

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keren Horinek a prisoner at HMP Norwich on 7 June 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*



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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Keren Horinek died in hospital on 7 June 2017 from aspiration pneumonia while a prisoner at HMP Norwich. He was 71 years old. We offer our condolences to Mr Horinek's family and friends.

Our investigation found that Mr Horinek received good and compassionate care from the healthcare team at Norwich. The standard of healthcare Mr Horinek received was equivalent to that which he could have expected to receive in the community.

However, we found deficiencies in the emergency response procedures at Norwich. When Mr Horinek became unwell on 5 June 2017, there was a delay in the ambulance being despatched because the prison officer making the call could not answer basic questions asked by the ambulance service call handler. As a result of our investigation, the prison has made changes to its procedures to avoid this happening again.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman

November 2017

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Summary

Events

1. On 21 May 2014, Mr Horinek was remanded into custody at HMP Chelmsford for sexual offences against children. He had a history of cardiovascular disease, high blood pressure and chronic obstructive pulmonary disease (COPD – a collection of lung conditions that cause breathing difficulties). On 7 August, Mr Horinek was sentenced to six years imprisonment and was transferred to HMP Bure.
2. On 13 May 2016, he was diagnosed with vascular dementia (damage caused by a reduced blood supply to the brain). Following deterioration in his condition, he was transferred to the elderly care unit at HMP Norwich on 31 March 2017.
3. On 5 June, Mr Horinek was found collapsed on the floor of his cell. Healthcare staff asked for an ambulance to be called. The communications officer telephoned 999 at 6.29pm but could not answer the call handler's questions, so transferred the call to healthcare. A prison nurse told the call handler that while Mr Horinek's condition was not immediately life threatening, he still required hospital admission via ambulance.
4. Mr Horinek's health deteriorated and at 7.08pm healthcare staff requested an update on the ambulance. The prison's communications officer telephoned 999, but again, could not answer the call handler's questions. The officer tried to transfer the call to the healthcare department but the line was initially engaged and when he did transfer the call, the healthcare assistant was unable to confirm the correct address for the prison or provide basic information about Mr Horinek.
5. The call handler asked to speak to a nurse, who (five minutes after the call was first made) confirmed that Mr Horinek's condition had deteriorated and an ambulance was required urgently. The ambulance arrived at 7.30pm and Mr Horinek was escorted to hospital by two officers. He was not handcuffed during the escort or during his time in hospital.
6. The following day, Mr Horinek was diagnosed with heart failure. His condition deteriorated and he died at 11.10pm on 7 June. Hospital doctors recorded that he died from aspiration pneumonia, with heart failure, kidney failure and dementia as underlying causes.

Findings

7. The standard of healthcare provided to Mr Horinek was equivalent to that which he could have expected to receive in the community. He was appropriately referred for assessment when he showed signs of confusion, which led to his diagnosis of vascular dementia. When his condition deteriorated he was transferred to a suitable location, the elderly care unit at Norwich, where he received good, compassionate care.

8. There was a delay in despatching an ambulance when Mr Horinek became acutely unwell on 5 June 2017 because the prison officer who made the 999 call could not provide the call handler with basic information about Mr Horinek's condition. The prison has since made changes to its procedures to avoid this happening again. We therefore make no recommendation.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact her. No one responded
10. The investigator obtained copies of relevant extracts from Mr Horinek's prison and medical records.
11. The investigator interviewed two members of staff at Norwich on 8 August.
12. NHS England commissioned a clinical reviewer to review Mr Horinek's clinical care at the prison.
13. We informed HM Coroner for Greater Norfolk District of the investigation. We have sent the coroner a copy of this report.
14. The investigator wrote to Mr Horinek's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Norwich

16. HMP Norwich is a multi-function prison, which predominately serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides a 24 hour healthcare service.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Norwich was in September 2016. Inspectors reported that an appropriate range of nurse-led clinics included provision for long-term conditions such as asthma, diabetes and chronic obstructive pulmonary disease. E wing, which housed some older prisoners, was calm and supportive and men living there appreciated the environment.

Independent Monitoring Board

18. 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 28 February 2017, the IMB reported that, the major impact upon the prison stemmed from staff shortages; safety was compromised, prisoners were offered a restricted regime and personal officer duties were extremely constrained. However, overall, prisoners received fair treatment in the establishment.
19. The IMB found that the care of the mentally ill prisoners is comparable if not better than the care received in the community.

