Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Mason a prisoner at HMP Oakwood on 23 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 Peter Mason died on 23 January 2017 of ischaemic heart disease (a condition that affects the supply of blood to the heart) at HMP Oakwood. Mr Mason was 73 years old. I offer my condolences to Mr Mason's family and friends.

Mr Mason had a history of heart disease and was seen regularly by healthcare staff for reviews of his overall health. He was prescribed appropriate medication for his heart condition in line with NICE guidelines.

Officers found Mr Mason unresponsive in his cell on 23 January 2017. I am satisfied that Mr Mason's death was unforeseeable and that the care he received while at Oakwood was equivalent to that which he could have expected to receive in the community.

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 17 August 2013, Mr Peter Mason was remanded into custody for assault and threats to kill, and sent to HMP Bullingdon. He had ischaemic heart disease and, before coming into prison (in 2001), had a heart attack and a coronary artery bypass operation. On 17 December, Mr Mason was sentenced to five years in custody. While in Bullingdon he did not have any cardiovascular or older persons' reviews.

2. Mr Mason was transferred to HMP Oakwood on 24 February 2014. On 7 April, a nurse completed an 'over 55s check' with Mr Mason. He was independently mobile and self caring. Mr Mason's blood pressure was high and four days later, on 11 April, a hypertension care plan was created. This included diet and lifestyle advice with monthly blood pressure checks. Mr Mason had a cardiovascular review with a prison GP on 21 June. No concerns were raised.

3. On 14 May 2015, Mr Mason took an intentional overdose of 200 zopiclone tablets. He spent eight days in hospital before being discharged back to prison. Mr Mason was then managed under Prison Service suicide and self harm prevention procedures (ACCT). Mr Mason had a cardiovascular review three weeks later, on 11 June. Again, no concerns were raised at this time. He remained well apart from treatment for in-growing toenails, haemorrhoids and various dental treatments.

4. Mr Mason had a QOF review (quality outcomes framework review) on 30 September 2016. A QOF review looks at long term health conditions. No concerns were highlighted as part of this review.

5. On 19 January 2017, healthcare staff again reviewed Mr Mason. They identified no concerns regarding his physical health at this time.

6. On 23 January, at approximately 5.10pm, an officer witnessed Mr Mason walking around the wing after collecting his evening meal. At 5.25pm, two officers went to Mr Mason's cell. One officer opened the door and found Mr Mason apparently kneeling in his cell. He called out, but when he did not get a response approached the bed and lifted Mr Mason's head. On lifting his head he found bloody vomit on the mattress where his head had been resting.

7. The other officer immediately called a code blue over his radio at 5.29pm. He moved Mr Mason to the floor and started cardiopulmonary resuscitation. Healthcare staff arrived at 5.32pm and chest compressions continued. Paramedic staff arrived at 5.44pm. Mr Mason did not respond to resuscitation attempts and a paramedic doctor confirmed Mr Mason's death at 6.33pm.

Findings

8. Mr Mason had a history of ischaemic heart disease and healthcare staff saw him regularly for reviews of his overall health. They prescribed medication for his heart condition in line with NICE guidelines.

9. Healthcare staff saw Mr Mason on 30 September 2016 for a QOF review, and then on 19 January 2017 where a long term health conditions care plan (in line with NICE guidelines) was created. While the clinical reviewer was happy that his heart disease would have been covered as part of this review, his view was that the recording in the care plan was confusing. It does not state which NICE guidelines are being covered (e.g. which long term health condition) and the QOF review notes in the medical record do not explicitly mention his heart disease.

10. Despite this, we agree with the clinical reviewer overall conclusion that the care Mr Mason received while at Oakwood was equivalent to that which he could have expected to receive in the community.

Recommendation

- The Head of Healthcare should review the process for the management of long term conditions and ensure that disease specific reviews are taking place in line with NICE guidance, and are clearly recorded.

The Investigation Process

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

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

13. The investigator interviewed one member of staff at Oakwood on 2 March 2017.

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

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

16. The investigator wrote to Mr Mason's son-in-law, his next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Oakwood

18. HMP Oakwood opened in 2012. It is near Wolverhampton and managed privately by G4S. Oakwood is one of the largest prisons in England and Wales, providing places for up to 1,605 Category C male prisoners.

19. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Oakwood was in December 2014. Inspectors reported that health services had improved considerably since the last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans. However, there were often delays in arranging external hospital appointments because of the high demand and insufficient escort staff.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board made up of unpaid volunteers from the local community who help to help ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2016, the IMB reported that, due to the uncertainty arising from the change of healthcare provider (Worcester Health and Care Trust provided healthcare services before April 2016), there were a high number of vacancies and the use of agency staff had lowered continuity of care.

Previous deaths at HMP Oakwood

22. Mr Mason was the seventh prisoner to die from natural causes (the second from ischaemic heart disease) at Oakwood since January 2016. There were no significant similarities with the circumstances of the previous deaths.

Key Events

23. On 17 August 2013, Mr Peter Mason was remanded into custody for assault and threats to kill, and sent to HMP Bullingdon. He suffered with depression and after a suicide attempt two months earlier (June), spent time as an inpatient in hospital. Mr Mason had ischaemic heart disease and, before coming into prison (in 2001), had had a heart attack and a coronary artery bypass operation.

24. Mr Mason was a non-smoker and prescribed ramipril (for high blood pressure), atorovastatin (to reduce his cholesterol), aspirin (to thin his blood and prevent blood clots), omeprazole (an antacid for gastro-oesophageal reflux disease) and olanzapine for depression. Mr Mason was managed under ACCT procedures after threatening to self harm. (ACCT – Assessment, Care in Custody and Teamwork, a prison multidisciplinary system to ensure prisoners at risk of suicide or self harm receive appropriate care and support.)

25. On 17 December, Mr Mason was sentenced to five years in custody. While in Bullingdon a mental health nurse and psychiatrist reviewed Mr Mason on a regular basis. He did not have any cardiovascular or 'older person' review.

2014

26. Mr Mason transferred to HMP Oakwood on 24 February 2014. During an initial reception health screening, a nurse noted his previous heart attack and medication. Mr Mason remained on an open ACCT as he still had thoughts of committing suicide. Mr Mason's blood pressure was high at 162/85. On 11 March, a psychiatrist additionally prescribed Mr Mason mirtazapine to help treat his depression which had not improved.

27. A nurse completed an 'over 55s check' with Mr Mason on 7 April. He was independently mobile and self caring. His blood pressure remained high at 150/81 and she asked that this be reviewed, and noted that he had cholesterol related arthritis. Four days later on 11 April, a hypertension care plan was created for Mr Mason. This included diet and lifestyle advice with monthly blood pressure checks.

28. Mr Mason's ACCT was reviewed on 5 June. He had ongoing thoughts of self harm but confirmed that he had no plans to commit suicide at this time. The ACCT was closed with staff to monitor weekly.

29. Mr Mason had a cardiovascular review with a prison GP on 21 June, which raised no concerns. Mr Mason complained mirtazepine made him sick, so a doctor changed the prescription to zopiclone on 23 September.

2015

30. On 14 May 2015, an officer found Mr Mason in his cell unresponsive. A code blue was called and he was taken to hospital. A hospital doctor admitted Mr Mason to the critical care unit and treated him for an overdose of 200 zopiclone tablets. On 20 May, Mr Mason told a visiting prison nurse that he had nothing to live for outside prison and had taken an intentional overdose. The hospital declined to complete a psychiatric assessment believing that this should be done

on return to prison. The hospital discharged him back to Oakwood on 22 May and staff opened an ACCT. All Mr Mason's medication was now 'not in possession'. Mr Mason had a cardiovascular review three weeks later, on 11 June. No concerns were raised at this time. He remained well apart from treatment for in-growing toenails, haemorrhoids and various dental treatments.

31. Staff closed Mr Mason's ACCT on 10 August. Support from prison mental health services continued.

2016

32. Mr Mason had a QOF review (quality outcomes framework review) on 30 September 2016. A QOF review looks at long term health conditions. It is unclear from Mr Mason's records if a cardiovascular check was completed as part of this review, and no concerns were highlighted.

2017

33. On 19 January 2017, a nurse created a care plan for Mr Mason. It stated that "Ensure his needs are met in accordance with NICE guidelines" and listed seasonal vaccinations, receiving prescribed medication and having annual reviews by the GP. A nurse identified no concerns regarding his physical health.

