Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Moorman a prisoner at HMP Leyhill on 28 August 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*

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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 Mark Moorman died on 28 August 2016 of a heart attack related to chronic obstructive pulmonary disease at HMP Leyhill. Mr Moorman was 41 years old. I offer my condolences to Mr Moorman's family and friends.

The clinical reviewer concluded that the care Mr Moorman received was equivalent to that which he could have expected to receive in the community. However, I am disappointed that the first officer on the scene did not use an emergency code and an ambulance was not called much sooner.

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. Mr Mark Moorman received an initial sentence of four and a half years in prison for robbery. He was released on licence on 19 November 2010 and recalled in November 2014. On 27 November 2014, he was sentenced to 28 days in prison for acquisitive offences to run concurrently with his previous sentence and was sent to HMP Exeter. Mr Moorman was transferred to HMP Leyhill on 2 November 2015 after spending a period in Dartmoor.

2. Mr Moorman had a history of substance misuse and asthma. A nurse assessed him on his arrival at Leyhill, gave advice about his asthma and smoking cessation and a doctor prescribed an inhaler. He had an asthma review on 14 December and a doctor prescribed a new inhaler.

3. On 9 August 2016, Mr Moorman had a severe asthma attack and told staff he had not been carrying his inhalers with him as he had not had any recent symptoms. Staff called an ambulance, but he recovered and did not go to hospital. Paramedics and a healthcare nurse thoroughly assessed him and reminded him to attend an asthma review booked for the 17 August. Mr Moorman cancelled the appointment. Another was made for September. Staff did not record the reason for the cancellation or whether they explained the importance of attending appointments.

4. On the evening of 26 August, at approximately 11.00pm, prisoners alerted an officer that Mr Moorman was having severe breathing difficulties. The officer attended, phoned the control room and requested an ambulance. The Senior Officer (SO) in the control room asked him to get more information about Mr Moorman and his condition before she called an ambulance, which the officer did. The SO called an ambulance at 11.23pm. Paramedics attended at 11.50pm. Ten minutes later Mr Moorman had a cardiac arrest and was taken to hospital. He was on a life support machine for two days but died on 28 August.

Findings

5. The clinical reviewer concluded that the care Mr Moorman received was equivalent to that he could have expected to receive in the community. Nonetheless, healthcare staff could have done more to find out and record why Mr Moorman cancelled an asthma review nine days before he collapsed.

6. We are concerned that an emergency code was not called by the officer who was first on the scene when Mr Moorman collapsed and that the SO in the control room asked the officer for more information before requesting an ambulance.

Recommendations

- **The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensures the control room calls an ambulance immediately when an emergency code is used.**

The Investigation Process

7. 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.

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

9. The investigator interviewed one member of staff and three prisoners at Leyhill on 9 September 2016.

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

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

12. One of the Ombudsman's family liaison officers contacted Mr Moorman's step mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not respond.

13. Mr Moorman's mother was informed the initial report was available, but did not wish to receive a copy or make any comment.

14. 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

HMP Leyhill

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

16. 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 7.30am to 4.30pm, Monday to Friday. A local NHS centre, Hanham Health, provides GP and out of hours services.

HM Inspectorate of Prisons

17. 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. However, after the inspection the Care Quality Commission issued a 'Requirement to Improve' notice. It related to a regulation concerning 'Person-Centred Care' and specifically Agincare's, (a sub contracted care provider), failure to complete and review patient records.

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 January 2016, the IMB reported that there was a high standard of healthcare, with access to GPs every weekday. Prisoners with chronic illnesses received a care plan booklet explaining their condition, medication and test results, with sections to record their own comments.

Previous deaths at HMP Leyhill

19. Mr Moorman was the sixth prisoner to die at Leyhill from natural causes since the beginning of 2015. There are no similarities with this case.

