Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terrence Moule a prisoner at HMP Oakwood on 12 July 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 Terrence Moule died on 12 July 2016 of a heart attack at HMP Oakwood. He was 53 years old. I offer my condolences to Mr Moule's family and friends.

I am concerned that the GPs who saw Mr Moule did not always seem to know his medication regime, chase blood tests or consider ECG results when they were clearly available. That said, I agree with the clinical reviewer that these shortcomings did not affect the outcome and that Mr Moule's death was not predictable.

I am also concerned that, when Mr Moule collapsed, staff in the control room did not call an ambulance as soon as an officer called the code blue emergency, but instead waited for a member of healthcare staff to tell them one was needed. I have made a recommendation about unacceptable delays in calling an ambulance before, which the prison accepted and should by now have been implemented.

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 **February 2017**

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Summary

Events

1. Mr Terrence Moule was sentenced in October 2014 to four and a half years imprisonment for sexual offences and sent to HMP Elmley. He was moved to HMP Oakwood in December 2014. When he arrived at Oakwood, a healthcare assistant noted he was prescribed bisoprolol for high blood pressure (doctors at Elmley had also previously noted he had an irregular heart rhythm). She opened a hypertension care plan, which included regular monitoring of his blood pressure.

2. In January 2015, Mr Moule stopped taking his bisoprolol and as his blood pressure was by then in the normal range, healthcare staff did not re-prescribe it until September 2015 when it increased again.

3. In May 2016, a prison GP saw Mr Moule and noted that his blood pressure had dropped again. To prevent it from dropping further, the GP stopped the bisoprolol but ordered blood tests and an electrocardiogram test (ECG – a test that measure heart rhythms). The ECG was done within four weeks and even though a GP reviewed them and noted that they were 'non-acute', other GPs who subsequently saw Mr Moule did not seem to be able to locate the results on the medical records system. Neither did they note that the blood tests were still outstanding, so these were never done. There was also some confusion between the GPs as to whether Mr Moule was prescribed blood pressure medication or not.

4. On 12 July 2016, a prisoner found Mr Moule collapsed in his cell at 11.26am. He alerted an officer, who quickly called a code blue emergency (which indicates that a prisoner is unconscious or not breathing), and healthcare staff attended. Control room staff did not call for an ambulance until healthcare staff arrived at Mr Moule's cell and checked whether one was on the way. Paramedics arrived at 11.50am and declared Mr Moule dead at 12.10pm.

Findings

5. The clinical reviewer noted that when healthcare staff found Mr Moule had high blood pressure, they opened a hypertension care plan and completed reviews in line with good practice. However, when GPs conducted reviews in 2016, they seemed unsure of what preceding doctors had prescribed, where ECG results were and whether anyone had done scheduled blood tests. Although this apparent lack of effective oversight is troubling, we agree with the clinical reviewer that Mr Moule's death could not have been predicted.

6. We are concerned that control room staff did not immediately call an ambulance when an officer called a code blue emergency.

Recommendations

- The Head of Healthcare should ensure that healthcare staff complete medication reviews accurately taking into account all the available information.

- The Head of Healthcare should ensure that there is a clear process for scheduling tests and reviewing results which all staff understand.
- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is received.

The Investigation Process

7. 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.

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

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

10. 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.

11. One of the Ombudsman's family liaison officers contacted Mr Moule's daughter, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She wanted to know:

    - Why doctors stopped Mr Moule's beta-blocker medication? Was it not regulating his blood pressure and what happens when you take someone off this medication?
    - What medication Mr Moule was on at the time of his death?
    - Were there any delays in Mr Moule getting to see GPs or other healthcare professionals?

12. Mr Moule's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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

Background Information

HMP Oakwood

14. 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 male prisoners.

15. Worcester Health and Care Trust provided the healthcare services until 31 March 2016. From 1 April 2016, Care UK became the provider of healthcare services. Healthcare services include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

16. 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

17. Each prison has an Independent Monitoring Board made up 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 March 2016, the IMB reported that, due to the uncertainty arising from the change of healthcare provider, there was a high number of vacancies and the use of agency staff had lowered continuity of care. The healthcare department worked with Macmillan nurses to provide end of life care, but there was no nurse cover during the night.

