Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Hale a prisoner at HMP Parc on 26 August 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*

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 Alan Hale died on 26 August 2016 of a heart attack at hospital. He was 75 years old. I offer my condolences to Mr Hale's family and friends.

Mr Hale had a number of long-term health conditions which healthcare staff initially managed well and reviewed frequently. While, there appears to have been a deterioration in the quality of Mr Hale's chronic disease management from 2015, overall, he received a satisfactory standard of healthcare at Parc.

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 **April 2017**

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Summary

Events

1. On 15 July 2013, Mr Alan Hale was sentenced to 10 years in prison for sexual offences. Mr Hale suffered from asthma, type 2 diabetes, heart disease, high blood pressure, osteoarthritis in his left hip, prostate problems, problems with cataracts and was a smoker.

2. Healthcare staff monitored Mr Hale's chronic health conditions frequently. They provided ongoing support and prescribed medication.

3. Shortly before 7.00am on 13 August 2016, Mr Hale told a prison custody officer that he was having breathing difficulties. The officer shouted to colleagues for assistance. One officer telephoned the healthcare department for nurses to attend, another officer called an emergency medical code to indicate that Mr Hale had collapsed. Healthcare staff arrived and started cardiopulmonary resuscitation. Nurses successfully resuscitated Mr Hale and paramedics took him to hospital. Mr Hale's condition deteriorated and he died on 26 August, with his family present.

Findings

4. Healthcare Inspectorate Wales found that Mr Hale's care was satisfactory. We are satisfied that he received care equivalent to that he could have expected to receive in the community and that he received appropriate care at Parc.

5. Despite satisfactory care, there was no documented evidence that from 2015 healthcare staff had followed his specific care plans to manage Mr Hale's medical conditions.

6. When Mr Hale collapsed in his cell, there was a delay in summoning assistance, as an officer had not charged his radio.

Recommendations

- The Head of Healthcare should ensure that prisoners with chronic conditions have detailed care plans and are managed and reviewed in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and ensures there are no delays in calling for emergency assistance.

The Investigation Process

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

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

9. The investigator interviewed three members of staff at HMP Parc on 13 October 2016.

10. Healthcare Inspectorate Wales (HIW) reviewed Mr Hale's clinical care at the prison. HIW conducted joint interviews with the investigator on 13 October 2016.

11. We informed HM Coroner for Cardiff and Vale of Glamorgan District of the investigation, who gave us the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Hale's family, to explain the investigation. They raised no matters for the investigation to consider.

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

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

Background Information

HMP Parc

15. HMP Parc is a medium security prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18.

16. Integrated Services, a branch of G4S, provides 24-hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24-hour GP cover.

HM Inspectorate of Prisons

17. The most recent inspection of Parc was in January 2016. Inspectors found that significant chronic recruitment and retention problems affected secondary health screening. They said there were easily accessible automated defibrillators, which ensured prompt emergency care.

18. In their survey of prisoners, significantly fewer prisoners than in comparator prisons said the quality of health provision was good. Inspectors noted that support for prisoners with complex health needs, including life long conditions were generally good.

Independent Monitoring Board

19. 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 February 2016, the IMB found that the prison was well managed. The Board said that the HMIP survey results about health provision could be explained by a lack of access to healthcare services rather than the quality of the service.

Previous deaths at HMP Parc

20. Mr Hale was the seventh prisoner to die from natural causes since January 2015, and there has been one since. There were no significant similarities with the circumstances of these deaths.

Key Events

21. On 15 July 2013, Mr Alan Hale was sentenced to 10 years in prison for sexual offences and sent to HMP Parc. Mr Hale had longstanding and complex health problems. These included asthma, type 2 diabetes, heart disease (due to blocked arteries he had had a triple heart bypass eight years previously), hypertension (high blood pressure), osteoarthritis in his left hip, prostate problems, cataracts and he smoked cigarettes.

22. At an initial health screen, a nurse noted that the prison doctor would need to see Mr Hale to issue his medication for his conditions. A doctor reviewed him and re-prescribed his medications, which included tamsulosin (for an enlarged prostate) aspirin, paracetamol, atorvastatin (to lower cholesterol), bendroflumethiazide (to treat hypertension), three asthma inhalers, metformin (for diabetes), and lisinopril (for hypertension and heart disease).

23. Healthcare staff treated Mr Hale's health conditions appropriately with medication and reviewed him regularly. They created care plans to monitor his asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD – a progressive lung disease) and pain. He attended appointments for the diabetic clinic and had annual asthma reviews. He had dental and ophthalmology appointments.

