

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Follows a prisoner at HMP Stoke Heath on 25 August 2017

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*



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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr William Follows died on 25 August 2017 of myocarditis (inflammation of the heart) at HMP Stoke Heath. He was 75 years old. We offer our condolences to Mr Follows' family and friends.

Mr Follows died of a rare heart condition, with no record of any heart problems. We are satisfied that staff at Stoke Heath could not have predicted or prevented his death. The investigation found that Mr Follows' care was equivalent to that which he could have expected to receive in the community.

We did, however, identify some weaknesses in the emergency response. There was a short delay in calling an ambulance and a further delay getting a defibrillator to Mr Follows' cell after he was found collapsed. However, the delays were unlikely to have affected the outcome for Mr Follows.

This version of our report, published on our website, has been amended to remove the names of staff and prisoners involved in our investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

1. In June 2016, Mr William Follows was sentenced to five years imprisonment for firearms offences and sent to HMP Birmingham.
2. Mr Follows suffered from a number of long-term conditions including high blood pressure, high cholesterol and gout. Healthcare staff created appropriate care plans and saw Mr Follows to monitor his conditions, but he did not always take his medication and often failed to attend appointments.
3. On 14 October, Mr Follows was moved to HMP Stoke Heath. A nurse conducted an initial reception screen and recorded a high blood pressure reading. Over the next four months, healthcare staff saw Mr Follows frequently, often for gout, and occasionally took his blood pressure.
4. On 16 February 2017, a prison GP saw Mr Follows about a flare-up of gout and noted that his clinical observations, including his blood pressure, were normal. Mr Follows had minimal contact with healthcare staff over the next six months, though he did see nurses daily to collect his medication.
5. On 25 August, at 7.52am, an officer unlocked Mr Follows' cell and reminded him to collect his medication. Around 45 minutes later, an officer found him lying face down on the floor of his cell and called a nurse. She entered his cell, noted he did not have a pulse and called an emergency medical code at 8.48am. An ambulance was called at 8.51am. Two prison managers arrived and helped to move Mr Follows onto his back so that a nurse could start cardiopulmonary resuscitation (CPR). Healthcare staff arrived quickly with the emergency medical equipment, but did not bring a defibrillator. They left Mr Follows' cell to collect one and returned eight minutes later. Staff continued CPR until 9.30am, when a paramedic confirmed that Mr Follows had died.
6. The post-mortem showed that Mr Follows died from myocarditis (inflammation of the heart muscle).

Findings

7. We are satisfied staff could not have predicted or prevented Mr Follows' sudden death and that he received a standard of care equivalent to that which he could have expected to receive in the community.
8. We are concerned that staff did not take a defibrillator to Mr Follows' cell when responding to the emergency medical code blue and that control room staff did not call an ambulance immediately. Although this is unlikely to have affected the outcome in Mr Follows' case, it could be significant in other cases.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that control room staff should call an ambulance immediately and staff should take all appropriate medical equipment, including a defibrillator, to code blue emergencies.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Stoke Heath 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 Follows' prison and medical records.
11. The investigator interviewed three members of staff at Stoke Heath on 11 October 2017.
12. NHS England commissioned a clinical reviewer to review Mr Follows' clinical care at the prison.
13. We informed HM Coroner for Shropshire, Telford and Wrekin area of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The investigator wrote to Mr Follows' daughter 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.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HM Prison Stoke Heath

16. HMP Stoke Heath is a medium security prison in Shropshire holding up to 782 adult and young adult men. Primary care services are provided by Shropshire Community Health NHS Trust, secondary mental health services by South Staffordshire NHS Foundation Trust.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Stoke Heath was in April 2015. Inspectors reported that emergency resuscitation equipment and automated defibrillators were only available in the healthcare centre and had to be collected from there before responding to an incident, which could lead to delays. All nursing staff had undertaken mandatory training in this area but no custody staff were trained to use defibrillators.

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 30 April 2017, the IMB reported that a full range of medical services had been provided despite staff shortages.

Previous deaths at HMP Stoke Heath

19. Mr Follows was the third prisoner to die of natural causes at Stoke Heath since January 2017. There were no significant similarities between these deaths.

Key Events

20. On 13 June 2016, Mr William Follows was sentenced to five years imprisonment for firearms offences and sent to HMP Birmingham.
21. At an initial reception screen, a nurse noted that Mr Follows had a history of gout and hypertension (high blood pressure). A prison GP reviewed Mr Follows' medication and prescribed doxazosin and olmesartan (for high blood pressure), atorvastatin (for high cholesterol), and mirtazapine (an antidepressant). The next day, a nurse saw Mr Follows for a secondary health screen and recorded that he had high blood pressure. She confirmed that Mr Follows did not smoke or have a family history of heart disease and requested a follow-up review.
22. Over the next three months, healthcare staff saw Mr Follows to monitor and treat his chronic conditions and created multiple care plans. Records show that Mr Follows initially refused to take his blood pressure medication and that he often failed to attend appointments. On 25 September, a nurse saw Mr Follows to review his blood pressure care plan and noted that he did not report any concerns. There is no record of a blood pressure reading.
23. On 14 October, Mr Follows was moved to HMP Stoke Heath. A nurse conducted a health screen and recorded a high blood pressure reading. Three days later, a prison GP reviewed Mr Follows' medication, but did not see him in person. On 12 November, a nurse saw Mr Follows for a review and arranged for him to have an older person's health assessment on 16 November. However, staff did not provide Mr Follows with an appointment slip and he failed to attend. Healthcare staff continued to see him, often for gout, but there is no record that they offered him another older person's assessment or that they reviewed his care plans.
24. On 14 December, a prison GP reviewed Mr Follows' blood test results and noted that he had a slightly high cholesterol level. There is no record that he suggested any further action. Healthcare staff took Mr Follows' blood pressure when they could and evidence shows that his readings fluctuated between normal and high.
25. On 16 February 2017, a prison GP saw Mr Follows for an examination and recorded that his blood pressure, pulse and oxygen saturation level were all within the normal range. He diagnosed a flare up of gout and prescribed colchicine (a natural anti-inflammatory medication). Over the next six months, Mr Follows had minimal involvement with healthcare and did not report any concerns about his health. Prison GPs reviewed his prescriptions when required and nurses saw him daily to issue medication. However, there is no record that staff took Mr Follows' blood pressure or that they monitored his cholesterol level.

