Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Byles a prisoner at HMP Bullingdon on 16 February 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

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 Paul Byles died on 16 February 2016 of a heart attack at HMP Bullingdon. He was 48 years old. I offer my condolences to Mr Byles' family and friends.

Mr Byles' death was very sudden and he often refused tests or to cooperate with recommended treatment. Nevertheless, the clinical reviewer found that healthcare staff at Bullingdon missed some opportunities to intervene and, as a result, considers that Mr Byles' care did not fully reflect community standards.

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 **September 2016**

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Summary

Events

1. On 15 April 2015, Mr Paul Byles was sentenced to 12 months in prison and was sent to HMP Bullingdon. He was released on licence on 7 September but was recalled to Bullingdon on 13 November, after breaching the conditions of his licence.

2. Mr Byles had a history of heroin and crack cocaine and smoked cigarettes. He declined a referral to the substance misuse team but accepted a referral for help with giving up smoking. He did not take any medication.

3. At an appointment with a prison GP on 27 November, Mr Byles had a full set of blood tests. The results, including his cholesterol levels, were normal but the GP did not use a standard test to assess Mr Byles' risk of developing cardio-vascular disease.

4. On 31 January 2016, Mr Byles told a nurse he had chest pain and dizziness, which he had not experienced before. The nurse did not investigate, but referred him for a routine GP appointment. On 1 February, he reported having chest pain again. This time a nurse carried out an ECG and blood test. A prison GP reviewed the results and noted that they were normal.

5. Later on 1 February, a GP examined Mr Byles and diagnosed angina. Mr Byles refused to be admitted to the prison's inpatient unit for observation or to be referred to a hospital chest pain clinic.

6. On 16 February, Mr Byles complained of chest pain again. He collapsed in the prison's healthcare centre while he was waiting for a nurse to assess him, Healthcare staff gave him emergency treatment and paramedics took Mr Byles to hospital by air ambulance. Mr Byles died shortly after he was admitted to hospital.

Findings

7. When Mr Byles arrived at HMP Bullingdon, he had a comprehensive set of blood tests with normal results. However, a GP did not use a standard test for assessing risk of developing cardiovascular disease, which would have shown that he was at raised risk and prompted some consideration of whether he needed lipid lowering therapy, such as statins.

8. Although Mr Byles was not always fully cooperative with treatment and declined a referral to a chest pain clinic, the clinical reviewer considered that, when he reported typical signs of cardiac problems, healthcare staff did not always investigate appropriately or arrange follow-up appointments. The clinical reviewer considered that these were missed opportunities to make a definitive diagnosis.

Recommendations

- The Head of Healthcare should ensure that prisoners are assessed for cardiac risk factors in line with NICE guidelines.
- The Head of Healthcare should ensure that all healthcare staff are aware of current clinical guidance for managing chest pain and that prisoners presenting with such symptoms are assessed urgently, in line with NICE guidelines.

The Investigation Process

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

10. The investigator visited Bullingdon on 26 February 2016. She obtained copies of relevant extracts from Mr Byles' prison and medical records. She spoke to two prisoners at Bullingdon and subsequently to an ex-prisoner, who wanted to speak to her but they did not have additional information about Mr Byles' care.

11. NHS England commissioned a clinical reviewer to review Mr Byles' clinical care at the prison.

12. We informed HM Coroner for Oxfordshire of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Byles' partner and his mother to explain the investigation. Mr Byles' partner asked for as much information as possible about the events surrounding his collapse.

14. Mr Byles' partner received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.

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

Background Information

HMP Bullingdon

16. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Virgin Care provides healthcare services. There is 24-hour healthcare cover with 21 inpatient beds.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Bullingdon was in June 2015. The Inspectorate noted that healthcare services had improved from a relatively low base and were now reasonably good. Support for those with lifelong conditions was good. Inpatients received good GP, mental health and nursing input.

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 July 2015, the IMB noted there had been improvements in healthcare, as recruitment was more effective. Waiting lists had reduced and patient attendance rates had increased. Following the implementation of the Care Act 2014, community services were assessing and providing targeted personal care for prisoners on all wings.

Previous deaths at HMP [Prison]

19. Mr Byles was the fourth prisoner at Bullingdon of natural causes since January 2013. There were no significant similarities with the circumstances of the previous deaths

Key Events

20. On 15 April 2015, Mr Paul Byles was sentenced to 12 months in prison for a violent offence and was sent to HMP Bullingdon. He was released on licence on 7 September. On 13 November, he was recalled to prison after breaching the conditions of his licence.

21. At an initial health screen at Bullingdon on 13 November, a nurse noted that Mr Byles had a history of using heroin and crack cocaine. He said he had smoked crack cocaine the day before but refused to be referred to the substance misuse team. He said he had stopped taking anti-depression medication in October 2015 and did not take any other medication. Mr Byles agreed to be referred for help to give up smoking.

22. On 27 November, a prison GP reviewed Mr Byles and arranged a full set of blood tests including renal and liver function, a full blood count and a serum lipid (cholesterol) level. (Abnormal levels of lipids in the blood are risk factors for heart disease.) He noted the results of these tests were all normal.