24. On 10 January 2015, Mr Hale told a healthcare assistant that he generally felt unwell. She checked his blood pressure (it was low at 100/55, the normal range is between 90/60 and 120/80). His oxygen blood level was low at 93% (normal range is above 97%). His pulse was 70 (within normal range which is between 60 and 100). She booked a review the next day for Mr Hale and told him if he felt worse to contact healthcare staff. She checked Mr Hale's blood pressure the next day. It had improved to 143/80 and he told her he felt better.

25. On 21 July, Mr Hale had a blood test. The results showed his cholesterol level was very high. A prison GP told Mr Hale that a poor diet with high sugar was not good for his diabetes and existing heart disease. Mr Hale said he ate a packet of biscuits per night and had no intention of stopping. The GP prescribed rosuvastatin to try to lower his cholesterol, and recommended that his cholesterol levels be checked in three months. This did not happen.

26. A nurse completed a review on 7 February 2016. Mr Hale said he had his medication in possession. He knew what his medications were for and when to take them. He said he was in pain waiting for a hip replacement and had no concerns about his diabetes, hypertension, cholesterol or COPD. His blood pressure was 146/70 (a little high) and his blood sugar level was 8.1 (normal range for a diabetic). She noted that further reviews should be completed as per his care plans. Apart from diabetic foot care and social care appointments, a nurse completed the last recorded care plan review on 15 February to cover the next three months.

27. In March 2016, Mr Hale had a recurrent chest cough which despite antibiotic prescriptions, did not clear. Healthcare staff recommended increased use of his inhalers and on 12 March, Mr Hale told a nurse that he was better.

28. On 8 April, Mr Hale was vomiting and felt dizzy. A nurse examined him. His pulse was normal, 76 beats per minute and his blood sugar levels were 5.9 (normal range). He told her that he was feeling better. She told him to contact healthcare staff if needed.

29. Two days later, a nurse went to Mr Hale's cell during the night as he was having trouble breathing. She noted that his chest was crackling and he had coughed up discoloured phlegm. She prescribed antibiotics and made a GP appointment for a review in two days.

30. A locum GP reviewed Mr Hale on 13 April. She noted he had a slight wheeze and the antibiotics were clearing his chest infection. She said he should continue with the course of antibiotics.

31. A nurse completed care plan reviews on 29 May for all of Mr Hale's conditions. Apart from hip pain (as he was waiting for a hip replacement), he said that everything was satisfactory.

32. On 7 July, Mr Hale had an operation for a left hip replacement. He returned to Parc on 18 July. Healthcare staff saw him daily to help with his recovery.

Events on Saturday 13 August 2016

33. Mr Hale was in a single cell on a wing for older vulnerable prisoners (X3). Just before the changeover of night shift to day staff, at approximately 7.00am, he pressed the alarm bell. Officer A (a night shift officer) went to his cell door and opened the observation flap. Mr Hale said he was having breathing difficulties and was holding his chest. The officer said he asked a colleague (who was working with him) to go to the telephone to ring for a nurse to attend. He said he remained at the observation flap and saw Mr Hale deteriorating. He saw Mr Hale move backwards towards the bed and collapse. He said he shouted for Officer B to come to the cell. He said that he did not use his radio to call an emergency code, as his radio battery was flat.

34. Officer B told the investigator that he was on the day shift duty in the office of the adjacent unit, X1. Officer A telephoned him and asked him to join him at Mr Hale's cell door. Officer B said that he went to the cell and looked through the observation flap. He saw Mr Hale was having difficulties breathing. He said that Officer A asked him to call the emergency radio code blue (an emergency code, which indicates that a prisoner is unconscious, not breathing or having breathing difficulties). Records show the radio call was made at 6.59am. Officer B said that he entered the cell and reassured Mr Hale that nurses were on the way. He said that Mr Hale said he was having breathing difficulties and then collapsed onto the bed. He said he could hear the nurses running along the corridor. With assistance from Officer A, he placed Mr Hale on the floor in the recovery position as nurses arrived.

35. A nurse said that she had received a telephone call from an officer on X3 that a prisoner was having difficulty breathing. On the way to the cell, she heard the radio emergency call code blue. She said in the cell Mr Hale said he was having breathing difficulties and clutching his chest. She used the radio to summon further healthcare assistance. She said that she asked Mr Hale if he had used

his asthma pumps, he said he had. She said Mr Hale then collapsed. She asked the officers to place him on the floor as she went to get oxygen, which was not far away, down the corridor. She also asked an officer to collect an emergency medical bag.