Previous deaths at HMP Norwich

20. Mr Horinek was the ninth person to die from natural causes, the third from pneumonia since 2016.

Key Events

21. On 21 May 2014, Mr Horinek was remanded into custody at HMP Chelmsford for sexual offences against children. He had a history of cardiovascular disease, high blood pressure and chronic obstructive pulmonary disease (COPD - a collection of lung conditions that cause breathing difficulties).
22. On 7 August, Mr Horinek was sentenced to six years and was transferred to HMP Bure. Mr Horinek was a smoker and during an initial health screening told staff that he did not want to give up smoking. Mr Horinek took warfarin (a medication to thin his blood) and the dosage was monitored regularly. He had monthly health checks where his blood pressure and weight were checked and his risk of falls was reviewed.

2015

23. On 14 July 2015, a nurse practitioner completed a dementia test with Mr Horinek. He was unable to state his age, for how long he had been in prison and when asked a number of other questions would just smile if he was unable to answer. During this test he was vague with slow responses, indicating severe cognitive impairment. She requested a blood test and electrocardiogram (ECG – a test to check the heart’s electrical activity and rhythm).
24. An ECG on 17 July showed atrial fibrillation, a heart condition that causes an irregular and often an abnormally fast heart rate. When the nurse reviewed Mr Horinek on 31 July, she found him unshaved and dishevelled. She was concerned about his ability to care for himself and referred him to the prison’s mental health team.
25. On 4 August, Mr Horinek was assessed by a mental health nurse. He had poor memory and was heavily reliant on other prisoners and wing staff to follow the prison regime.

2016

26. On 16 March 2016, officers on the wing reported to healthcare staff that Mr Horinek was not washing, not changing his clothes regularly and wetting the bed most nights. His memory was deteriorating and he looked dishevelled. A nurse referred Mr Horinek to Social Services for an assessment of personal needs.
27. A consultant psychiatrist assessed Mr Horinek on 22 March. Mr Horinek had difficulty in expressing himself and the psychiatrist suspected vascular dementia, recommending a magnetic resonance imaging (MRI) scan to look for evidence of stroke or cerebrovascular disease. An MRI scan on 13 May confirmed a diagnosis of vascular dementia (damage caused by a reduced blood supply to the brain), this being the cause of Mr Horinek’s cognitive impairment.
28. Mr Horinek attended the prison’s stop smoking clinic on 10 November. He attended weekly.
29. On 28 November, Social Services visited Mr Horinek in prison due to his deteriorating short-term memory and his need for prompting to undertake all

activities of daily living. Prison staff were happy to continue to support Mr Horinek and it was agreed that no further input was required at this time.

2017

30. The psychiatrist reviewed Mr Horinek again on 18 January 2017. He explained that the management of his condition should focus on reducing the risk of further brain damage due to lack of blood supply. He confirmed that Mr Horinek's prescribed medication was appropriate.
31. On 21 March, a nurse noticed that Mr Horinek was finding it increasingly hard to communicate his needs. When asked how he was feeling he would just smile and put his thumbs up.
32. Mr Horinek was referred to the SALT team (speech and language therapy) on 25 March for speech therapy and a swallowing assessment after he was seen coughing while taking his medication.
33. On 26 March, Mr Horinek refused to take his medication. He was unable to communicate the reasons for refusal. A mental health nurse reviewed Mr Horinek two days later, on 28 March. Mr Horinek had no awareness of time, place or person and was assessed as not having the capacity to make decisions for his own welfare due to deterioration in his mental state. His speech had deteriorated dramatically since his last review on 2 March. Mr Horinek's cell was now cleaned and washing and laundry done by other prisoners on the wing. He also had to be prompted to collect his meals. A nurse reported that, "In my view this man is vulnerable and high risk at present and will need safeguarding to protect his welfare as his ability for decision making appears to be greatly diminished".
34. Due to his deteriorating health and inability to communicate caused by the progression of his vascular dementia, it was decided Mr Horinek needed a prison with 24 hour healthcare. Mr Horinek was transferred to the elderly care unit at HMP Norwich on 31 March.
35. On arrival at Norwich, healthcare staff created an older person's care plan providing support with hygiene, mobility, eating and pressure area care. Despite encouragement by prison and healthcare staff, Mr Horinek continued to refuse some of his medication and his compliance with taking his tablets varied day by day.
36. On 8 May, Mr Horinek had a SALT assessment. A prison GP reported that Mr Horinek appeared to comprehend most of what was being said but had no verbal expression. He would use gestures, thumbs up/down to respond to his questions. Mr Horinek had no signs of aspiration when drinking fluids and the GP advised that he could continue with a normal diet. (Aspiration is breathing in a foreign object into the airway such as food or fluids. Inhaling a substance into the lungs can cause inflammation and infection.) He advised that (due to the risk of aspiration) staff should monitor Mr Horinek for coughing, chest infections, choking and breathing difficulties.

