Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Pembridge a prisoner at HMP Leyhill on 28 April 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 Jonathan Pembridge died on 28 April 2017 of ischaemic heart disease at HMP Leyhill. His diabetes was a contributing factor. Mr Pembridge was 48 years old. We offer our condolences to Mr Pembridge's family and friends.

There was no indication in the prison medical records that Mr Pembridge had presented with any signs of heart disease. His death from ischaemic heart disease could not have been foreseen by healthcare staff. We are satisfied that the care he received for his diabetes was equivalent to that which he could have expected to receive in the community.

We are concerned, however, that there was a delay of five minutes in calling an ambulance. An ambulance should have been called as soon as prisoners alerted staff that Mr Pembridge had collapsed. We are also concerned that no representative from healthcare attended the medical emergency. The clinical reviewer found that this aspect of Mr Pembridge's care was not equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2017**

Contents

Summary 1
The Investigation Process 2
Findings 8

Summary

Events

1. Mr Jonathan Pembridge arrived at HMP Leyhill on 26 September 2016, having been sentenced to 16 years imprisonment for sexual offences in March 2010. He had type 1 (insulin controlled) diabetes, but was very poor at keeping his blood sugar levels in the appropriate range.

2. On 28 April 2017, at around 3.35pm, a prisoner heard Mr Pembridge collapse in the education block toilets. He alerted another prisoner, who telephoned the prison's communications room and asked for help. A member of prison staff radioed for the prison duty manager to attend the education block, but did not give a reason. When the prison manager arrived he radioed a request for an ambulance, which was called at 3.40pm. The ambulance arrived at 3.51pm. Paramedics were unable to resuscitate Mr Pembridge and he was confirmed dead at 4.25pm. The post-mortem showed he died from ischaemic heart disease.

3. The only member of healthcare staff on duty that day, a healthcare assistant, was not carrying a radio and did not become aware of the medical emergency until after the paramedics had arrived.

Findings

4. There is no indication in the prison medical records that Mr Pembridge had presented to healthcare staff with any signs of heart disease. His death from ischaemic heart disease could not have been foreseen. The clinical reviewer found that the standard of diabetes care Mr Pembridge received at Leyhill was equivalent to that which he could have expected to receive in the community.

5. The prison's emergency response was poor and resulted in a delay of five minutes in calling an ambulance. Staff should have called a medical emergency code as soon as they were told that Mr Pembridge had collapsed. Although the duty manager asked for an ambulance to be called when he arrived at the scene, he did not use a medical emergency code. Even had he done so, the only member of healthcare staff on duty would have been unaware because she was not carrying a radio. The clinical reviewer found that the failure of the member of healthcare staff on duty to attend the medical emergency was not equivalent to community care.

Recommendations

- The Governor should ensure that communications room staff are authorised to call a medical emergency code and request an ambulance without the need for management or healthcare authorisation.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate medical emergency code.
- The Head of Healthcare should ensure that if there are limited staff on duty at least one should be a registered nurse, who should always carry a prison radio so they are able to respond to medical emergencies.

The Investigation Process

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

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

8. The investigator interviewed five members of staff at Leyhill, on 15 and 26 June 2017.

9. NHS England commissioned a clinical reviewer to review Mr Pembridge's clinical care at the prison. He attended all prison interviews.

10. We informed HM Coroner for Avon of the investigation who gave us a copy of the post-mortem report. We have sent the coroner a copy of this report.

11. The investigator wrote to Mr Pembridge's brother on 10 May 2017, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. We did not receive a response to this letter.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Leyhill

13. HMP Leyhill is an open prison in South Gloucestershire, holding up to 515 prisoners who require minimum security. Some are life sentence prisoners preparing for release.

14. Inspire Better Health, a partnership of eight health care providers led by Bristol Community Health, provides all health and substance misuse services. Primary care services are available from 8am to 4pm, Monday to Friday. A local NHS centre, Hanham Health, provides GP and out of hours services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Leyhill was in September 2016. Inspectors reported that Leyhill was, overall, a safe and decent establishment. In terms of its healthcare provision, the inspection found that a small team of experienced nurses ran effective clinics for most long term conditions and GPs ran one for heart disease. Healthcare staff were easily identifiable and their interactions with prisoners were professional and compassionate. They were in date with all mandatory training and had good access to appraisals and clinical supervision.

