Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Druce a prisoner at HMP Littlehey on 21 November 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 Martin Druce died on 21 November 2016 of a heart attack while a prisoner at HMP Littlehey. Mr Druce was 58 years old. I offer my condolences to Mr Druce's family and friends.

Mr Druce suffered from osteoarthritis, high blood pressure and asthma. Healthcare staff managed his long-term conditions well and reviewed him frequently, prescribing appropriate medication when required. I am satisfied that Mr Druce received a good standard of healthcare at Littlehey, equivalent to that he could have expected to receive in the community. However, there was some confusion in the emergency response which the prison needs to address.

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 **October 2017**

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Summary

Events

1. On 15 September 2015, Mr Martin Druce was remanded to custody for sexual offences. He was moved to HMP Norwich on 30 September. Mr Druce suffered from a number of chronic health conditions, including osteoarthritis, asthma and hypertension (high blood pressure). Healthcare staff at Norwich monitored and reviewed his conditions frequently and supported him to stop smoking.

2. On 14 March 2016, Mr Druce was sentenced to nine years imprisonment and was transferred to HMP Littlehey ten days later. Over the next seven months, healthcare staff monitored and reviewed his conditions frequently. A prison pharmacist reviewed his prescriptions regularly and prison GPs conducted examinations when required.

3. On 28 October, a nurse noted that Mr Druce had unexplained weight loss and requested blood tests and a GP appointment. Prison GPs identified an abnormality and made an urgent colorectal (lower bowel specialist) referral. On 11 November, Mr Druce reported diarrhoea and vomiting to a prison nurse who kept him under review. A GP saw him three days later and prescribed rehydration salts.

4. On 17 November at around 3.20pm, a prisoner found Mr Druce collapsed and notified prison staff. Three officers responded and one of them called for an immediate medical response over the radio network. Three minutes later, the same officer issued an emergency code red (indicating bleeding), which was subsequently changed to a code blue (indicating loss of consciousness or breathing problems).

5. Another officer arrived within minutes, obtained a defibrillator and noticed that Mr Druce's breathing had begun to deteriorate. The officer, suspecting a heart attack, fitted the defibrillator, which issued a shock, and started cardiopulmonary resuscitation. In the meantime, healthcare staff arrived and aided in the resuscitation effort. The first paramedic arrived at 3.41pm and Mr Druce was taken to hospital at 4.25pm. Hospital staff diagnosed an acute kidney injury, which had resulted in a heart attack.

6. Mr Druce briefly regained consciousness on 18 November, but suffered another four heart attacks and was placed on ventilator to aid his breathing. His condition did not improve and, on 21 November, hospital doctors decided to stop all treatment. Mr Druce died later that day at 2.35pm.

Findings

7. We agree with the clinical reviewer that Mr Druce received good care at Littlehey, which was equivalent to that he could have expected to receive in the community.

8. However, we are concerned that one of the officers that found Mr Druce did not issue the correct medical emergency code. This meant that the control room did not immediately call an ambulance and that responding staff were not fully aware of the seriousness of the situation.

Recommendation

- The Governor 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 that an emergency ambulance is called immediately.

The Investigation Process

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

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

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

12. We informed HM Coroner for Ipswich of the investigation. Our investigation was suspended for a month until we received the post-mortem report from the coroner. We have sent the coroner a copy of this report.

13. The investigator wrote to Mr Druce's partner 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.

14. The initial report was shared with the Prison Service. The Prison Service highlighted a difference of opinion with regards to our interpretation of the emergency response procedures, which we have addressed.

Background Information

HMP Littlehey

15. HMP Littlehey in Cambridge is a medium security prison holding approximately 1,200 men. A large proportion of the population are convicted of sexual offences.

16. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. Prior to April 2015, Cambridgeshire and Peterborough NHS Trust provided healthcare services. The prison healthcare centre is open from 7.30am to 5.00pm, Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Littlehey was in March 2015. Inspectors noted that an experienced nurse manager and two senior nurses provided effective clinical leadership. Despite chronic problems in recruiting nursing staff, health services had not been affected as regular highly skilled agency staff filled any shortfalls. A small group of regular GPs had significantly improved patient care. Prisoners with lifelong conditions were identified effectively and nurses with additional specialist training provided relevant clinics. There was excellent and compassionate joint working between the health provider, prison and community services for prisoners with palliative care and end-of-life needs.

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 January 2016, the IMB reported that the transfer to a new healthcare provider in April 2015 went smoothly with no adverse impact on service delivery.

19. The Board recognised the significant demands the elderly prison population made upon healthcare services, in particular the increasing number of hospital escorts, subsequent stays and the resulting risks associated with the redeployment of staff. They also expressed concern about future funding.

