Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Slevin a prisoner at HMP Buckley Hall on 20 February 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 Michael Slevin died of heart disease in hospital on 20 February 2017 while a prisoner at HMP Buckley Hall. He was 63 years old. I offer my condolences to his family and friends.

We are satisfied that Mr Slevin received a good standard of clinical care at Buckley Hall. The post-mortem examination found Mr Slevin had heart disease, which was not known before he died. Although we are satisfied that there was nothing healthcare staff could have done to predict or prevent Mr Slevin's sudden death, there was a deficiency in the emergency response.

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 **January 2018**

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Summary

Events

1. On 5 May 2016, Mr Michael Slevin was sentenced to six years in prison for violent offences. On 26 May 2016, he was moved from HMP Manchester to HMP Buckley Hall.

2. At his initial health screen, a nurse noted that Mr Slevin was a healthy weight, smoked up to 20 cigarettes per day and had a history of alcohol misuse. He declined smoking cessation advice and support from the drug and alcohol recovery team (DART).

3. There are few significant entries in Mr Slevin's medical record.

Events of 19 and 20 February 2017

4. On the evening of 19 February, an officer locked Mr Slevin's cell. Mr Slevin did not complain of any pain and did not say that he felt unwell.

5. The next morning, Mr Slevin was talking to a prisoner when he suddenly felt unwell and collapsed. Another prisoner alerted an officer, who responded immediately and noticed Mr Slevin was unresponsive but breathing. The prisoner who alerted the officer had placed him in the recovery position. At 8.26am, the officer immediately radioed a medical emergency code blue (which indicates that a prisoner has difficulty breathing). The North West Ambulance Service log confirmed that they received a call for an ambulance at 8.26am.

6. A nurse and healthcare assistant responded to the code blue, and attended Mr Slevin's cell. They administered oxygen. They had not brought the defibrillator with them and the nurse had to ask for it. However, Mr Slevin became agitated and the nurse could not apply the defibrillator. The nurse then asked for the ambulance to be prioritised. A first responder arrived at his cell at 8.35am and paramedics arrived at 8.42am. The paramedics monitored Mr Slevin in his cell, though they were unable to take his full clinical observations because he was being combative and was very distressed. The paramedics gave Mr Slevin aspirin and sodium chloride but were unable to give him morphine or use a glyceryl trinitrate spray. At 9.30am, the paramedics took Mr Slevin to hospital and they arrived at the hospital ten minutes later. Mr Slevin had a cardiac arrest at hospital and died at 10.55am.

Findings

Clinical care

7. The clinical reviewer concluded that the standard of care Mr Slevin received was equivalent to that which he could have expected to receive in the community. He did not display any symptoms associated with heart disease. We are satisfied that healthcare staff treated him appropriately and there was nothing that healthcare staff could have done to prevent his death.

Emergency response

8. There was a delay obtaining the defibrillator, which did not affect Mr Slevin's treatment. However, in other circumstances, this delay could be significant.

9. We are satisfied that the officer promptly called a code blue emergency when they found that Mr Slevin had collapsed and that the prison's control room immediately called for an ambulance.

Recommendation

- The Governor and Head of Healthcare should ensure that:
    - Healthcare staff routinely bring all necessary emergency equipment with them to the scene of an emergency.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Buckley Hall informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

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

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

13. We informed HM Coroner for Greater Manchester North of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Slevin's wife to explain the investigation. As she was not aware of the full circumstances of Mr Slevin's death, she did not have any specific matters for the investigation to consider.

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

16. Mr Slevin's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Slevin's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

17. The final report was shared with HMPPS. HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Buckley Hall

18. HMP Buckley Hall is a medium security prison which holds just over 400 men. There are four residential blocks, one of which is a dedicated drug recovery wing. Manchester Mental Health and Social Care Trust provide healthcare seven days a week, with a multidisciplinary team of GPs, general and mental health nurses.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Buckley Hall was in June 2016. Inspectors reported that the Head of Healthcare was an advanced nurse practitioner who provided effective leadership to a small team of healthcare professionals with a reasonable range of competencies. They found that not all healthcare staff were up to date with mandatory training, and not all received regular, documented clinical supervision. Primary care services were appropriate for the prison population and met their needs.

20. The prison had recently introduced a well man screening clinic to attract new patients. Access to GPs had improved since the last inspection and was similar to that in the community with out-of-hours cover. Healthcare staff visited patients in the segregation unit daily. The prison had developed palliative care policies but these were rarely required.

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 July 2016, the IMB reported that primary care services were considered generally good. The waiting time for prisoners to see a doctor or dentist was low and much improved compared to the figures recorded in the IMB's previous annual report. The healthcare department has policies in place for adult safeguarding and for managing prisoners who need palliative care.

Previous deaths at HMP Buckley Hall

22. Mr Slevin was the third prisoner to die from natural causes at Buckley Hall since January 2015. There has been one death since. There were no significant similarities between the investigations.