5 June 2017

37. At 6.20pm on 5 June, during a routine check, a healthcare assistant found Mr Horinek on the floor of his cell. A nurse examined Mr Horinek and found him clammy and cold to the touch. He was helped onto his bed so observations could be taken. Mr Horinek's oxygen levels ranged from 90-94% (a normal range is 95-100%). A blood pressure reading could not be taken as Mr Horinek was agitated. The nurse telephoned the officer in the Communications Room and asked him to call an ambulance.
38. At 6.29pm, the officer immediately telephoned 999 requesting an ambulance. The ambulance service call handler asked if Mr Horinek was breathing. He confirmed "I believe so", and asked the call handler if he could transfer the call to someone on the scene of the incident as he had no further details. The call handler agreed but asked if, in future, the person making the 999 call could confirm at the start of the call if the patient was awake and breathing.
39. The officer transferred the call to the healthcare department and a prison officer answered. The call was then handed over to the nurse. The nurse provided the prison address and details of Mr Horinek's condition, and confirmed that while Mr Horinek's condition was not immediately life threatening, an ambulance was required.
40. Before the call ended, the call handler explained to the nurse that it was imperative they were told straightaway whether a patient was awake and breathing when a 999 call was made. She explained that without these answers the ambulance service computer system would not allow them to progress the call any further and this led to delays in despatching an ambulance.
41. At 7.08pm, healthcare staff asked the officer to find out where the ambulance was as Mr Horinek's oxygen levels had started to drop. When he telephoned 999 he was told by the ambulance service call handler that before the computer would allow him to access the information relating to the previous call he would need to take some information from him. He confirmed that Mr Horinek was awake, but again asked to transfer the call believing that a member of healthcare staff was waiting to provide this information.
42. The officer tried to transfer the call to the healthcare department but the line was engaged. He used his radio on two occasions asking healthcare staff to clear the phone line. He transferred the call 58 seconds later and a healthcare assistant answered. The healthcare assistant was unable to confirm the correct address for the prison and had to log on to her computer before she was able to confirm Mr Horinek's age and date of birth.
43. Four minutes and forty three seconds into the call, the call handler realised he was speaking to a healthcare assistant and asked if a nurse was available. The nurse (who was sitting with Mr Horinek) returned to the office to take the call. The nurse told the call handler that Mr Horinek's condition had deteriorated and an ambulance was required urgently. The ambulance arrived at 7.30pm. Mr Horinek was escorted to hospital by two officers. He was not handcuffed during the escort.

44. Mr Horinek was admitted to hospital for investigation and moved to the critical care ward the next day after a diagnosis of heart failure. Mr Horinek refused all oral medication, accepting only medication that could be given intravenously. After discussion with a hospital doctor Mr Horinek agreed to a DNACPR order. (A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.)
45. On 7 June Mr Horinek's breathing became laboured. Oxygen was given at 7.30pm with no improvement. Mr Horinek died at 11.10pm that night. Mr Horinek was not restrained during his time in hospital.

Contact with Mr Horinek's family

46. A prison manager telephoned Mr Horinek's sister when he was taken to hospital on 5 June. His sister explained that she had not been in contact with her brother for a number of years. She told him that if her brother died she was happy to be told over the phone and a visit was not required.
47. On 7 June, a prison manager telephoned Mr Horinek's sister to tell her that her brother had died. A family liaison officer contacted Mr Horinek's sister the following day to offer support and answer any questions she had.
48. Mr Horinek's funeral was on 23 June 2017. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

49. After Mr Horinek's death, a prison manager debriefed the staff involved in the hospital bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support.
50. The prison posted notices informing other prisoners of Mr Horinek'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 Horinek's death.

Post-mortem report

51. A post-mortem was not required by the coroner as the cause of death certified by the hospital, was accepted as 1a) aspiration pneumonia, b) heart failure, kidney failure and dementia.