Previous deaths at HMP Littlehey

20. Mr Druce was the ninth person to die from natural causes at Littlehey since January 2016. There have been two subsequent deaths. There were no similarities with the circumstances of the previous deaths.

Key Events

21. On 15 September 2015, Mr Martin Druce was remanded to custody for sexual offences and sent to HMP Bedford. He transferred to HMP Norwich on 30 September. Mr Druce suffered from a number of chronic health problems, including osteoarthritis, asthma and hypertension (high blood pressure). He had a history of schizophrenia and smoked cigarettes.

22. At an initial reception screen at Norwich, a nurse recorded that Mr Druce had a history of hypertension (high blood pressure) and asthma. A prison GP confirmed that he was receiving treatment for schizophrenia and reviewed his medication. The GP prescribed Mr Druce ramipril and doxazosin to treat his high blood pressure. Over the next five months, healthcare staff monitored and reviewed Mr Druce's conditions frequently and they measured his blood pressure on four occasions. While at Norwich, his blood pressure level varied between normal and high. Healthcare staff completed asthma and hypertension reviews and helped Mr Druce to stop smoking. Doctors regularly reviewed Mr Druce's medication and conducted examinations when required.

23. On 14 March 2016, Mr Druce was sentenced to nine years imprisonment and moved to HMP Littlehey ten days later. At an initial reception screen at Littlehey, a nurse manager recorded that Mr Druce had recently stopped smoking and that he suffered from asthma and hypertension. A prison GP reviewed Mr Druce's medication but did not see him in person.

24. On 26 March, healthcare staff found that Mr Druce's blood pressure level was normal.

25. On 11 May, Mr Druce saw a nurse for a mental health check and hypertension review. He told her that he had started smoking again and she provided smoking cessation and lifestyle advice. Over the next four months, healthcare staff monitored Mr Druce's mental and physical health frequently. He reported suffering from hip pain on a number of occasions and doctors treated him with pain relief tablets (naproxen, paracetamol and co-codamol) and an injection (methylprednisolone).

26. On 28 September, Mr Druce had a dizzy spell and a nurse saw him for a review. She recorded that his blood pressure was within the normal range (100/60) but his pulse rate was irregular. She did an electrocardiogram test (ECG – to monitor the electrical rhythms of the heart), which, despite showing some occasional irregularities, did not identify any immediate concerns. On 5 October, Mr Druce reported ongoing shoulder pain and neck stiffness to a prison GP, who noted his recent dizzy spell and requested a chest and shoulder X-ray. The GP also found that Mr Druce's blood pressure was normal. Mr Druce had the X-rays at hospital on 20 October and no abnormalities were detected.

27. On 28 October, a nurse saw Mr Druce for a mental health check and hypertension review and noted that he had unexplained lost weight, though his blood pressure was normal. She requested blood tests and booked him a GP appointment. A prison GP saw Mr Druce three days later and noted that his blood test results showed signs of anaemia (a lack of red blood cells). She ordered repeat blood tests. On 8 November, she reviewed the results, which

indicated the presence of inflammation. A prison GP saw Mr Druce the following day and noted he had lost weight, was suffering increased constipation and had abnormal blood test results. The GP made an urgent two week colorectal (lower bowel specialist) referral, in line with national guidelines for suspected cancer.

28. On 11 November, Mr Druce reported diarrhoea and vomiting to a nurse, and she advised him to stay in his cell and drink fluids. She liaised with a prison GP, who advised her to keep Mr Druce under regular review and not to give him medication for loose stools or vomiting. On 14 November, a prison GP examined Mr Druce and noted that his diarrhoea and vomiting had settled. She prescribed rehydrating salts and booked him a review appointment for later that afternoon, but he failed to attend. A nurse contacted prison staff on the wing for an update and they reported that Mr Druce said he felt much better.

Events from Thursday 17 November 2016

29. At around 11.30am on 17 November, Mr Druce reported diarrhoea to prison staff and left the wing to attend healthcare. There is no record that he attended and it would appear that he later returned to the wing without comment. There is no record that prison or healthcare staff checked on Mr Druce when he returned to the wing.

30. At around 3.20pm, a prisoner found Mr Druce collapsed at the bottom of the stairs leading down from the wing landing and notified prison staff. (CCTV footage shows Mr Druce came down the stairs alone. He stumbled, briefly held on to a railing and dropped face first onto the floor.)

31. Three officers responded immediately and moved Mr Druce into the recovery position. One officer noticed that Mr Druce had blood around his mouth and called an immediate medical response over the radio network at 3.23pm. He called an emergency code red (which indicates that a prisoner has a suspected fracture or severe loss of blood) over the radio at 3.26pm. However, it would appear that this was quickly changed to an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems).