23. On 31 January 2016, Mr Byles told a nurse that he was dizzy and had chest pain that extended down his left arm. He said he had experienced this type of pain before but it was worse that morning. She assessed Mr Byles and noted that his blood pressure was low. She did not carry out an ECG (an electrocardiogram, which tests the heart's rhythm and electrical activity) but made a routine GP appointment for 5 February.

24. On 1 February, Mr Byles went back to the healthcare centre and said he was still suffering from chest pain. A nurse did an ECG test and arranged blood tests. A prison GP reviewed the results later that day and noted the ECG and blood tests were normal.

25. The same day, another prison GP assessed Mr Byles and diagnosed that the pains were caused by angina. He arranged to admit Mr Byles to the prison's inpatient unit for observation and treatment but Mr Byles refused to be admitted and also refused to be referred to the chest pain clinic at hospital. The GP did not arrange a follow-up appointment.

26. On 11 February, an officer took Mr Byles to the healthcare centre, after he complained of chest pain again. A nurse noted that Mr Byles refused to have an ECG or blood test and Mr Byles signed a disclaimer noting this. She did not record Mr Byles' pulse, blood pressure or oxygen saturation level, but gave him medication for indigestion.

27. At 2.30pm on 16 February, Mr Byles went to the healthcare centre and told a nurse he had chest pain. She asked him to wait while she reviewed his medical record. A few minutes later she came back to speak to Mr Byles, but he had gone to the toilet. She told an officer that she would assess Mr Byles after she had finished with other patients.

28. At 2.47pm, a prisoner told the nurse that Mr Byles had collapsed in the toilet area. She went immediately and found Mr Byles lying on the floor. Another nurse

radioed for an emergency ambulance and the prison's control room requested one immediately.

29. Two nurses started cardiopulmonary resuscitation. A few minutes later, a prison GP arrived to assist. The GP gave Mr Byles adrenaline and the nurses gave him oxygen.

30. At approximately 3.05pm, paramedics arrived and took over emergency treatment. The paramedics called an air ambulance, which arrived at 3.24pm. At 4.14pm, the air ambulance took Mr Byles to hospital. He was admitted to the intensive care unit but did not recover. At 4.42pm, doctors recorded that he had died.

Contact with Mr Byles' family

31. A prison manager acted as the family liaison officer (FLO). Mr Byles had named his partner as his next of kin and the FLO visited her that evening, informed her of his death and offered condolences and support. Mr Byles' partner said she would speak to his mother.

32. The next morning, the FLO telephoned Mr Byles' mother and offered his condolences. He kept in contact with Mr Byles' partner and his mother until Mr Byles' funeral on 3 March. The prison contributed to the costs in line with national instructions.

Support for prisoners and staff

33. After Mr Byles' 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.

34. The prison posted notices informing staff and prisoners of Mr Byles' 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 Byles' death.

Post-mortem report

35. The Coroner concluded that the cause of death was myocardial infarction (heart attack) and coronary artery thrombosis (a blood clot inside a blood vessel of the heart).

Findings

Clinical care

36. The clinical reviewer considered that Mr Byles' standard of care at Bullingdon was not equivalent to that which he could have expected to receive in the community. A GP took appropriate blood tests in November 2015, but the clinical reviewer considered that the GP should also have assessed Mr Byles' cardiovascular risk, using a standard risk assessment tool (Qrisk2) in line with National Institute for Health and Care Excellence (NICE) guidelines. Although Mr Byles' cholesterol test was normal, the clinical reviewer noted that the overall results of such an assessment would have shown Mr Byles had a raised risk of developing coronary heart disease and prompted some consideration of whether lipid-lowering therapy was necessary.

37. When Mr Byles saw a nurse on 31 January 2016, he showed signs and symptoms associated with angina or a heart attack. Despite this, the nurse did not carry out an ECG test or make an urgent referral to a GP. Instead, she made a routine GP appointment for six days later. The next day, Mr Byles has an appropriate ECG and blood test but declined to be admitted to the inpatient unit and did not want to be referred to a hospital chest pain clinic. Although a prison GP diagnosed angina, he did not arrange a follow-up appointment, which the clinical reviewer considered should have happened.

38. On 11 February, Mr Byles refused to have an ECG test or blood test. It is also possible that he would not allow the nurse to assess him by taking his clinical observations - pulse, blood pressure and oxygen saturation level – but this was not recorded. The clinical reviewer considered that as Mr Byles had typical cardiac symptoms and a new diagnosis of angina, the nurse should have taken his observations and referred him to a GP.

39. Mr Byles' death was very sudden and he often refused tests or to cooperate with treatment. Nevertheless, healthcare staff missed some opportunities to intervene. We make the following recommendations:

    The Head of Healthcare should ensure that prisoners are assessed for cardiac risk factors in line with NICE guidelines.

    The Head of Healthcare should ensure that all healthcare staff are aware of current clinical guidance for managing chest pain and that prisoners presenting with such symptoms are assessed urgently, in line with NICE guidelines.

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