Key Events

23. On 5 May 2016, Mr Michael Slevin was sentenced to six years in prison for violent offences. On 26 May, he moved from HMP Manchester to HMP Buckley Hall.

24. At his initial health screen, a nurse noted that Mr Slevin was a healthy weight, he smoked up to 20 cigarettes per day and he had a history of alcohol misuse. Mr Slevin declined smoking cessation advice and support from the drug and alcohol recovery team (DART).

25. A nurse from the mental health team assessed Mr Slevin. He noted that Mr Slevin had severe depression due to a car accident. He had tried to take his own life on several occasions, including an overdose two years earlier. The nurse referred him to the mental health team, but he did not want to engage with them. A prison GP reviewed Mr Slevin and prescribed paroxetine, an antidepressant. Mr Slevin was also prescribed co-codamol for headaches, naproxen for arthritic pain and omeprazole to prevent stomach irritation caused by naproxen.

26. There are few significant entries in Mr Slevin's medical record. In June, he was referred to hospital for a biopsy and removal of a tissue tag in his mouth. A nurse offered Mr Slevin a bowel screening on 27 November, which he declined. After suffering a fall on 3 December, Mr Slevin had a tooth extracted on 5 December.

27. On 19 December 2016, the mouth tissue biopsy produced a normal result and Mr Slevin cancelled a follow-up appointment.

Events of 19 and 20 February 2017

28. On the evening of 19 February, an officer locked Mr Slevin's cell. He did not report any pain or that he felt unwell.

29. At 8.00am on 20 February, the wing was unlocked. Mr Slevin was chatting to a prisoner, when he suddenly felt unwell. He told the prisoner that he did not feel right and said he was not going to work. He sat down to take his boots off. At that point another prisoner was walking past and saw Mr Slevin fall from the chair.

30. At approximately 8.25am, a prisoner shouted to an officer on the landing below that Mr Slevin had collapsed.

31. The officer immediately went into Mr Slevin's cell. The prisoner had placed him in the recovery position. She saw that Mr Slevin had been incontinent of urine and that he was unresponsive but breathing. At 8.26am, she immediately radioed a medical emergency code blue emergency (which indicates that a prisoner is having difficulty breathing). The North West Ambulance Service log confirmed that they received a call for an ambulance at 8.26am.

32. A nurse and a healthcare assistant responded to the code blue, and attended Mr Slevin's cell with an emergency bag and oxygen. The nurse immediately administered oxygen to Mr Slevin and asked an officer to collect the defibrillator from the wing office. At the office, the officer asked a nurse for the defibrillator. The nurse collected a defibrillator, an emergency bag and oxygen and went with

the officer to Mr Slevin's cell. As they arrived, Mr Slevin became agitated and vomited and the defibrillator could not be applied. The nurse asked the control room to prioritise an ambulance and with the healthcare assistant tried to move Mr Slevin onto his bed. At 8.35am, a first responder arrived at Mr Slevin's cell and the paramedics arrived seven minutes later.

33. Paramedics monitored Mr Slevin in his cell, though they were unable to take his full clinical observations because he was being combative and was very distressed. The paramedics gave Mr Slevin aspirin and sodium chloride, but were unable to give him morphine or use a glyceryl trinitrate spray. At 9.30am, the paramedics took Mr Slevin to hospital and they arrived at the hospital ten minutes later. At hospital, Mr Slevin had a cardiac arrest and died at 10.55am.

Contact with Mr Slevin's family

34. When Mr Slevin was taken to hospital, a senior manager notified Mr Slevin's wife.

35. The prison immediately appointed an officer as the family liaison officer, and she arrived at the hospital at 11.30am with the senior manager. They offered their condolences and remained in contact with Mr Slevin's wife. Mr Slevin's funeral took place on 8 March. The prison service contributed to the cost of his funeral in line with national policy.

Support for prisoners and staff

36. After Mr Slevin's death a senior 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.

37. The prison posted notices informing other prisoners of Mr Slevin'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 Slevin's death.

Post-mortem report

38. The post-mortem examination concluded that Mr Slevin died of ischaemic heart disease.

Findings

Clinical care

39. The clinical reviewer concluded that the standard of care Mr Slevin received was equivalent to that which he could have expected to receive in the community. He had little interaction with healthcare while at Buckley Hall and although a smoker, he did not display any symptoms associated with heart disease. We are satisfied healthcare staff treated him appropriately. Mr Slevin's death was sudden and unexpected and there was nothing that healthcare staff could have done to prevent it.

Emergency response

40. We agree with the clinical reviewer that although a delay obtaining a defibrillator did not affect Mr Slevin's treatment, as he was breathing and had not gone into cardiac arrest, it could be significant in different circumstances.

41. When Mr Slevin became unwell, the responding officer appropriately called a code blue. We are also satisfied that the log from the North West Ambulance Service shows that the prison's control room immediately called for an emergency ambulance. In relation to the delay in obtaining the defibrillator, we make the following recommendation:

    The Governor and Head of Healthcare should ensure that:

    - **Healthcare staff take all necessary equipment when responding to a medical emergency code blue.**

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