34. Mr Mason rang his cell bell at 4.48pm on 23 January. Officer A responded. Mr Mason told him (through the door hatch) that his cell door was stuck and he couldn't open it. The officer pulled at the door and after a little resistance was able to open it. He said he would report it as a potential fault to get it fixed. Mr Mason appeared well and was calm in mood, thanking him for his help. He left Mr Mason in his cell with the door open.

35. At approximately 5.10pm, Officer A saw Mr Mason walking around the wing after collecting his evening meal. He visited another prisoner for a few minutes before returning to his cell with his food tray.

36. At 5.25pm, Officer A spoke to his colleague, Officer B, about Mr Mason's cell door. Both officers went to Mr Mason's cell to have another look. When they arrived the cell door was almost shut. When Officer A opened the door he could see Mr Mason kneeling, bent over the bed in what appeared to be a praying position. He called out, but when he did not get a response he approached the bed. He was aware of Mr Mason's mental health issues (and previous suicide attempt) so lifted his head off the mattress to check for any injuries. On lifting his head, he found bloody vomit where Mr Mason's head had been resting.

37. Officer B called a code blue over his radio at 5.29pm. They moved Mr Mason to the floor and started cardiopulmonary resuscitation (CPR). Officer A left the cell to collect the defibrillator from the wing. On his return at 5.32pm, healthcare staff were also in attendance. Chest compressions continued. Paramedic staff arrived at 5.44pm and gave adrenaline, with a second ambulance arriving at 5.51pm. Mr Mason did not respond to resuscitation attempts and a paramedic doctor confirmed death at 6.33pm.

Contact with Mr Mason's family

38. Mr Mason's next of kin was his son-in-law. A family liaison officer had previously spoken with Mr Mason's son-in-law. It had been agreed that if anything happened to Mr Mason while he was in prison she could telephone him and a visit was not required. She telephoned Mr Mason's son-in-law at 7.13pm that evening to inform him of Mr Mason's death. She kept in regular contact with Mr Mason's family to offer support. The prison offered a contribution towards the cost of the funeral in line with national policy. Mr Mason was cremated on 28 February 2017.

Support for prisoners and staff

39. After Mr Mason's death, the Head of Safer Custody and the Deputy Director debriefed the 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.

40. The prison posted notices informing prisoners of Mr Mason'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 Mason's death. A member of the chaplaincy team also visited the wing to speak to any prisoners who wanted support.

Post-mortem report

41. The post mortem report indicated that Mr Mason died from ischaemic heart disease.

Findings

Clinical care

42. Mr Mason had a history of ischaemic heart disease and healthcare staff saw him regularly for reviews of his overall health. Recent reviews by healthcare staff in September 2016 and on 19 January 2017 raised no concerns. We are of the opinion that the clinical care Mr Mason received while at Oakwood was equivalent to the level of care expected in the community.

43. The National Institute for Healthcare Excellence (NICE) guidance for ischaemic heart disease sets out clear guidance for treatment of patients with this condition. Mr Mason was prescribed medication for his heart condition in line with NICE guidelines.

44. The clinical reviewer commented in his review that there is an expectation that Mr Mason would have annual reviews for long term health conditions. Mr Mason had a cardiovascular review in June 2015 and 2016. His medical records show that, on 30 September 2016, Mr Mason attended the prison's QOF clinic to review his long term conditions. While the clinical reviewer was happy that his heart disease would have been covered as part of this review, the records do not explicitly show what long term conditions were reviewed at this time. No concerns were raised for Mr Mason's physical health during this review.

45. Mr Mason's medical record shows that, on 19 January 2017, a care plan related to ensuring that his needs are met within NICE guidelines was completed. However, the clinical reviewer has highlighted in his review that the care plan was not clearly labelled regarding which guideline (which health conditions) it relates to. He comments that, "I have no doubt that this [his ischaemic heart disease] was being reviewed, but the recording of this is confusing in the SystmOne record". We make the following recommendation:

    The Head of Healthcare should review the process for the management of long term conditions and ensure that disease specific reviews are taking place in line with NICE guidance, and are clearly recorded.

46. Records show that Mr Mason was often reluctant to engage with the prison mental health services. Despite this, he received a good level of mental health care under both the ACCT process and by the mental health nurse and psychiatrist.

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