Independent Monitoring Board

16. 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 2017, the IMB reported that Leyhill was, overall, a safe and decent establishment. The Board considered that healthcare services provided were at least as good as those available in the outside community.

Previous deaths at HMP Leyhill

17. Mr Pembridge is the eighth person to die from natural causes since 2015. We have previously made a recommendation to address delays in calling an ambulance.

Key Events

18. On 24 March 2010, Mr Jonathan Pembridge was sentenced to 16 years in prison for sexual offences. He was sent to HMP Gloucester. Mr Pembridge had type 1 (insulin controlled) diabetes and had had a below the knee amputation as a result of a motorbike accident in 1990. He later developed phantom limb syndrome (the ability to feel sensations and even pain in a limb or limbs that no longer exist).

19. In 2011, after repeated chest infections which resulted in coughing fits causing him to pass out, Mr Pembridge was diagnosed with chronic obstructive pulmonary disease (COPD - a collection of lung diseases including chronic bronchitis and emphysema). This was treated with steroids, antibiotics and asthma inhalers. Mr Pembridge was moved to HMP Albany on 12 April 2011.

20. During a diabetic review on 25 June 2012, Mr Pembridge told a nurse that he had been a diabetic for over 15 years. The nurse noted that he appeared to have an understanding of his condition and its management, but continued to take sugar, eat cakes and chocolate, all foods not suited to a diabetic. He explained the potential risks of continuing to eat such foods and also gave stop smoking advice. Mr Pembridge agreed to choose healthier options.

21. Mr Pembridge was moved to HMP Ashfield on 31 July 2013. While at Ashfield, Mr Pembridge's blood sugars remained high. On 20 August 2013, Mr Pembridge had a diabetic review with a nurse. He explained that ever since he was diagnosed, he had had high blood sugars. He found that if he had a blood sugar of 9 or below he felt wobbly and would need to have a cup of tea with sugar. (An ideal blood sugar level should be between 4-7mmol.) Mr Pembridge admitted to reducing his insulin to keep his blood sugars elevated. The nurse explained the risks of doing so and the effect of having uncontrolled blood sugar levels. Mr Pembridge continued to monitor his own blood sugar levels with regular advice and guidance from healthcare staff. Mr Pembridge also attended the prison's diabetic clinic every six months.

22. After a review in the diabetic clinic on 4 November 2014, Mr Pembridge's insulin regime was changed. Mr Pembridge said he was keen to reduce his sugar levels and agreed to try 'basal-bolus' insulin therapy. (Basal-bolus insulin therapy - also called intensive insulin therapy - uses long-acting (basal) and mealtime (bolus) insulin together to closely mimic the body's normal insulin pattern throughout the day.)

23. Mr Pembridge's insulin regime was again changed in March 2016 when he attended hospital for a specialist diabetic review. Despite advice and encouragement from healthcare staff, Mr Pembridge's HbA1c levels remained high, ranging from 101 – 144mmol. (HbA1c is a measure of the average blood glucose level over the previous 3 months. An ideal level would be 20-42mmol.)

24. Mr Pembridge was moved to HMP Leyhill on 26 September 2016. On 2 December, Mr Pembridge had a diabetic review with the nurse manager. She gave stop smoking advice but Mr Pembridge said he had no interest in giving up or cutting down. Mr Pembridge's HbA1c was raised at 108 mmol and he admitted to her that he had a sweet tooth and liked to eat puddings after his

meals. Diet and lifestyle advice was given and he was told to try to limit his sweet treats to once a week, or reduce portion sizes, given his very poor control.

25. Mr Pembridge's insulin regime was 14units levemir BD and four units of novorapid at mealtimes. He was asked to increase his novorapid by two units and increase levemir by two units every three days until he found a good balance with his sugar levels. The nurse manager asked Mr Pembridge to keep a weekly food diary and to record his blood sugar levels for her to review.

26. On 12 December, Mr Pembridge saw the nurse manager for a diabetic review. His blood sugar levels had improved and he told her that he was feeling much better for it. She noted that his sugar levels had "come down from the 20's to the 10's and some readings were now within normal range".

27. Mr Pembridge continued to monitor his blood sugar levels and record a weekly food diary. His morning levels were now within a normal range, but he admitted that he was still making some poor food choices resulting in higher readings in the afternoon after lunch.

