Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roger Hearsey a prisoner at HMP Elmley on 6 August 2015

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 Roger Hearsey died of heart disease in hospital on 6 August 2015. He was 67 years old. I offer my condolences to Mr Hearsey's family and friends.

Mr Hearsey had served just two months of a twelve year sentence before he died. His health was very poor and he had a number of chronic conditions including heart failure and chronic obstructive lung disease. While the investigation found that healthcare staff generally looked after Mr Hearsay well, there was little continuity of GP care and poor management of his complex medication.

I am also very concerned that, despite his poor mobility, heart failure and chronic lung condition, Mr Hearsey was given a cell on a third floor landing, which made daily living difficult.

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 **March 2016**

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Summary

Events

1. On 10 June 2015, Mr Roger Hearsey was sentenced to 12 years in prison and sent to HMP Elmley. He suffered from severe heart failure, which would have significantly limited his life expectancy. He had chronic obstructive lung disease, type 2 diabetes, diabetic neuropathy (nerve damage usually in the legs and feet) and ischaemic heart disease. He took a range of medication, including diuretics for heart failure. Initially, he was admitted to the prison's inpatient unit for assessment and healthcare staff began care plans to manage his conditions.

2. On 12 June, a prison GP reviewed Mr Hearsey and decided he did not need to remain in the inpatient unit. He stopped one of his diuretic medications because his blood pressure was low. He noted that Mr Hearsey's mobility was poor; he used a walking stick, and was unable to do any physical exercise. On 14 June, prison staff allocated him a single cell on the third landing of a houseblock.

3. Mr Hearsey was taken to hospital twice on 14 and 15 June with chest pains, breathing difficulties and low oxygen levels. A chest X-ray and ECG were normal. He was admitted to the inpatient unit for observation and discharged back to his cell on 16 June.

4. On 23 July, a blood test showed Mr Hearsey had low serum sodium levels and a prison GP stopped another of his prescribed diuretic medications. By 27 July, Mr Hearsey's serum sodium level was nearly normal again, but doctors do not appear to have considered restarting the diuretic medication.

5. On 3 August, Mr Hearsey reported being increasingly short of breath. A prison GP prescribed Mr Hearsey additional medication for his chronic lung condition but did not consider his heart failure or reinstating his diuretic medication.

6. On 5 August, Mr Hearsey collapsed after climbing the stairs to get to his cell. Healthcare staff gave emergency treatment and paramedics took Mr Hearsey to hospital by air ambulance. Mr Hearsey died in hospital on 6 August.

Findings

7. Prison healthcare staff managed Mr Hearsey's chronic conditions using appropriate care plans. Although there was a problem with continuity of GP care, his general medical care was good. However, the clinical reviewer considered that when Mr Hearsey's reported increasing breathlessness on 3 August, doctors focused too much on an exacerbation of his chronic lung disease rather than his heart failure and whether there was a need to reintroduce diuretics. Although Mr Hearsey had a poor prognosis, he considered that the decision to stop the diuretic medication without specialist advice and without sufficient monitoring or follow up might have been a factor in the deterioration in his health that led to his death. We are satisfied that there was an appropriate and quick emergency response when Mr Hearsey collapsed on 5 August, but we are concerned that a prisoner with poor mobility, severe heart failure and chronic lung disease was located on an upper landing.

Recommendations

- The Head of Healthcare should ensure that clinicians obtain specialist advice before withdrawing diuretics from patients with severe heart failure and there is a daily review when diuretics are stopped.
- The Head of Healthcare should ensure that prisoners with terminal or serious life–limiting long-term conditions have a named GP to oversee their care.
- The Governor should ensure that prisoners with health conditions that affect their mobility have appropriate accommodation in the prison, which meets their needs.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

9. The investigator visited Elmley on 12 August and obtained copies of relevant extracts from Mr Hearsey's prison and medical records. She spoke to the prisoner who had responded to our notice.

10. NHS England commissioned a clinical reviewer to review Mr Hearsey's clinical care at the prison. The investigator and clinical reviewer interviewed two members of healthcare staff at Elmley on 23 October 2015. The investigator interviewed one member of prison staff.

11. We informed HM Coroner for Central and South East Kent 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 Hearsey's sister to explain the investigation. Mr Hearsey's sister did not have any specific concerns she wanted the investigation to consider.

13. Mr Hearsey's sister received a copy of the initial report. She did not identify any factual inaccuracies.

14. The initial report was shared with the Prison Service. They identified no factual inaccuracies.

Background Information

HMP Elmley

15. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent and holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services at Elmley. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

16. The most recent inspection of Elmley was in June 2014. The Inspectorate reported that the overall quality of health services was reasonably good, but there was a high rate of non-attendance at primary care clinics. Planned preparation for discharge from the inpatient unit back to the prison or to an external placement were appropriate.

