Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Gibson a prisoner at HMP Frankland on 8 January 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 Peter Gibson died at HMP Frankland on 8 January 2016, of a gastro-intestinal bleed. He was 68 years old. I offer my condolences to those who knew Mr Gibson.

On 8 January, Mr Gibson vomited blood and was taken to the healthcare centre. He was assessed and a non-emergency ambulance called, but this was delayed. An officer later found Mr Gibson unresponsive but did not use an emergency code, which caused a delay in calling an emergency ambulance. Mr Gibson's death was sudden and unexpected, but the investigation found that his initial assessment could have been improved by using a structured tool and that healthcare staff should have monitored him during the time he was waiting to go to hospital.

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 **August 2016**

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Summary

Events

1. Mr Peter Gibson was serving a sentence of 13 years and six months and had been in prison since 2013. He had been at Frankland since June 2014.

2. Mr Gibson had no significant medical history and was not prescribed any medication. In July 2014, a mental health nurse assessed Mr Gibson and found he was suffering from dementia, with short-term memory loss. Mr Gibson had limited contact with healthcare staff and no identified physical health problems, but a further assessment in October 2015, showed that his cognitive ability had deteriorated.

3. At 11.50am on 8 January 2016, Mr Gibson vomited blood. After an initial nurse assessment, Mr Gibson was taken to the prison healthcare centre and a GP examined him shortly before 1.00pm. In consultation with hospital staff, the GP agreed he should be assessed further in hospital, but not as an emergency. An ambulance was expected to take Mr Gibson to hospital within one hour.

4. At 1.25pm, an officer locked Mr Gibson in a cell in the healthcare centre to wait for the ambulance. At 2.40pm, a nurse checked with the ambulance service, who said there was a delay, except for emergencies, which the nurse said was not the case. Officers checked Mr Gibson intermittently while he waited for the ambulance and noted he was either watching television or sleeping. Healthcare staff did not monitor him or take any clinical observations.

5. At 4.10pm, an officer found Mr Gibson unresponsive and called nurses, but did not use an emergency medical code. A GP and a nurse arrived quickly and began to try to resuscitate Mr Gibson, but considered this was unlikely to be successful, as he appeared to be dead. The officer asked the control room to call an emergency ambulance ten minutes later, at 4.20pm.

6. A paramedic arrived at 4.32pm and agreed with the GP that Mr Gibson had died and that they should stop attempting resuscitation.

Findings

7. The clinical reviewer noted that the nurse who first saw Mr Gibson after he vomited on 11 January responded quickly and made an appropriate clinical decision to refer him to the GP. However, she considered that the use of a structured assessment tool would have helped determine the seriousness of Mr Gibson's condition and inform clinical decisions. We are concerned that no member of healthcare staff monitored Mr Gibson for the three hours he was waiting in the healthcare centre. As a result, no one took his clinical observations, which might have indicated his condition had deteriorated and he needed emergency treatment. While it would not have made a difference in this case, the officer who found Mr Gibson collapsed should have used an emergency medical code to alert the control room to call an ambulance immediately.

Recommendations

- The Head of Healthcare should ensure that healthcare staff use a structured assessment tool, such as NEWS, to help assess, monitor and respond to acute illness.
- The Head of Healthcare should ensure that all prisoners admitted to the healthcare centre are appropriately monitored and have an agreed frequency of clinical observations.
- The Governor should ensure that prison staff use an emergency medical code in a life-threatening situation, irrespective of the prisoner's location in the prison, so that the control room is alerted to call an ambulance immediately.

The Investigation Process

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

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

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

11. The investigator and clinical reviewer interviewed four members of healthcare staff at Frankland on 9 March 2016 and spoke to the prisoner who had responded to our notice.

12. We informed HM Coroner for Durham and South Darlington of the investigation who gave us the post-mortem report. We have sent the coroner a copy of this report.

13. Mr Gibson had no contact with any family or friends in the community while he was in prison and the prison was unable to trace any family members or friends after his death.

14. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Frankland

15. HMP Frankland is one of eight high security prisons in England and Wales. It holds more than 800 men. There is 24-hour inpatient care. G4S Forensic & Medical Services provide general nursing services and substance misuse services. GP and Pharmacy services are provided by Spectrum Healthcare.

