover and the hospital provided a discharge letter, a medication list and medication. A nurse spoke to Mr Ingram the next day and noted that he suffered with heart failure, hypertension and chronic kidney disease. Appropriate care plans were implemented, including one to cover risk of falls.

27. A locum GP spoke to Mr Ingram later that day and he reiterated that he did not want staff to resuscitate him. That same day, healthcare staff issued Mr Ingram with a wrist alarm to call for assistance if he needed it.

28. On 16 January at 10.54pm, after activating his alarm, a nurse found Mr Ingram kneeling by his bed. He told her that he had become disorientated and fallen. Mr Ingram had only minor grazes and staff monitored him throughout the night.

29. On 24 January, a nurse highlighted that staff should be aware of Mr Ingram's risk of falling and that he needed his walking stick with him at all times. Food and drink was left in reach of his bed or chair and he had easy access to his wheelchair. However, on 25 January, Mr Ingram fell again when he got up to use the toilet.

30. A physiotherapist and an occupational therapist saw Mr Ingram the next day and he told them that he had fallen a number of times due to a lack of balance or standing too quickly. The occupational therapist advised him to ask for assistance if he need to move. They discussed the benefits of a walking frame but there is no record of Mr Ingram getting one.

31. Staff regularly advised Mr Ingram to call for help when he needed it and they reviewed his falls care plan monthly. However, he had over ten recorded falls between January and July 2016.

32. Healthcare staff monitored Mr Ingram regularly each day and administered medication when he could not collect it himself. During the night they checked him every hour. Worcestershire social care provided healthcare staff to assist Mr Ingram with his personal hygiene, seven days a week, often twice a day. He had regular visits from members of the prison chaplaincy.

33. On 9 February, a senior prison manager told Mr Ingram that the Secretary of State had not approved his early release. Mr Ingram was disappointed but took the news well.

34. On 21 March at 9.56am, Mr Ingram collapsed when a nurse was assisting him to the toilet. A locum GP examined him and decided the most likely cause was a rapid drop in his heart rate and blood pressure. He temporarily stopped Mr Ingram's blood pressure medication.

35. On 11 April, a locum GP reviewed Mr Ingram after he reported swollen lower limbs, a symptom of his heart condition. The GP increased his prescribed bumetanide medication (a diuretic used to treat water retention) and advised him to keep his legs elevated when possible.

36. On 27 April, Mr Ingram's wife telephoned the prison to complain that her husband had missed some GP appointments. Mr Ingram's wife visited him regularly each week and Mr Ingram chose to attend his visits rather than see the GP. A nurse booked Mr Ingram a GP appointment for later in the week, having first checked that his wife was not visiting that day.

37. A GP examined Mr Ingram on 13 June, after he reported diarrhoea. His blood pressure was low (though this was generally normal for Mr Ingram) and his abdomen soft. There was no sign of dehydration and the swelling in his ankles had gone down. The GP reduced his bumetanide medication to the previous level and planned to reduce it further if his breathing and the swelling in his ankles remained satisfactory.

38. On 3 August, a prison GP reviewed Mr Ingram and noted that Mr Ingram's condition could be treated on a standard wing. Despite this opinion, Mr Ingram remained in the inpatient unit.

39. On 12 September, a prison GP examined Mr Ingram after he reported increased breathlessness. He did not have chest pain but the swelling in his lower limbs had increased. The GP arranged a chest X-ray, suspecting a build up of fluid in the lungs, and increased his diuretic medication.

40. A prison GP saw Mr Ingram on 26 September but he did not have the results from his recent X-ray. Mr Ingram continued to be short of breath and they discussed another change in his diuretic medication. The GP reviewed the X-rays later that day and noted it showed excess fluid around the right lung with opaque lumps in his chest that could be malignant. The GP arranged a follow up appointment.

41. A prison GP saw Mr Ingram two days later. In light of the X-ray results and Mr Ingram's breathlessness, the GP recommended he go to hospital for further tests. Mr Ingram initially refused, as he had a visit planned with his wife, but went later that day. Hospital staff noted that his heart failure had not worsened.

42. On 29 September, after further discussion with Mr Ingram about the results of his chest X-ray, a prison GP made an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. After problems with the first referral, Mr Ingram received an appointment for 19 October.

43. Mr Ingram attended his appointment on 19 October. The consultant suggested that the fluid on Mr Ingram's lungs could be due to a number of factors but that aggressive investigation or treatment was not in his best interest. The consultant arranged further tests, including a magnetic resonance imaging scan (MRI – a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body) of his chest and abdomen.

44. On 9 November, Mr Ingram missed a hospital appointment for an ultrasound scan (a scan that uses high-frequency sound waves to create an image of part of the inside of the body) because the taxi firm used by the prison could not provide a vehicle with wheelchair access. The re-arranged appointment, planned for 24 November, did not go ahead because Mr Ingram arrived two hour late after a misunderstanding between the prison and the hospital regarding the time of his appointment. The rearranged appointment on 15 December, and a further appointment on 12 January 2017, went ahead as planned.