28. On 21 February 2017, the nurse manager noticed that Mr Pembridge's sugar levels were mostly in double figures. He was still feeling well in himself with "no symptoms of micro/ macro vascular risks associated with poor control". She reiterated the importance of a good diet to aid blood sugar levels to reduce the risk of vascular complications associated with poor diabetes control.

28 April 2017

29. On 28 April, Mr Pembridge attended his Independent Living Skills class in the prison Education Department. He had attended this class for a number of months and the aim was to help him prepare for his eventual release from prison. This was his final class and prisoners had been asked to prepare and cook their favourite meals to celebrate completing the course.

30. Mr Pembridge cooked and then ate soup and bread, steak and chips and then trifle. At around 3.15pm, the tutor left the room to allow everyone to complete an end of course assessment questionnaire in private. Once completed, Mr Pembridge and the other prisoners left the classroom. On the way out of the education department Mr Pembridge entered the toilets.

31. A prisoner (from a different class) went to the toilet at roughly 3.35pm. He heard laboured breathing coming from one of the toilet cubicles. It sounded like someone had a wheezy chest and then he heard a loud bang and the sound of someone falling to the floor. He went to the maths classroom and told the teacher that someone had collapsed.

32. The prisoner then shouted to the Education Orderly, a prisoner, who was sitting on the reception desk, that there was 'a man down' and help was needed. The telephone on his desk connected to the communications room. He telephoned an OSG, explaining that a prisoner had collapsed in the toilet and they needed help.

33. The OSG radioed the duty prison manager (Oscar 1) and asked him to attend the education block. He did not tell the manager why he was required to attend.

When the manager arrived he found prisoners removing the door to the toilet cubicle, as Mr Pembridge had collapsed behind the door blocking access. As soon as he realised what had happened he radioed communications saying, “Oscar 1, ambulance to education please”. The OSG called an ambulance immediately at 3.40pm.

34. The duty prison manager helped to move Mr Pembridge out of the toilet cubicle. He was not breathing, so he started cardiopulmonary resuscitation (CPR). When a defibrillator was attached it advised ‘no shock’ (meaning no heart rhythm was detected). He continued CPR with a prisoner’s assistance.

35. The ambulance arrived at 3.51pm. Mr Pembridge’s throat was blocked with vomit and food and paramedics were unable to insert an airway. His blood sugar level was recorded as high, showing he was hyperglycaemic. The Helicopter Emergency Medical Service (HEMS) critical care team arrived at 4.10pm. The HEMS crew was unable to resuscitate Mr Pembridge and at 4.25pm a paramedic doctor confirmed Mr Pembridge’s death.

36. All healthcare staff were attending training at HMP Eastwood Park (roughly a ten minute drive away), apart from a healthcare assistant who had been asked to stay behind to dispense medication. The healthcare receptionist told the investigator she received a call from the OSG to say that someone was unwell in education (the OSG did not recall making this call). She asked the healthcare assistant if she should advise them to call an ambulance given there were no nurses on site, and she confirmed she should.

37. The healthcare assistant saw the healthcare receptionist roughly 20 minutes later when she said that an officer had come to healthcare asking for a printout of Mr Pembridge’s medical record as the “defib hadn’t worked”. She made her way to the education block with the healthcare defibrillator. However, on her arrival she saw the HEMS critical care team arrive so returned to healthcare.

38. Paramedics were unable to resuscitate Mr Pembridge and he was confirmed dead at 4.25pm.

Contact with Mr Pembridge’s family

39. A family liaison officer (FLO) telephoned Mr Pembridge’s uncle, his next of kin, at 5.15pm on 28 April to tell him that Mr Pembridge had died. She spoke to him again on 1 May, once he had had a chance to speak to the rest of Mr Pembridge’s family, to offer support and answer any questions he had. He asked that a visit from the prison Governor did not take place and said that he would like Mr Pembridge’s brother to act as the new next of kin.

40. The FLO spoke to Mr Pembridge’s brother on 2 May. He was happy for the prison to assist with the funeral arrangements. The prison contributed to the cost of Mr Pembridge’s funeral in line with national policy.

Support for prisoners and staff

41. After Mr Pembridge’s death, the 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.

42. The prison posted notices informing other prisoners of Mr Pembridge'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 Pembridge's death.

Post-mortem report

43. The post-mortem report shows that Mr Pembridge died from ischaemic heart disease. Diabetes mellitus was a contributing factor.