32. Within minutes, a Supervising Officer (SO) arrived and noticed that Mr Druce was unresponsive, but breathing. He collected a defibrillator from a nearby office but when he returned, Mr Druce's breathing had deteriorated. Suspecting that Mr Druce had had a heart attack, he fitted the defibrillator, which issued one shock, and started cardio pulmonary resuscitation (CPR). In the meantime, a nurse arrived and assisted with the resuscitation effort. The first response paramedic arrived 3.41pm and attended to Mr Druce. Additional paramedics subsequently arrived and they took Mr Druce to hospital by ambulance at 4.25pm. Two officers escorted him without restraints.

33. Hospital staff admitted Mr Druce to the urgent care unit and diagnosed an acute kidney injury with abnormal levels of blood salts and potassium, which resulted in a heart attack. Mr Druce briefly regained consciousness on 18 November but, despite efforts to balance his blood salts and aid his breathing, he suffered four more heart attacks. Hospital doctors consulted heart specialists at another hospital, but they were unable to provide further care as Mr Druce was not suitable for a heart transplant. Mr Druce remained on a ventilator.

34. Mr Druce's condition did not improve and, at around 1.15pm on 21 November, hospital doctors decided to stop all treatment. The ventilator was switched off at 2.20pm and Mr Druce died at 2.35pm.

Contact with Mr Druce's family

35. On 17 November, the prison assigned a prison manager as the prison's family liaison officer. He and the deputy family liaison officer attended the address of Mr Druce's partner, his nominated next of kin, to explain the situation and to offer support. The prison manager remained in contact with Mr Druce's partner and gave her details to hospital staff, so that she could call for updates on his condition. On 18 November at 6.25pm, the deputy family liaison officer contacted Mr Druce's partner to inform her that he was awake.

36. On 19 November, the deputy family liaison officer contacted Mr Druce's partner to advise her that he had suffered another heart attack. She remained in frequent contact with Mr Druce's partner over the next 24 hours and agreed to notify her of his death in person.

37. On 21 November at 4.30pm, the prison manager and deputy family liaison officer attended Mr Druce's partner's address to break the news of his death. They offered their condolences and support. They provided ongoing support to Mr Druce's family and attended his funeral, which was held on 21 December. The prison contributed towards the cost of the funeral in line with national policy.

Support for prisoners and staff

38. On 17 November, 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.

39. On 21 November, after Mr Druce's death, a prison manager debriefed the escort officers at the hospital to ensure that they had the opportunity to discuss any matters arising and to offer support. The staff care team also offered support.

40. The prison posted notices informing other prisoners of Mr Druce'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 Druce's death.

Post-mortem report

41. A post-mortem examination found that Mr Druce died from a myocardial infarction (a heart attack).

Findings

Clinical care

42. Mr Druce had a number of long-term health conditions that included osteoarthritis, asthma and hypertension. Healthcare staff managed these conditions well and gave Mr Druce advice to try to help him stop smoking.

43. The clinical reviewer noted that doctors appropriately reviewed Mr Druce when a routine blood test showed abnormalities in his blood and made an urgent hospital referral. When Mr Druce reported diarrhoea and vomiting healthcare staff appropriately consulted prison GPs and monitored his condition frequently. The clinical reviewer concluded that Mr Druce's acute kidney injury, presumably linked to dehydration related to the episode of diarrhoea and vomiting, could not have been anticipated.

44. The swift response from all those involved in the emergency response on 17 November, resulted in the successful resuscitation of Mr Druce. The clinical reviewer considered that the resuscitation attempt was good and commended staff for their prompt, appropriate and effective effort.

45. We are satisfied that, overall, the level of care Mr Druce received at Littlehey was good and was equivalent to that he would have expected to have received in the community.

Emergency code

46. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system based on the instruction. Littlehey's local policy instructs staff to call a code blue emergency to indicate when a prisoner is unconscious or having breathing difficulties and a code red when a prisoner has a severe loss of blood, severe burns or a suspected fracture. Calling either emergency medical code should automatically trigger the control room to call an ambulance.

47. An officer initially called an immediate medical response over the radio network. This meant that responding staff were not made aware of the seriousness of the situation and that the control room did not call an ambulance until he called an emergency code red. This caused a slight delay. When this report was sent to the Prison Service to check its factual accuracy, the prison maintained that the officer, who was first to attend the scene, thought Mr Druce was mumbling and therefore responsive, and that his call for medical assistance, rather than use of an emergency code, was appropriate. Having again reviewed the CCTV footage of the incident, we disagree that Mr Druce appeared responsive and consider that a medical emergency code should have been called straightaway.

48. While a code blue may have been more accurate in the circumstances, we recognise that Mr Druce was bleeding and that the code appears to have been changed promptly. Issuing the correct emergency code earlier would not have affected the outcome for Mr Druce, but in other circumstances, any delay in calling an ambulance and taking the correct medical equipment to an emergency could be crucial. We make the following recommendation:

The Governor 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.

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