45. A prison GP examined Mr Ingram on 16 January, and reviewed his medical history and recent treatment. He considered Mr Ingram to be at the end of life stage, though, in his opinion, more from lung cancer than heart disease. He attempted to contact Mr Ingram's specialist for an update without success.

46. Healthcare staff continued to see Mr Ingram regularly each day in line with his various care plans and to issue medication. Carers also saw him daily to assist with his hygiene and personal care.

Events of 23 January 2017

47. On 23 January, a prison GP wanted to see Mr Ingram but he was on a visit with his wife. The GP arranged another appointment in two days time.

48. Mr Ingram returned from his visit at around 3.00pm. He appeared settled but told a nurse that he did not feel well. He took his medication as prescribed.

49. Mr Ingram's condition continued to deteriorate and a nurse examined him shortly after 7.00pm. She found that he was distressed, too breathless to speak in full

sentences and his earlobes, lips, fingers and toes were blue. Another nurse arrived and gave him oxygen. They agreed he needed a paramedic assessment and, at 7.08pm, staff called an ambulance.

50. Paramedics arrived at 8.00pm, examined Mr Ingram and confirmed he needed to go to hospital for further assessment. They took him to hospital escorted by two prison officers and restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

51. A doctor admitted Mr Ingram and at 11.00pm, while still in the accident and emergency department, officers removed the escort chain.

52. Mr Ingram remained in hospital but his condition continued to deteriorate and he died shortly after 10.00am on 29 January.

Contact with Mr Ingram's family

53. Stafford appointed a family liaison officer when Mr Ingram was admitted to hospital in December 2015. The officer stayed in contact with Mr Ingram's wife, his named next of kin, until his discharge and transfer to Hewell.

54. On 17 January 2016, Hewell appointed a Senior Officer (SO) as the family liaison offer. He spoke with his counterpart at Stafford and, on 19 January, contacted Mr Ingram's wife to introduce himself. They discussed visiting arrangements at Hewell and the progress of Mr Ingram's application for early release on compassionate grounds.

55. The SO spoke to Mr Ingram's wife on a number of occasions when she telephoned to raise concerns about his care and about his early release on compassionate grounds.

56. On 24 August, an officer replaced the SO as the family liaison officer. She spoke to Mr Ingram's wife that day while she was at the prison visiting her husband.

57. The officer kept in contact with Mr Ingram's wife, speaking to her on several occasions when she visited Mr Ingram in prison. She continued to raise concerns about his care and of her hopes for his early release.

58. On 23 January 2017, Mr Ingram was taken to hospital. Mr Ingram's wife attended the hospital at 11.50pm, after it became clear that he would be admitted. The senior prison manager on duty spoke with Mr Ingram's wife at the hospital. She explained that the officer was on leave for three days. She agreed to be a point of contact and she also authorised for other family members to visit Mr Ingram in hospital. The officer contacted Mr Ingram's wife when she returned to work on 26 January.

59. On 29 January, a member of the hospital staff contacted Mr Ingram's wife and advised her that the family should attend the hospital, though he died before his wife and family arrived. The officer went to the hospital with a senior prison manager but Mr Ingram's wife had left before they got there. She returned to the prison and telephoned Mr Ingram's wife to offer her condolences. Later that day, she visited Mr Ingram's wife at home with a member of the prison chaplaincy.

60. The officer remained in contact with Mr Ingram's wife until Mr Ingram's funeral. Mr Ingram's funeral was held on 24 February, and the prison contributed towards the cost in line with national guidance.

Support for prisoners and staff

61. The prison posted notices informing other prisoners of Mr Ingram'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 Ingram's death.

62. A senior prison manager attended the hospital after Mr Ingram's death and spoke to the prison staff on the bedwatch and offered support. One of the officers was from HMP Gartree so a manager at Hewell telephoned Gartree to make sure the care team there was aware. The officer based at Hewell was referred to the care team and to a prison counsellor.

63. However, there is no record that a prison manager held a debrief involving prison and healthcare staff or that support was offered to them.

Post-mortem report

64. A post-mortem examination indicated the immediate cause of Mr Ingram's death was from congestive heart failure (when the heart is unable to pump blood around the body properly) caused by pulmonary hypertension (high blood pressure that affects the arteries in the lungs and right side of the heart) and cor pulmonale (an enlargement and failure of the right side of the heart as a response to increased vascular resistance or high blood pressure in the lungs). There was no indication of lung cancer.

Findings

Clinical care

65. The clinical reviewer was satisfied that the care Mr Ingram received at Hewell was equivalent to that he could have expected to receive in the community. He received a great deal of support from the health and social care team and though he missed two hospital appointments towards the end of 2016 due to administrative and communication issues, these were not related to and did not impact on his death.

66. Mr Ingram was aware of his condition and poor prognosis. Staff had regular discussions with him about his wishes regarding resuscitation. When a chest X-ray identified a suspicion of lung cancer he was referred to a specialist.