Previous deaths at HMP Oakwood

18. Mr Moule was the third person to die of natural causes at HMP Oakwood. There have been two subsequent deaths. We have made a recommendation about the emergency response procedure before.

Key Events

19. On 17 October 2014, Mr Terrence Moule was sentenced to four and a half years imprisonment for sexual offences and sent to HMP Elmley. He transferred to HMP Oakwood on 17 December 2014.

20. Mr Moule had issues with substance misuse and he went through an alcohol detoxification programme at Elmley. On his second day at Elmley, a prison GP saw Mr Moule, who presented with an irregular heat rhythm and blood pressure at 150/100 (the 'normal' range is between 120/80 and 140/90). The GP noted this was 'slightly high' so prescribed a beta-blocker, bisoprolol, to control his heart rhythm and reduce his blood pressure.

21. When Mr Moule arrived at Oakwood, a prison GP re-prescribed his bisoprolol. A healthcare assistant created a hypertension care plan which included direction on when to alert a GP that Mr Moule was to have six monthly reviews, regular blood tests and lifestyle advice including smoking cessation. (Mr Moule cut down on his smoking but did not stop or attend the smoking cessation advice appointments he was offered.)

22. On 22 February 2015, Mr Moule told the healthcare assistant that he had not been taking his bisoprolol since the end of January. However, his blood pressure was in the normal range at 138/83, so she arranged for him to be reviewed on a monthly basis for the next two months. On both these occasions his blood pressure was in the normal range.

23. On 22 September, Mr Moule had another medication review with the healthcare assistant. His blood pressure had increased to 156/93. A further review with another healthcare assistant on 29 October gave readings in his left arm of 165/123 and 151/89 in his right arm. Mr Moule told her that he did not know that he needed a repeat prescription for bisoprolol because he thought it was a course of treatment, which finished when he ran out of tablets. He saw a prison GP the same day, who re-prescribed the bisoprolol.

24. On 18 January 2016, Mr Moule saw a healthcare assistant, and his blood pressure reading was 147/97. She decided to put him on the list for fortnightly checks and healthcare staff routinely did these.

25. On 19 May, Mr Moule saw a prison GP, who reviewed Mr Moule's recent blood pressure readings and took new readings, which were 136/74 in his right arm and 144/70 in his left. The GP decided to stop the prescription for bisoprolol as his blood pressure had fallen and to keep him on the medication might have resulted in it falling too low. He also arranged for Mr Moule to have an electrocardiogram (ECG), blood tests, monthly blood pressure readings and a GP review in four weeks.

26. Staff took Mr Moule's blood pressure more regularly than the doctor had suggested (on 26 May, 2 June and 11 June) and the readings were 133/78, 144/70 and 156/103 respectively. With the third reading, Mr Moule told a healthcare assistant that he was feeling stressed because he only had six months left in prison. He also said that he had been smoking and drinking lots of coffee, which she said he should avoid.

27. Mr Moule had his ECG on 14 June. The following day, a GP reviewed the results, marked it as 'not acute' (meaning that there were no serious problems) and added it to Mr Moule's medical record.

28. On 16 June, a prison GP reviewed Mr Moule's medication (Mr Moule was not present, as this was done remotely) but incorrectly noted that he was on bisoprolol. A healthcare assistant measured Mr Moule's blood pressure at 163/92.

29. On 30 June, a prison GP saw Mr Moule, who said he was feeling anxious and stressed and that he had not taken his medication for two weeks. Mr Moule's blood pressure was 146/96. Although the ECG results were in Mr Moule's medical record, the GP recorded that he was still waiting to have it done and for blood tests to be run. He also arranged for bisoprolol to re-start from 5 July.

30. On 7 July, a prison GP saw Mr Moule, who said that he had not had his blood tests. He asked for the blood tests to be completed and for Mr Moule's blood pressure to be checked in one to two weeks, as he had restarted his bisoprolol prescription.

