

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Williamson a prisoner at HMP Thameside on 31 August 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Kenneth Williamson died on 31 August 2016 of acute pericarditis at HMP Thameside. He was 60 years old. I offer my condolences to Mr Williamson's family and friends.

I am satisfied that Mr Williamson received an appropriate standard of care at HMP Thameside, equivalent to that which he could have expected in the community. However, there were deficiencies in the emergency response and in family liaison from which the prison needs to learn.

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 2017

Contents

Summary 1
The Investigation Process 3
Key Events 5
Findings 7

Summary

Events

1. On 16 August 2016, Mr Kenneth Williamson was sentenced to nine years imprisonment for sexual offences and sent to HMP Thameside.
2. At an initial reception screen, a nurse noted that Mr Williamson suffered from sciatica and a GP examined him the same day. On 17 August, during a secondary health screen, Mr Williamson told a healthcare assistant that he had an upcoming hospital appointment but he refused to disclose any further information. He gave consent for healthcare staff to request his community medical record, although there is no evidence they did so.
3. On 31 August, at 4.16am, an officer conducted a morning roll check and looked through the observation hatch on Mr Williamson's cell. He saw two prisoners sleeping, but could not remember seeing any movement. Another officer unlocked the cell at 9.13am, but did not open the door or look inside.
4. At around 12.00pm, the same officer checked on Mr Williamson following a request from his cellmate. He noticed that Mr Williamson's skin was blue and called for an immediate emergency response. Two officers responded quickly. One of the officers checked Mr Williamson's vital signs and started cardiopulmonary resuscitation (CPR), while the other called an emergency response code blue.
5. A nurse arrived just after the officer called the code blue, without oxygen or a defibrillator, which she then requested. She noted that Mr Williamson was extremely cold, stiff, and without a pulse. With the help of prison staff, the nurse moved Mr Williamson onto the floor and continued CPR until a prison GP arrived with paramedics and they made a joint decision to stop. The GP confirmed that Mr Williamson had died at 12.19pm.

Findings

6. We are satisfied that Mr Williamson received an appropriate standard of care at Thameside, which was equivalent to that he could have expected to have received in the community. However, we consider that the prison should have obtained a copy of his community medical record.
7. We are concerned that the officer who performed the morning unlock did not appropriately check on Mr Williamson's wellbeing.
8. We are also concerned that the officer who found Mr Williamson did not issue the correct medical emergency code. This meant that the control room did not call an ambulance and that healthcare staff did not bring the appropriate medical equipment.
9. Prison and healthcare staff responded quickly to the emergency but we do not consider it was necessary or appropriate to attempt resuscitation, as it was apparent that Mr Williamson had been dead for some time.

10. We are concerned that the prison did not notify Mr Williamson's next of kin of his death in person, in line with prison service instructions.

Recommendations

- The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners, in line with PSO 3050.
- The Director should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including using the appropriate emergency code to effectively communicate the nature of a medical emergency and ensure an emergency ambulance is called immediately.
- The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate, in line with national guidelines.
- The Director should ensure that the prison complies with prison service guidance about contacting the families of deceased or seriously ill prisoners.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Thameside informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Williamson's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Williamson's clinical care at the prison.
14. The investigator and clinical reviewer interviewed four members of staff and one prisoner at HMP Thameside on 27 October 2016. The investigator interviewed three additional members of staff at Thameside on 4 October.
15. We informed HM Coroner for Inner London South of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Williamson's wife, to explain the investigation. She had no specific matters for the investigation to consider.
17. Mr Williamson's family received a copy of the initial report. They did not make any comments.
18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Thameside

19. HMP Thameside is a local prison in south east London that holds up to 900 men. It is privately run by Serco. Health services are delivered by the Oxleas NHS Foundation Trust. There is 24 hour nursing provision and an 18 bed inpatient unit.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Thameside was in September 2014. Inspectors reported that health care services were being transformed and that all care had improved. There was an appropriate range of clinics, and care plans were in place in line with national guidance.

Independent Monitoring Board

21. 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 June 2016 the IMB reported that healthcare had improved but there were still unnecessary delays and unsatisfactory communication between prisoners and staff.