Events of 25 August

26. At 7.52am, an officer unlocked and entered Mr Follows' cell. He noticed that Mr Follows was still in bed and said, "good morning", before reminding him to collect his medication. Mr Follows' responded by saying "give me five minutes". In his statement, he said that Mr Follows presented as normal and that he did not have any concerns about him.

27. Around 45 minutes later, a nurse informed an officer that Mr Follows had not been to collect his medication. The officer said he would check on him. At 8.46am, he entered Mr Follows' cell and found him lying face down on the floor. He called the nurse, who was a short distance away on the wing. The nurse entered the cell and noticed Mr Follows did not have a pulse and, at 8.48am, called an emergency medical code blue (which indicates that a prisoner is unconscious or has breathing problems.). She tried to turn Mr Follows, but found this difficult due to his weight and the size of the cell. Control room staff called an ambulance at 8.51am.
28. In the meantime, two prison managers arrived and helped to move Mr Follows onto his back so the nurse could start cardiopulmonary resuscitation (CPR). The control room log indicates that additional healthcare staff arrived with the emergency medical equipment at 8.54am, but they did not bring a defibrillator. The nurse asked staff to collect a defibrillator, which arrived on the scene at 9.02am. Healthcare staff applied the pads to Mr Follows, but the device advised not to shock. An ambulance arrived at the prison at 9.04am, and three minutes later, a paramedic arrived at Mr Follows' cell to assist staff with CPR. The resuscitation attempt continued until 9.30am, when a paramedic pronounced that Mr Follows had died.

Contact with Follows' family

29. At 11.45am, a prison family liaison officer and her deputy attended the address of Mr Follows' daughter, his nominated next of kin. Two of Mr Follows' grandchildren met them at the front gate and said that their mother had gone shopping. The family liaison officer broke the news and one of the grandchildren phoned their father, who spoke to the family liaison officer's deputy and later went to collect his wife. At 12.45pm, Mr Follows' daughters arrived home clearly upset and asked them to leave. At 4.35pm, the family liaison officer contacted Mr Follows' daughter by phone to explain her role and to offer support.
30. The family liaison officer continued to provide support to Mr Follows' family and his funeral took place on 18 September. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

31. After Mr Follows' death, the prison's Governor 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.
32. The prison posted notices informing other prisoners of Mr Follows' 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 Follows' death.

Post-mortem report

33. A post-mortem examination found that Mr Follows had died of giant cell and granulomatous myocarditis (inflammation of the heart muscle).

Findings

Clinical care

34. Mr Follows did not have a significant amount of contact with healthcare staff at Stoke Heath and mainly saw them to collect his medication and following a flare-up of gout. He did not display any symptoms suggestive of a heart condition and there is no evidence that he complained of any symptoms that may have suggested problems with his heart, such as chest pain or shortness of breath.
35. The clinical reviewer considered that overall, the care Mr Follows received at Stoke Heath was equivalent to that which he could have expected to receive in the community.

Emergency response

36. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Stoke Heath's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.
37. We are satisfied that the officer responded quickly when he noticed that Mr Follows had collapsed and alerted a nurse, who used an appropriate emergency medical code. However, staff in the control room did not call an ambulance immediately in line with prison policy. Instead, they asked for confirmation that an ambulance was required, which delayed the calling of an ambulance by three minutes.
38. Evidence from the ambulance log and an operational support grade confirms that paramedics were allowed swift entry to the prison. However, the control room log suggests there was a 19-minute delay before an ambulance was allowed access. While we are satisfied that there was no delay, control room staff should ensure that the log is filled in correctly.
39. Although we agree with the clinical reviewer that prison and healthcare staff managed the emergency response well, we are concerned that the healthcare staff who responded to the emergency code blue did not bring a defibrillator. They had to leave Mr Follows' cell to collect the defibrillator, which meant that this piece of equipment was not available until 14 minutes after the emergency code had been called. PSI 03/2013 requires staff to bring all equipment relevant to the nature of the emergency. A nurse told the investigator that although defibrillators were located throughout the prison and that a device was kept with the emergency equipment, staff did not always take one to a code blue. A defibrillator is a critical piece of life saving equipment that we consider should be taken every time an emergency code blue is called.

40. While quicker access to a defibrillator and the immediate calling of an ambulance would not have changed the outcome for Mr Follows, in other emergency situations it could be crucial. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that control room staff should call an ambulance immediately and staff should take all appropriate medical equipment, including a defibrillator, to code blue emergencies.

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