Findings

Clinical Care

52. Mr Horinek was appropriately referred for assessment when he became increasingly confused, which led to his diagnosis of vascular dementia. When his health deteriorated and his communication skills worsened, he was moved from Bure to the elderly care unit in Norwich, which had been identified as a suitable place to meet his care needs.
53. Mr Horinek received good and compassionate care from the healthcare team at the elderly care unit in Norwich. All his care needs were assessed and regularly monitored providing him with quality care while in custody.
54. All medications were prescribed appropriately to treat Mr Horinek's pre-existing conditions and to try to prevent any further damage to his brain.
55. Mr Horinek died from aspiration pneumonia, a chest infection that can develop after accidentally inhaling something into the lungs, such as a small piece of food. Mr Horinek's swallowing ability was assessed by the SALT team two months before he died and they confirmed that he did not have any swallowing difficulties at that time. They told staff to look out for episodes of coughing, chest infections, choking or breathing difficulties. There is no evidence in Mr Horinek's medical records of any concerns raised to warrant a re-referral to SALT.
56. We are satisfied that the standard of healthcare Mr Horinek received was equivalent to that which he could have expected in the community.

Ambulance Request

57. We found there were deficiencies in the process for requesting an ambulance for Mr Horinek on 5 June, when he was found collapsed on the floor of his cell. Although a 999 call was made immediately, there were delays in despatching an ambulance to the prison because the officer who made the call could not provide responses to the call handler's standard questions about the status of the patient. There was a total delay of 51 seconds before the nurse was able to take the call and provide the necessary information required for an ambulance to be despatched.
58. The investigator contacted East of England Ambulance Service and has been provided with ambulance records and a recording of the 999 call. Mr Horinek's condition was graded by the ambulance service as a 'Green 1', not immediately life threatening. An ambulance was dispatched at 6.34pm, 7.01pm and 7.12pm but on each occasion had to be diverted to higher priority emergency calls. The prison was unaware of this at the time. An investigation by East of England Ambulance Trust confirms that based on the information provided by the nurse, the emergency call was graded correctly.
59. When the officer made a second call to the ambulance service at 7.08pm, he again had limited information and had to transfer the call. This is despite the call handler on the previous call emphasising the importance of having the basic

information the ambulance service required to hand when making the 999 call. It took 58 seconds to transfer the call as the phone line in healthcare was engaged. The healthcare assistant who answered the phone was unable to provide basic information quickly and when the call handler asked to speak to a qualified nurse she could be heard shouting (on the recording of the call provided) “the ambulance wants to speak to a proper nurse”. This was followed by background conversation and loud laughter. This is inappropriate considering the situation.

60. The nurse took the call 5 minutes and 26 seconds after the initial call was made. Mr Horinek’s condition was now graded as ‘Red 2’, immediately life threatening. The ambulance arrived at 7.30pm.
61. While we appreciate that in a prison setting, the person making the 999 call will not be with the patient, the prison should have procedures in place to ensure that the ambulance service is given the information it requires at the time the call is made. The lengthy delays caused in this particular case were unacceptable.
62. The investigator spoke to the officer, who said that before the first 999 call he was unaware that the call handler would ask him for information. When he was asked to phone and get an update on the ambulance, healthcare staff did not provide any information on Mr Horinek. He was again unaware that during the second follow-up call he would be asked for information.
63. The officer told the investigator that since Mr Horinek’s death he now requests the information, ‘Are they awake/ breathing?’ on his radio while making the 999 call. The investigator visited the communications room while at Norwich. The communications officer on duty confirmed that it was now (since Mr Horinek’s death) standard practice to obtain the information as described by the officer.
64. On 1 July 2017, an Emergency Ambulance Access Protocol was agreed by the Acting Director East Prisons Group and East of England Ambulance Service NHS Trust. This protocol is now in use at Norwich Prison and instructs staff, “upon arrival at the incident, the attending prison staff, will contact the Communications Room via UHF radio, or equivalent and provide the relevant information detailed in Appendix 1”. Appendix 1 of this protocol lists what information should be provided to the person making the 999 call, such as, is the patient awake/ breathing, whether they have chest pain and/ or bleeding.
65. On 14 August, the Deputy Governor issued a notice to staff reminding them of the importance of providing information to the Communications Officer during an emergency response.
66. The delays caused while requesting the ambulance did not have a detrimental effect on this occasion, but could do so in the future. We are satisfied that the issues highlighted above have been addressed and so we do not make a recommendation.

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