HM Inspectorate of Prisons

16. The report of the most recent inspection of Frankland in March 2016 has not yet been published. At the previous inspection in December 2012, inspectors found that health facilities were good. The quality of services was generally good but a high number of staff vacancies inhibited delivery. The Care Quality Commission took part in the inspection, and found that the services operated by Care UK (the provider at the time) were of a good standard and working relationships with other partners helped them to deliver effective care.

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 most recent annual report for the year to November 2015, the IMB said that the quality of healthcare provision was generally good and in some individual cases, outstanding. However, the IMB was concerned about the affect of staffing vacancies on healthcare provision.

Previous deaths at HMP Frankland

18. Mr Gibson was the fifth prisoner to die of natural causes at Frankland since the start of 2015. Since his death, there has been one other death from natural causes at the prison. There were no significant similarities with the circumstances of the other deaths.

Key Events

19. On 8 November 2013, Mr Peter Gibson was sentenced to 13 years and six months in prison for sexual offences and sent to HMP Durham. On 2 June 2014, he moved to HMP Frankland.

20. At an initial health screen at Frankland, a nurse noted that Mr Gibson had no significant medical history. He was not prescribed any medication and the nurse recorded that he was fit and well.

21. On 18 July, prison officers were concerned that Mr Gibson appeared confused. A mental health nurse assessed him and found he was suffering from dementia. He did not receive any active treatment, but nurses monitored him closely and began a care plan to help manage his physical and mental health needs. Mr Gibson has short-term memory loss but, on 27 August, said he did not want this investigated further.

22. Mr Gibson had only limited contact with healthcare staff until October 2015, when he refused to have another mental health assessment. In November, he agreed to an assessment, which showed his cognitive ability had deteriorated. Nurses monitored Mr Gibson and wing staff helped him with daily living tasks.

Events of 8 January 2016

23. At 11.50am on 8 January 2016, Mr Gibson vomited while waiting to collect his lunch on the wing. A nurse reviewed him and noted he had 'coffee ground vomit', which indicates coagulated blood from the stomach in the vomit. He was unable to give a clear account of what had happened before he was sick due to his short-term memory problem. His pulse was fast and his oxygen saturation level was below normal. She did not consider Mr Gibson's condition was an emergency and arranged for a prison GP to see him in the healthcare centre.

24. At 12.57pm, a GP examined Mr Gibson, but was unable to obtain a blood pressure reading. His pulse was fast and his abdomen appeared distended. She discussed Mr Gibson's condition with staff at the Medical Assessment Unit at the University Hospital of North Durham (UHND), who agreed Mr Gibson needed further assessment in hospital, but did not need to be admitted as an emergency.

25. At 1.25pm, an officer locked Mr Gibson in a cell in the healthcare centre to wait until they could arrange an ambulance. Mr Gibson was sitting in a wheelchair watching television at the time. At 1.45pm when the nurse came back from her lunch break, the GP asked her to organise an ambulance to take Mr Gibson to hospital. She telephoned the ambulance service and asked for an ambulance within one hour.

26. At 2.40pm, the nurse telephoned the ambulance service to chase up the ambulance. At 2.45pm, the ambulance service called back and told a nurse there had been a delay. (Ambulance timings cannot be guaranteed as they can be diverted to emergency calls.) The ambulance service offered to upgrade the request to an emergency but the nurse said this was not necessary. The ambulance service said they would send an ambulance as soon as possible.

27. At 2.45pm, an officer checked Mr Gibson, who was sitting in his wheelchair watching television. At approximately 3.40pm, another officer went to give Mr Gibson his weekly order from the prison shop. Mr Gibson appeared to be asleep at the time.

28. At approximately 4.10pm, an officer checked Mr Gibson, as she was concerned he was still waiting for an ambulance. She found him slumped in the wheelchair and there was a large amount of blood and urine on Mr Gibson's clothes and the floor. She called for help from nearby healthcare staff but did not use a medical emergency code. A nurse attended immediately and found Mr Gibson unresponsive. He was unable to find a pulse and noted that Mr Gibson appeared lifeless. A GP arrived and noted there was a significant amount of blood and other bodily fluids on the floor. She thought it looked as if Mr Gibson was dead, but after a brief discussion with the nurse, they decided to attempt cardiopulmonary resuscitation. They attached a defibrillator but this found no shockable heart rhythm.

29. At 4.28pm, the officer asked the control room to call an emergency ambulance. The control room log shows this was done immediately. A paramedic arrived at 4.32pm. At 4.40pm, the paramedic and the GP decided to stop any further resuscitation attempts and agreed that Mr Gibson had died.