Independent Monitoring Board

17. 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 October 2014, the IMB reported that that long term chronic disease management was well monitored and patients with complex cases were seen for regular reviews.

Previous deaths at HMP Elmley

18. Mr Hearsey was the seventh prisoner to die of natural causes at Elmley since January 2014. There were no significant similarities with the circumstances of the previous deaths.

Key Events

19. On 9 June 2015, Mr Roger Hearsey was remanded to HMP Elmley. The next day he was sentenced to 12 years in prison. His health was very poor and his life expectancy was limited. He suffered from left ventricular heart failure, chronic obstructive lung disease (COPD - the name for a collection of lung diseases including chronic bronchitis and emphysema), type 2 diabetes, diabetic neuropathy and ischaemic heart disease. He had a pacemaker fitted to regulate his heart rhythm.

20. When Mr Hearsey arrived at Elmley, he was admitted to the prison's inpatient unit to monitor and assess his medical conditions. Nurses began care plans to manage Mr Hearsey's heart failure, diabetes and COPD. Prison GPs re-prescribed medication for heart failure, which included three diuretics (bendrofluazide, spironolactone and bumetanide to reduce fluid retention), medication for depression and anxiety (citalopram, lorazepam), insulin for diabetes and medication for COPD.

21. On 12 June, a prison GP reviewed Mr Hearsey and noted he was unable to do any physical exercise, had poor mobility and used a walking stick. The GP stopped his daily dose of bendrofluazide because Mr Hearsey's blood pressure was low. He assessed Mr Hearsey as suitable for discharge from the inpatient unit.

22. On 14 June, Mr Hearsey moved to a single cell on the third landing of a standard prison houseblock. At 5.13pm that day, a nurse reviewed Mr Hearsey when he complained of a sharp and constant pain in his chest. The nurse gave him aspirin, completed an electrocardiogram (ECG - used to record the electrical activity of the heart) and arranged for Mr Hearsey to go to hospital for assessment. At 10.18pm, Mr Hearsey returned to the prison's inpatient unit for observation.

23. At 9.58am on 15 June, a prison GP examined Mr Hearsey, who still had chest pain, was breathless and had low oxygen saturation (82%). The doctor sent Mr Hearsey back to hospital. At 7.50pm, Mr Hearsey returned to the prison's inpatient unit. The hospital discharge summary said the results of a chest X-ray and electrocardiogram test were normal. Hospital doctors prescribed pain relief. On 16 June, a prison GP reviewed Mr Hearsey and decided he could return to his usual cell.

24. Mr Hearsey continued to report chest pain and breathlessness and on 21 June, a prison GP referred him urgently to the chest clinic and diabetes specialist at hospital. Appointments were not received by the time of Mr Hearsey's death. Healthcare staff monitored him daily, as part of his cardiovascular and diabetes care plan.

25. On 2 July, a locum GP noted that Mr Hearsey's diabetes was poorly controlled and his kidney function was poor. The GP diagnosed chronic kidney disease and referred him to a kidney specialist.

26. On 23 July, a blood test result showed Mr Hearsey was suffering from a low serum sodium level (salt in the blood, which is important for maintaining blood

pressure). Because of this, on 26 July, a prison GP stopped Mr Hearsey's dose of bumetanide. On 27 July, a blood test result showed Mr Hearsey's serum sodium level had increased to just below the normal range. However, there is no record that a doctor reviewed his diuretic medication.

27. On 3 August, a nurse noted that Mr Hearsey was short of breath after very short distances and said he had difficulty breathing during the night. The next day, a prison GP examined Mr Hearsey who said he was breathless when going to collect his meals. The GP prescribed additional medication for COPD.

28. At 11.38am on 5 August, prisoners alerted staff that Mr Hearsey had collapsed after climbing up the stairs to his cell. Two officers attended immediately and found Mr Hearsey unresponsive. One officer radioed a code blue (which indicate a prisoner is unresponsive or has difficulty breathing). The control room called an ambulance immediately.

29. Within two minutes, a nurse arrived with emergency equipment and began cardiopulmonary resuscitation. Shortly after, other nurses and a prison GP arrived. The GP gave Mr Hearsey adrenaline and the nurses gave him oxygen and maintained his airway.

