Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Karim Zaman a prisoner at HMP Wayland on 13 December 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Karim Zaman died on 13 December 2015, of a heart attack, while a prisoner at HMP Wayland. He was 54 years old. I offer my condolences to Mr Zaman's family and friends.

Mr Zaman had several long-term health conditions, including high blood pressure and diabetes, both risk factors for cardiac disease, but these were not well managed in prison. More effective monitoring might not have prevented Mr Zaman's sudden death from a heart attack but I consider that there is a need for both prisons to manage long-term health conditions in line with community standards. When Mr Zaman collapsed, staff did not use an emergency code, which caused a slight delay in calling an ambulance and in bringing a defibrillator. I am satisfied that this did not affect the outcome for Mr Zaman, as staff responded well and promptly, but in other circumstances this could be crucial.

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 **June 2016**

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Summary

Events

1. On 17 August 2015, Mr Karim Zaman was remanded to HMP Elmley and was sentenced to six and a half years in prison on 28 August. On 30 September, he was transferred to HMP Wayland. Mr Zaman had several existing chronic health conditions, including type 2 diabetes, hypertension (high blood pressure) and high cholesterol.

2. At initial health screens at Elmley, healthcare staff recorded he had high blood pressure, was overweight, had previously smoked, and had raised blood sugar levels. A prison GP reviewed Mr Zaman and noted his community medical records but did not record that he had been diagnosed with diabetes. The GP re-prescribed medication for hypertension and high cholesterol. Healthcare staff did not draw up any care plans to manage Mr Zaman's chronic conditions.

3. At an initial health screen on 30 September, when Mr Zaman arrived at Wayland, a nurse noted that Mr Zaman had diabetes, hypertension and high cholesterol, and was taking medication for hypertension and high cholesterol.

4. On 1 October, a pharmacy technician reviewed Mr Zaman's medication, but recorded he had a 14 day supply of stomach medication, rather than for high blood pressure, and did not spot that the number of tablets left, indicating that Mr Zaman had not been taking them as prescribed. On 2 October, a nurse at a further health screen noted that Mr Zaman had a family history of diabetes. The nurse assessed him as fit to use the gym and referred him to a GP. On 6 October, a prison GP reviewed Mr Zaman. The computerised medical record system was not working and the GP requested, in writing, regular blood pressure monitoring, blood sugar and fasting blood tests. It does not appear that nurses saw this and there is no record that the monitoring or the blood tests ever took place and there were no care plans. Mr Zaman received no further medication for high blood pressure or to control his blood sugar levels at Wayland.

5. At approximately 11.20am on 13 December, Mr Zaman collapsed in the prison gym. Officers believed he was having a fit and phoned for healthcare staff. Nurses initially suspected a diabetic coma, but Mr Zaman's blood sugar level was normal. Mr Zaman then stopped breathing and nurses began cardiopulmonary resuscitation (CPR) immediately. Nurses asked for a defibrillator and shocked Mr Zaman three times, but he did not respond and they continued CPR. Paramedics arrived at 11.56am and took over emergency treatment. At 12.24pm, a paramedic recorded that Mr Zaman had died.

Findings

6. The clinical reviewer considered that healthcare staff should have implemented clear, personalised care plans to review and manage Mr Zaman's long-term health conditions and medication. Healthcare staff at both Elmley and Wayland did not manage Mr Zaman's health conditions in line with national guidelines. We cannot say that more effective monitoring would have prevented Mr Zaman's

sudden death from a heart attack, but it is important that prisons manage long-term health conditions in line with community standards.

7. A pharmacy technician at Wayland wrongly recorded Mr Zaman's medication and did not note that the amount of medication he had left indicated that he had not been taking it as prescribed. While it was Mr Zaman's responsibility to comply with his medication, this was a missed opportunity to advise him of the importance of taking it.

8. When Mr Zaman collapsed, officers and nurses responded promptly but officers did not initially use an emergency medical code. This caused a short delay in calling an ambulance and obtaining a defibrillator. While this does not appear to have affected the outcome for Mr Zaman, in other emergencies such a delay could be critical.

Recommendations

- The Heads of Healthcare at HMP Elmley and HMP Wayland should ensure that all patients with long-term health conditions have clear personalised care plans, with stated aims, planned interventions and monitoring, and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The Head of Healthcare at Wayland should ensure that pharmacy staff review and document medication in line with professional pharmacy standards.
- The Governor of HMP Wayland should ensure that in a life threatening situation prison staff use the appropriate emergency code which triggers the control room to call an ambulance immediately.

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