Findings

Diabetes Management

44. Despite receiving regular advice about diet, exercise and smoking from both prison healthcare staff and his hospital consultant, Mr Pembridge was poor at managing his diabetes. The nurse manager explained at interview that healthcare staff were of the view that it was a lifestyle choice and that he chose to enjoy foods that he knew were not good for him.

45. The clinical reviewer found that the standard of care Mr Pembridge received for his diabetes was equivalent to that which he could have expected to receive in the community.

Ischaemic Heart Disease

46. The post-mortem report showed that Mr Pembridge had "very severe coronary artery disease affecting each of the three main coronary vessels", with "evidence of scarring in the heart muscle indicative of at least one ischaemic event some time previously".

47. The pathologist comments that it is well recognised that 'silent' myocardial infarctions (heart attacks) can occur in people with diabetes (i.e. heart attacks that do not produce the classical chest pain presentation and may go unnoticed by the patient). He also stated that it is well recognised that a large meal and the associated redistribution of blood to the gut to aid digestion can precipitate cardiac events in patients with pre-existing heart disease. Mr Pembridge had just had a large meal before he collapsed.

48. There is no indication in the prison medical records that Mr Pembridge had ever presented to healthcare staff with any signs of heart disease while at Leyhill. His death from ischaemic heart disease could not have been foreseen.

Emergency Response

49. There was a delay of five minutes in calling an ambulance. A prisoner raised the alarm at 3.35pm, but an ambulance was not called until 3.40pm when the prison manager arrived at the education block, having been asked to go there by the OSG in the communications room.

50. The OSG explained that he did not call an ambulance before this as a code blue (the medical emergency code used when a prisoner is unconscious or having difficulty breathing, which instructs the communications room to call an ambulance) had not been called and he had to wait for either healthcare or a prison manager to give him the instruction to do so. He also said he was conscious that his radio call to the manager could be heard by all in the prison, so for reasons of privacy he did not give any details of the collapse when he asked him to go to the education block. This meant that the manager was unaware of the emergency until he arrived there.

51. Prison Service policy requires staff to radio a medical emergency code when they encounter a prisoner in a life threatening situation. This should alert staff, including healthcare, and trigger the immediate calling of an ambulance. This did

not happen in Mr Pembridge's case. After he collapsed in the education block a prisoner alerted the Education Orderly, who in turn called the communications room. At this point an emergency code blue should have been called and an ambulance requested. This would have alerted prison and healthcare staff that there was a medical emergency. Instead, the manager arrived at the education block, unaware of what had happened. Although he asked for an ambulance to be called as soon as he arrived, he did not radio a medical emergency code. We make the following recommendations:

The Governor should ensure that communications room staff are authorised to call a medical emergency code and request an ambulance without the need for management or healthcare authorisation.

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate medical emergency code.

52. All members of healthcare staff were on a training course at another prison on 27 April, apart from a healthcare assistant who was not carrying a radio. (The nurse manager told us at interview that from previous learning, to avoid medication errors, staff dispensing medication do not carry radios. She also said that 28 April was the only occasion in 12 months when there was not a registered nurse on site during standard hours.)

53. Following Mr Pembridge's collapse, a medical emergency code blue was not called but we are concerned that if it had been, the only member of healthcare staff on duty would have been unaware because she was not carrying a radio. Since Mr Pembridge's death, the healthcare assistant now chooses to carry a radio. She explained that while this is not a requirement (and the radio she carries is not a healthcare specific radio) she feels happier being able to hear what is going on in the prison while on duty.

54. Healthcare staff are on duty at Leyhill between 8am and 4pm Monday to Friday. It is important that healthcare staff can respond quickly to medical emergencies during those times and a qualified nurse should be available to attend. The clinical reviewer found that the failure of healthcare staff to attend the medical emergency following Mr Pembridge's collapse was not equivalent to the care he could have expected to receive in the community. The clinical reviewer found that the healthcare assistant's decision not to attend the scene when she saw the paramedics and HEMS team already there was not equivalent care. He found that as the healthcare representative, she had a responsibility to be present in case there was a need to co-ordinate transfer to hospital and to be present to support staff if necessary.

55. We make the following recommendation:

The Head of Healthcare should ensure that if there are limited staff on duty at least one should be a registered nurse, who should always carry a prison radio so they are able to respond to medical emergencies.

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