Events of 12 July 2016

31. On 12 July, Mr Moule spent the morning at work, tea-packing on the wing, and returned to his cell at about 10.18am after a brief chat with other prisoners. He also spoke to an officer.

32. At approximately 11.26am, a prisoner looked through the hatch of Mr Moule's cell and saw that he had collapsed on the floor and his face and arms were blue. He entered the cell, briefly, and came out again to shout for help. An officer was in the wing office and attended straight away. He checked on Mr Moule and found that his body was cold to the touch but his head was warm. He had also vomited and urinated. He could not feel a pulse so he called a code blue emergency at 11.28am. He turned Mr Moule on his back and started cardiopulmonary resuscitation (CPR). A prison manager helped with the CPR until healthcare staff arrived at 11.30am.

33. Three nurses attended the scene with an emergency bag and one nurse radioed to check an ambulance was on route. Control room staff said that they had not requested one but did so after the nurse's call (at 11.30am according to the control room log). The nurses attached a defibrillator to Mr Moule but it advised them not to administer a shock to Mr Moule. The nurses assisted his breathing with an ambu bag (a hand held device which helps ventilate patients who are not breathing properly). A prison GP also arrived at the scene to give assistance.

34. Paramedics arrived at the prison at approximately 11.50am. However, their efforts to resuscitate Mr Moule failed and they pronounced him dead at 12.10pm.

Contact with Mr Moule's family

35. Shortly after Mr Moule's death, the prison appointed a prison manager as the family liaison officer. She noted that Mr Moule's daughter was listed as his next of kin but that she lived in Kent. She asked the local police to deliver the news of her father's death.

36. At 8.35pm, after the police broke the news, the prison manager telephoned Mr Moule's daughter to offer her condolences and support. She and another prison manager stayed in touch over the next few days to offer support and explain various processes.

37. Mr Moule's funeral was held on 29 July and the prison contributed to the costs, in line with national policy.

Support for prisoners and staff

38. After Mr Moule's death, a prison manager 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.

39. The prison posted notices informing other prisoners of Mr Moule'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 Moule's death.

Post-mortem report

40. The coroner provided a copy of the post-mortem report, which confirmed that Mr Moule died of ischaemic heart disease.

Findings

Clinical care

41. The clinical reviewer noted that when healthcare staff found Mr Moule had high blood pressure, they opened a hypertension care plan and completed reviews in line with good practice.

42. We share the clinical reviewer's concerns that a prison GP reviewed his medication but incorrectly noted that he was on bisoprolol and that his ECG results, which were scanned onto Mr Moule's medical record on 15 June, were overlooked by him in the medication review on 16 June, and by another GP who saw Mr Moule on 28 June.

43. We are also concerned that another GP ordered blood tests for Mr Moule, which were reordered by a different GP, yet there was no record that these had taken place.

44. While the clinical reviewer considered that these shortcomings would not have affected the treatment programme for Mr Moule, whose death was not predictable, we are concerned that these simple mistakes occurred. We make the following recommendations:

    The Head of Healthcare should ensure that healthcare staff complete medication reviews accurately taking into account all the available information.

    The Head of Healthcare should ensure that there is a clear process for scheduling tests and reviewing results which all staff understand.

45. The clinical reviewer also noted that there were also differing practices among healthcare staff when it came to taking blood pressure readings. Some staff took readings from one arm and others from both. She felt that taking the readings from both arms was preferable because a significant difference between the two can indicate an increased risk of heart disease. As the approach varies in the general community, we do not make a recommendation but draw the Head of Healthcare's attention to this best practice.

Emergency response

46. After a prisoner found Mr Moule collapsed in his cell, an officer immediately called a code blue. However, staff in the control room did not call an ambulance until a nurse arrived at the scene and asked them to do so.

47. The prison's emergency protocol clearly says that if a code blue is called, control room staff should immediately call an ambulance, which can be stood down if not required. We are concerned that control room staff did not follow the protocol. It is of particular concern that we have previously recommended that the prison improve its emergency response procedures and this issue should by now have been addressed. While in this case the delay did not change the outcome for Mr Moule, it could be crucial in the future. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is received.

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