30. At 11.54am, paramedics arrived and took over Mr Hearsey's care. At 12.10pm, the paramedics requested an air ambulance, which arrived at 12.40pm and took Mr Hearsey to hospital. He was admitted to the hospital's intensive care unit

31. A manager at Elmley acted as the prison's family liaison officer. At 5.30pm on 5 August, the manager went to see Mr Hearsey's sister to let her know that he had been admitted to hospital. He arranged for her to go to the hospital. Mr Hearsey's condition declined and he died in hospital at 2.15pm on 6 August. His sister was with him at the time.

32. The manager remained in contact with Mr Hearsey's sister until after his funeral, which was held on 26 August. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

33. After Mr Hearsey's death, the manager debriefed the staff who had been involved in the emergency response and offered his support and that of the staff care team.

34. The prison posted notices informing staff and prisoners of Mr Hearsey's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Hearsey's death.

Post-mortem report

35. The coroner gave the cause of death as ischaemic heart disease and diabetes mellitus.

Findings

Clinical care

36. The clinical reviewer noted that Mr Hearsey was aware his condition was life-limiting. He had been in prison only two months before he died. Healthcare staff generally looked after him well and referred him to appropriate specialists for his diabetes, kidney function and heart problems. When he collapsed on 5 August, there was an effective emergency response. However, the clinical reviewer had concerns about the management of his diuretic medication and continuity of GP care, which we discuss below.

Management of diuretic medication

37. Mr Hearsey's heart failure was controlled with multiple medications including three diuretics (bendrofluazide, spironolactone and a high dose of bumetanide) to reduce the amount of salt and water in the body. On 12 June, a prison GP stopped Mr Hearsey's bendrofluazide because he had low blood pressure. There was no record of whether the low blood pressure was causing any symptoms.

38. In the last week of his life, Mr Hearsey developed low serum sodium (hyponatraemia), where the level of salt is abnormally low. The clinical reviewer noted that this is common in heart failure and is an indicator of a poor prognosis. On 26 July, because of the hyponatraemia, a prison GP stopped Mr Hearsey's dose of bumetanide, but did not record any plan to start it again once his sodium levels had improved. When Mr Hearsey's sodium levels increased to near normal the next day, no one appears to have considered reinstating his medication.

39. The clinical reviewer noted that it can be difficult to be sure of the cause of breathlessness when a patient has both heart failure and COPD. However, he was concerned that when Mr Hearsey reported becoming increasingly breathless, the GP focused too much on managing his COPD rather than considering a cardiovascular cause. He noted that stopping diuretics would inevitably have led to reduced heart function and shortness of breath and there were few clinical observations recorded to support a diagnosis of an exacerbation of COPD. Mr Hearsey was also prescribed citalopram for depression, which can cause low serum sodium, yet there was no record that this was considered.

40. The clinical reviewer noted that managing severe heart failure and hyponatraemia is very difficult and GPs should have considered seeking specialist advice about changing Mr Hearsey's medication. He concluded that stopping the diuretic medication, without adequate monitoring or follow-up, might have been a factor in the deterioration in Mr Hearsey's condition, that ultimately led to his death. We make the following recommendation:

    The Head of Healthcare should ensure that clinicians obtain specialist advice before withdrawing diuretics from patients with severe heart failure and there is a daily review when diuretics are stopped.

Continuity of GP

41. The clinical reviewer was concerned that there was no effective continuity of GP care. Mr Hearsey saw several prison GPs during the course of his illness and although he had relevant care plans, the GPs did not record sufficient information to ensure effective continuity of care. While we recognise that it will not always be possible for prisoners to see the same GP for each appointment, we consider that there should be a named GP responsible for the oversight and overall care of prisoners with a terminal illness or serious long-term condition. The named GP should ensure their condition is effectively monitored and that all relevant information about their care is recorded. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with terminal or serious life–limiting long-term conditions have a named GP to oversee their care.

Mr Hearsey's location

42. Shortly after Mr Hearsey arrived at Elmley, he was discharged from the inpatient unit, after a period of assessment. Because of the nature of his offence, Mr Hearsey was regarded as a vulnerable prisoner but there were no free cells in the main vulnerable prisoners unit, where there is a lift. Despite his poor mobility, severe heart failure and COPD, Mr Hearsey was allocated a cell on the third landing in another houseblock, which is used as an "over-flow" for vulnerable prisoners. There was no lift on his houseblock and he could only reach his landing by climbing two flights of stairs. The prison did not give Mr Hearsey any additional support to compensate, such as allocating a prisoner carer to collect his meals from the ground floor.

43. Mr Hearsey's heart failure and other chronic conditions severely restricted his mobility and made it difficult to climb stairs. His location on the third landing was clearly inappropriate. We make the following recommendation:

    The Governor should ensure that prisoners with health conditions that affect their mobility have appropriate accommodation in the prison, which meets their needs.

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