Previous deaths at HMP Thameside

22. Mr Williamson was the third prisoner to die of natural causes at HMP Thameside since January 2014. We have previously made a recommendation about emergency response.

Key Events

23. On 16 August 2016, Mr Kenneth Williamson was sentenced to nine years imprisonment for sexual offences and sent to HMP Thameside.
24. At an initial reception screening, a nurse noted that Mr Williamson suffered from sciatica (pain affecting the back, hip and outer side of the leg, caused by compression of a spinal nerve in the lower back) and arranged for a GP review. Later the same day, a prison GP examined Mr Williamson and prescribed co-codamol (a painkiller) and naproxen (an anti-inflammatory medication) to treat chronic back pain and omeprazole to counteract any side effects.
25. On 17 August, a healthcare assistant saw Mr Williamson for a secondary health screen. He obtained Mr Williamson's consent to request his community medical record and completed a medication in possession assessment. Mr Williamson told him that he had an upcoming appointment at the hospital but refused to provide any detail. Despite obtaining Mr Williamson's consent, there is no evidence that healthcare staff requested his community medical record.

Events on 31 August

26. At 4.16am, while conducting a morning roll check, an officer switched the light on in the cell shared by Mr Williamson and another prisoner cell and looked through the observation hatch. He told the investigator that he saw two prisoners asleep in the cell but could not remember if he saw any movement.
27. At 9.13am, Officer A unlocked Mr Williamson's cell but did not open the door or check inside. Mr Williamson's cellmate left the cell at 11.22am to collect his lunch and returned eight minutes later. He did not speak to Mr Williamson at that time and had spoken to him last at approximately 12.30am.
28. At 12.00pm, Officer A was in the process of locking the cell when the cellmate requested that he check on Mr Williamson. The officer said that Mr Williamson was lying on his bed with a blue colour to his skin and suspected that he may have died. He escorted the cellmate onto the landing and called for an immediate medical response over the radio network at 12.06pm. He waited outside Mr Williamson's cell and two officers quickly arrived. Officer B checked Mr Williamson's vital signs and began cardiopulmonary resuscitation (CPR). In the meantime, at 12.07pm, Officer C issued an emergency medical response code blue (which indicates that a prisoner is unconscious or has breathing problems). A control room operator immediately called for an ambulance.
29. A nurse arrived just as the call for healthcare assistance changed to a code blue emergency. As she did not know the seriousness of incident, she had not taken oxygen or a defibrillator, although she quickly requested these. She examined Mr Williamson and noted that he did not have a pulse and was extremely cold, stiff and cyanosed (a bluish discoloration of the skin). With the help of prison staff, she moved Mr Williamson onto the cell floor and attached a defibrillator, which advised not to shock. Officer B continued chest compressions while she and another nurse issued oxygen. At 12.18pm, a prison GP arrived with paramedics and they made a joint decision to stop CPR. At 12.19pm, the GP confirmed that Mr Williamson had died.

Contact with Mr Williamson's family

30. Shortly after Mr Williamson's death, the prison appointed a Muslim chaplain as a family liaison officer. At 3.00pm, the chaplain and the deputy Director arrived at the home address of Mr Williamson's wife to break the news of his death but there was no answer. They left a note of their contact details and returned to the prison. At 5.15pm, the chaplain received a call from Mr Williamson's son, who provided a telephone number for Mrs Williamson. At 5.30pm, concerned that it was getting late, the deputy Director contacted Mrs Williamson to arrange to visit the next day and informed her that Mr Williamson had died.
31. At 9.00am on 1 September, the deputy Director and the chaplain visited Mrs Williamson at her address and offered their condolences and support. The chaplain gave ongoing support until Mr Williamson's funeral, which was held on 19 October 2016. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

32. After Mr Williamson's death, the deputy Director 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 group counselling and one on one support.
33. The prison posted notices informing other prisoners of Mr Williamson'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 Williamson's death.