67. Mr Ingram had a number of falls during his first few months at Hewell, despite having a care plan in place to prevent them. Though reviewed monthly, the clinical reviewer considered the care plan superficial and recommended that the Head of Healthcare review the policy to confirm that it remains appropriate and in line with NHS standards.

68. Overall we agree that Mr Ingram received good care at Hewell.

Support for prisoners and staff

69. Chapter 12 of Prison Service Instruction (PSI) 64/2011 directs that:

> *"In line with PSI 08/2010 Post Incident Care a 'Hot Debrief' must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including Healthcare staff, should be invited. It may be useful to keep a record of those who attend.*
>
> *Governor/Directors are reminded that staff affected by a death in custody may require support at any time and on more than one occasion, including during police and PPO investigations, and during and after the completion of the inquest.*"

70. Hewell did not hold a debrief after Mr Ingram's death. Prison and healthcare staff who knew Mr Ingram or had been involved with his care were not given the opportunity to discuss the circumstances of his death and there is no record of them being offered appropriate support A prison manager explained that because Mr Ingram had been ill for some time and had died in hospital, where he had been for over a week, a debrief was not considered necessary.

71. The PSI explicitly states that a hot debrief must be held immediately after all deaths in custody, we make the following recommendation:

> **The Governor should ensure that a debrief takes place following a death in the prison and that staff involved are appropriately supported.**

Restraints, security and escorts

72. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

73. Between October 2016 and January 2017, Mr Ingram went out to hospital six times, mainly for pre planned appointments. On each occasion, with the exception of the last, a senior manager completed a risk assessment and spoke to healthcare staff about Mr Ingram's condition. No restraints were used.

74. However, on 23 January 2017, when Mr Ingram went out to hospital for the final time, the senior prison manager on duty authorised two officers to accompany him and the use of an escort chain.

75. Ordinarily the senior manager worked at Hewell Grange, the site of the open prison. She did not know Mr Ingram and had no knowledge of his medical history. She did not have immediate access to his security file but was aware of his security category (which identified him as medium risk) and of his index offence. She had no knowledge of the recent hospital appointments.

76. The senior manager spoke to healthcare staff and to the paramedics who explained that Mr Ingram was stable but needed to go to hospital straight away. They did not object to the use of restraints but she did not specifically ask about the risk Mr Ingram presented or his ability to escape. It is unfortunate that healthcare staff did not tell her that for recent hospital appointments Mr Ingram had not been restrained.

77. Ordinarily, medium risk prisoners at Hewell are handcuffed when escorted outside the prison. Because the senior manager could see that Mr Ingram had mobility issues and used a wheelchair she authorised the use of an escort chain instead (a lower form of restraint). She did not complete a written risk assessment at the time because she did not want to delay Mr Ingram's departure She told the investigator that when considering the need for restraints, in addition to the risk, she considered and had concerns about the prison's reputational credibility.

78. At 11.00pm, the senior manager reviewed the continued need to use restraints and authorised the escort chain to be removed. She went to the hospital shortly afterwards and spoke to medical staff and to Mr Ingram's wife. She later completed a written risk assessment document. Restraints were not used again.

79. While the Prison Service has a fundamental responsibility to protect the public, security must be balanced with humanity and be legally justified. We are

concerned that healthcare staff did not tell her that Mr Ingram had not been restrained previously when he went out to hospital on previous occasions.

80. We are satisfied that under the circumstances, with the information available to her, the senior manager's decision to authorise the use of an escort chain was understandable. We are pleased that the escort chain was removed soon after Mr Ingram was admitted to hospital.

Compassionate release

81. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

82. In December 2015, while still a prisoner at HMP Stafford, the prison submitted an application for Mr Ingram's early release on compassionate grounds to NOMS. The decision, received on 6 February 2016, after Mr Ingram had moved to Hewell, did not support early release. The reasons given included a life expectancy of more than three months (in a medical report dated 27 November 2015, the consultant cardiologist estimated 6-12 months) and the risk of re offending (Mr Ingram continued to deny his offences, expressed no remorse and refused to complete any offending focussed work to aid his rehabilitation)

83. Although at that time, the Secretary of State did not consider that Mr Ingram met the necessary criteria for early release on compassionate grounds, the prison Governor was asked to keep his case under review.

84. Mr Ingram's wife continued to campaign for her husband early release but Hewell did not submit an application. At the time of his death, Mr Ingram had already exceeded the 12 month estimate of life expectancy given by his cardiologist in November 2015, but the prison did not request an up to date prognosis.

85. Mr Ingram's Offender Manager told the investigator that Mr Ingram continued to deny his offences, showed no remorse and still refused to complete any offender focussed work. As such, despite a deterioration in his medical condition, his risk of re offending had not changed.

86. He also told the investigator that Mr Ingram had a parole hearing due at the end of February 2017, at which neither he nor Mr Ingram's Offender Supervisor intended to support his release on parole.

87. We consider that, under the circumstances, it was reasonable for staff at Hewell not to make a further application for compassionate release.

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