Contact with Mr Gibson's family

30. A prison manager acted as the prison's family liaison officer. Mr Gibson had not had any contact with family or friends while he was in prison and had not named a next of kin. She liaised with the police and Mr Gibson's offender manager, but they were unable to find any family or friends.

31. The prison arranged and paid for Mr Gibson's funeral, which was held on 20 January.

Support for prisoners and staff

32. After Mr Gibson's death, a prison manager debriefed the staff involved in the emergency response and offered her support and that of the staff care team.

33. The prison posted notices informing staff and prisoners of Mr Gibson'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 Gibson's death.

Post-mortem report

34. A post-mortem found that the cause of death was an intestinal infarction due to thrombosis of the superior mesenteric and portal veins (a gastro-intestinal bleed). The superior mesenteric vein (SMV) is a blood vessel that drains blood from the small intestine.

Findings

Clinical care

35. We are satisfied that the nurse responded quickly after Mr Gibson vomited on 8 January. She used her clinical experience to decide that Mr Gibson needed further medical assessment; she did not consider it was an emergency and appropriately referred him to a GP.

36. The clinical reviewer considered that the use of a structured tool such as the National Early Warning Score (NEWS) system, based on six routine clinical observations, would have helped determine the level of severity of Mr Gibson's condition. The use of the NEWS system would have supported and influenced the nurse's clinical opinion and given a clear set of observations for further monitoring. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff use a structured assessment tool, such as NEWS, to help assess, monitor and respond to acute illness.

37. We are concerned that after the GP assessed Mr Gibson and he waited in the healthcare centre for an ambulance, healthcare staff did not monitor him or take his clinical observations. Because of delays with an ambulance arriving Mr Gibson spent longer in the healthcare centre than anticipated. (Delays with ambulances are outside the remit of this investigation but we accept that priority is given to emergencies.) Again the use of the NEWS system would have helped indicate any deterioration while he was waiting. The nurse who was in charge of the inpatient unit and a colleague, both agreed that they would have expected a healthcare assistant to take observations every 15 minutes in these circumstances.

38. It would normally be the responsibility of the admitting clinician to task a healthcare assistant to do observations but it was not clear who this was in Mr Gibson's situation. Mr Gibson was waiting in the healthcare for an ambulance, which had originally been expected within an hour. A nurse had gone back to her duties on the wings and the GP, who had assessed Mr Gibson outside her normal clinic appointments, had gone back to her work. There did not appear to be a clearly designated person responsible for Mr Gibson's care while he was in the healthcare centre.

39. The clinical reviewer considered that there was a need for a clear protocol to ensure that all prisoners in the healthcare centre are properly monitored and have appropriate clinical observations taken. We make the following recommendations:

    The Head of Healthcare should ensure that all prisoners admitted to the healthcare centre are appropriately monitored and have an agreed frequency of clinical observations.

Emergency response

40. Prison Service Instruction (PSI) 03/2013 - Medical Emergency Response Codes, contains a mandatory instruction that prison staff should use an emergency medical code in a life threatening situations, such as when a prisoner is unconscious. This should alert the control room to call an ambulance immediately, without waiting for further information.

41. When the officer found Mr Gibson unresponsive, she did not use an emergency code and neither did any of the other staff. She said that she would have radioed an emergency code if Mr Gibson had been on a wing, but because healthcare staff were immediately on hand to assess him quickly, she did not consider this necessary. However, this meant that no one called an ambulance immediately and it was ten minutes more before she asked the control room to call an ambulance.

42. We understand that Mr Gibson was in the healthcare centre and received immediate medical attention. The clinical reviewer noted that the GP and the nurse attended promptly and made good attempts to resuscitate Mr Gibson. Although they considered that it was likely that Mr Gibson had died, we are satisfied that they acted appropriately in case there was a chance of reviving him. However, the failure to use an emergency code meant there was a delay calling an ambulance. This would not have altered the outcome for Mr Gibson, but in other emergencies it could be critical that an ambulance is called immediately, even when the prisoner is already in the healthcare centre. PSI 3/2013 makes it clear that an ambulance can be stood down if necessary but staff should not wait for healthcare staff to assess a prisoner in an emergency before calling an ambulance. We make the following recommendation:

    The Governor should ensure that prison staff use an emergency medical code in a life-threatening situation, irrespective of the prisoner's location in the prison, so that the control room is alerted to call an ambulance immediately.

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