Post-mortem report

34. The coroner confirmed that Mr Williamson died of acute pericarditis (inflammation of the sac surrounding the heart).

Findings

Clinical care

35. Mr Williamson had appropriate health screening assessments at Thameside and did not reveal any symptoms suggestive of a heart condition. His cellmate told us that he did not complain of any symptoms that may have suggested problems with his heart, such as chest pain or shortness of breath. The clinical reviewer concluded that healthcare staff managed Mr Williamson's sciatica appropriately and we are satisfied that the care he received was equivalent to that he could have expected in the community. However, we are concerned that healthcare staff did not seek to verify Mr Williamson's medical history.
36. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, requires that prison staff should try to obtain relevant information from the prisoner's GP or other relevant health services the prisoner has recently been in contact with, when new prisoners arrive in reception. In Mr Williamson's case, his age, reported sciatica and refusal to disclose the reason for an upcoming hospital appointment meant that it was all the more important to request his community medical record.
37. The apparent failure to request this information after Mr Williamson gave his consent meant that healthcare could not verify any underlying medical conditions. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners, in line with PSO 3050.

Unlock procedures

38. When the nurse arrived at 12.07pm, she noted that Mr Williamson was cold, stiff and without a pulse. This would indicate that he had been dead for some time. We are concerned that the officer who performed the morning unlock, at 9.13am, did not check Mr Williamson's wellbeing when they unlocked his cell.
39. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".
40. Additionally, Prison Service Instruction 75/2011 states that "there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process".
41. We do not know if checking on Mr Williamson during the unlock process might have prevented his death. It meant, though, that staff missed an opportunity to

check his wellbeing and resulted in his cellmate finding him dead. We make the following recommendation:

The Director should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention

Emergency code

42. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system based on the instruction. Thameside's local policy instructs staff to call an immediate medical response over the radio network to alert healthcare staff that their assistance is required. In more serious cases, a code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.
43. Officer A called an immediate medical response over the radio network shortly after Mr Williamson's cellmate alerted him of his condition. This meant that the nurse only took basic medical equipment with her and that the control room did not call an ambulance until Officer C issued a medical code blue, causing a slight delay. Officer A told us that in hindsight he should have called a code blue but the immediate medical response was the first thing that came to mind. While this would not have changed the outcome for Mr Williamson, in other circumstances, any delay could be crucial. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including using the appropriate emergency code to effectively communicate the nature of a medical emergency and ensure an emergency ambulance is called immediately.

Resuscitation

44. Staff responded quickly and attended to Mr Williamson within minutes of Officer A calling for an immediate medical response. Officer B told the investigator that Mr Williamson did not look right when he arrived, so he checked his vital signs and started CPR. When the nurse arrived, she assessed Mr Williamson and aided Officer B in the resuscitation attempt. This was despite there being clear signs that Mr Williamson had died, which included that his limbs were cold, he had no pulse, there were signs of rigor mortis, and his pupils were fixed and dilated. The nurse told the investigator that she recognised signs of rigor mortis upon arrival, but as the officer had already started CPR, she decided to continue and wait for a GP. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out cardiopulmonary resuscitation in these circumstances.
45. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The Oxleas NHS Foundation Trust emergency response operating procedure (August 2016) is clear that staff should not attempt

resuscitation if rigor mortis is present. European Resuscitation Council Guidelines 2015 say, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...”, such as the presence of rigor mortis. In 2016, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued revised guidance about making appropriate resuscitation decisions. The guidance says that every decision should be made on the basis of a careful assessment of each individual’s situation. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not necessary or appropriate.

Informing Mr Williamson’s next of kin

46. Prison Rule 22 states that if a prisoner dies or becomes seriously ill then the governor should ‘at once’ inform a prisoner’s spouse or nominated next of kin. PSI 64/2011, Safer Custody, requires that wherever possible, the family liaison officer and another member of staff will visit the next of kin or nominated person to break the news of the death.
47. When the deputy Director and the Muslim chaplain went to the address of Mr Williamson’s next of kin to break the news of Mr Williamson’s death, his wife was not there. They left a note with their contact details and returned to the prison. When they received Mrs Williamson’s telephone number, the deputy Director arranged to visit her following day, as it she felt it was too late to go back. We do not consider that 5.30pm was so late as to preclude a visit, particularly as the address was relatively close to the prison. While they had attempted to break the news of his death in person, we consider that it was inappropriate that they did not make a second attempt, once they knew Mrs Williamson had returned home. We make the following recommendation:

The Director should ensure that the prison complies with Prison Service guidance about contacting the families of deceased or seriously ill prisoners.

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