36. The nurse started cardiopulmonary resuscitation (CPR). A defibrillator was used. The reading from the defibrillator said no shockable rhythm was advised so she called for nine other healthcare staff and continued with CPR. Paramedics arrived at 7.25am. Mr Hale was resuscitated. At 7.44am, paramedics took Mr Hale to hospital. Two officers escorted Mr Hale but they did not restrain him.

37. At hospital, Mr Hale was placed in an induced coma. Healthcare staff frequently contacted hospital staff for updates on his condition. Doctors decided that no further treatment was possible. He died in hospital on 26 August at 2.37pm with his family present.

Contact with Mr Hale's family

38. On 13 August, when Mr Hale was admitted to hospital, the prison appointed a chaplain as the family liaison officer. Mr Hale had listed one of his daughters as his next of kin. The chaplain rang her at 8.55am to inform her that Mr Hale had been found unresponsive in his cell and had been taken to hospital.

39. Members of Mr Hale's family arrived at the hospital and at 12.20pm, the chaplain met them and offered advice and support. Mr Hale's family visited him frequently in hospital.

40. After Mr Hale died, the chaplain went to the hospital to meet Mr Hale's family. She offered her condolences. She exchanged contact details with Mr Hale's daughters and with the family agreement, arranged to visit Mr Hale's niece.

41. On 30 August, the chaplain and a colleague visited Mr Hale's niece and sister to offer advice. The chaplain remained in contact with the family until after Mr Hale's funeral. Mr Hale's funeral was held on 30 September and the prison contributed towards the costs of the funeral in line with national policy.

Support for prisoners and staff

42. After Mr Hale's death there should have been a debrief with staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The Safer Custody co-ordinator said that the usual process would be to conduct a hot debrief following any death in custody. On this occasion, unfortunately, there was no record that a hot debrief was held with the staff who were with Mr Hale at the time he died.

43. The prison posted notices informing staff and prisoners of Mr Hale'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 Hale's death.

Cause of death

44. The coroner gave the cause of death as cardiac arrest, due to heart disease as a consequence of hypertension and type 2 diabetes.

Findings

Clinical care

45. Healthcare Inspectorate Wales (HIW) found that the overall care Mr Hale received in prison was satisfactory. HIW said his chronic disease management was initially good but had deteriorated due to staffing problems. In spite of this, his underlying care was good.

Chronic Disease Management

46. HIW said that Mr Hale's diabetic care was only checked once from November 2014 and that from August 2015 his cholesterol levels were not measured. His COPD was not frequently monitored and was disjointed. HIW said that from 2015 checks became less comprehensive and frequent and his care plans were not followed.

47. HIW said that Mr Hale's chronic disease management could have been better. Good care plans had been devised but not always followed consistently. We recommend that:

    The Head of Healthcare should ensure that prisoners with chronic conditions have detailed care plans and are managed and reviewed in line with National Institute for Health and Care Excellence (NICE) guidelines.

48. In spite of the shortcomings identified, we agree with the clinical reviewer that, overall, Mr Hale's care and treatment in prison were satisfactory. We consider that it was equivalent to that he could have expected to receive in the community.

Emergency response

49. Prison Service Instruction (PSI) 03/2013, medical emergency response codes, gives clear guidance on the use of emergency codes and that a code blue emergency code (which indicates that a prisoner is unconscious or not breathing) should prompt the immediate request of an emergency ambulance.

50. When Officer A went to Mr Hale's cell and saw he had breathing difficulties, he was unable to use his radio to summon assistance. He said that an hour earlier, he had become aware that the battery needed charging. He knew that spare batteries were kept in the office. He said that as he was standing outside the cell and just about to finish his shift he had seen Officer B, so shouted to him. Although he was able to summon assistance quickly, it is essential that officers ensure that they have fully charged radios. When interviewed, he did understand the purpose of the emergency codes.

51. As no emergency radio code was used, the nurse did not bring an emergency medical bag. In addition, the defibrillator was locked away. On arrival, the nurse had to pass her keys and ask an officer to bring the defibrillator. We understand that since Mr Hale died, defibrillators are no longer locked away so all staff can have access to defibrillators, so we do not make a recommendation about this. However, Officer A, as first on scene, was unable to use his radio and though it did not affect the outcome for Mr Hale, it could in other circumstances. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and ensures there are no delays in calling for emergency assistance.

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