Key Events

Clinical care

20. Mr Mark Moorman's initial sentence was for four and a half years in prison for robbery. He was released on licence on 19 November 2010 and recalled in November 2014. On 27 November 2014, he was sentenced to 28 days for acquisitive offences to run concurrently with his previous sentence and was sent to HMP Exeter. Mr Moorman was transferred to HMP Leyhill on 2 November 2015 after a period in Dartmoor. He had a history of substance misuse and asthma.

21. On 3 November, a nurse completed Mr Moorman's initial health screen. She recorded that he had asthma and was a smoker and that she gave him advice about both. She checked his respiratory rate which was normal. On 17 November a prison GP prescribed salbutamol (an inhaler he had been previously prescribed).

22. On 14 December, a nurse saw Mr Moorman for an asthma review. He said he had given up smoking four weeks ago, asked for a new 'preventer' inhaler (salbutamol is a 'reliever' inhaler) and demonstrated that he knew how to use one. A prison GP prescribed Qvar 50 the same day.

23. Apart from a cut to his eye in December 2015, nothing of note happened until 29 July 2016 when a prison GP prescribed more Qvar 50.

24. In the early hours of 9 August 2016, officers called the out of hours doctor because Mr Moorman could not catch his breath. The GP advised them to request an ambulance, but when it arrived Mr Moorman had recovered.

25. A nurse saw Mr Moorman later that morning after the incident. Mr Moorman told her that he had not had his reliever inhaler with him at the time as his symptoms had recently been under control. She told Mr Moorman to carry his inhaler at all times. She conducted a comprehensive asthma review, which included advising him to stop smoking again and educating him how better to use his inhaler. She noted he had another review already booked for the 17 August and told him to keep his appointment. Mr Moorman saw a prison GP later that morning and she prescribed another salbutamol inhaler.

26. On 17 August 2016, Mr Moorman cancelled the appointment for his asthma review. Staff did not ask or record why he cancelled the appointment. A new appointment was made for 5 September.

27. On 22 August, Mr Moorman saw a Healthcare Assistant for a pre-release appointment. She took a full set of observations, including his respiratory rate and oxygen saturation levels, all of which were in the normal range.

The Emergency Response

28. Just after 11.00pm on 25 August, two prisoners were in the wing kitchen when they saw Mr Moorman walk past with an inhaler in one hand and his other hand held to his chest. He was walking slowly and sat on a bench outside it. One of the prisoners asked him if he was okay and Mr Moorman pointed to his throat. One of the prisoners went straight to the wing office to get an officer and the other went to get Mr Moorman's friend (another prisoner).

29. The prisoner returned with Mr Moorman's friend before the officer arrived. Mr Moorman was very pale. He tried to stand up as Officer A arrived and promptly collapsed forwards off the bench.

30. Mr Moorman was struggling to breathe. Officer A phoned the communications room and asked for an ambulance. He had a radio with him but he said he did not use it because the telephone was so close (in the wing office) and he viewed it as a more reliable way to communicate. He knew what the emergency codes were, but he knew he had to explain why he wanted an ambulance so thought it would be easier to do so on the phone. He spoke to a SO and told her that Mr Moorman was having either an epileptic fit or an asthma attack, was struggling to breathe and his body was going rigid and thought an ambulance was needed. She asked him to get Mr Moorman's name and as much detail as possible for the ambulance service. When he got back, the prisoners had moved Mr Moorman into the recovery position and he ascertained Mr Moorman's name and other details.

31. Officer A called the SO back and gave her Mr Moorman's identity details. He told her that he was semi-conscious and struggling to breathe. She radioed Officer B, to attend the scene and asked an OSG to relieve her in the communications room so that she could attend. Before she left, Officer B called the SO and told her that he thought an ambulance was needed. The SO called an ambulance at 11.23pm and the emergency services operator advised her to make sure someone took a defibrillator to the scene, which she did.

32. Mr Moorman remained conscious. The SO thought that his airways might be constricting because of anaphylactic shock and radioed the control room to update emergency services of such. Paramedics arrived at 11:50pm and Mr Moorman had a cardiac arrest approximately ten minutes later. A second ambulance arrived at 11.55pm and a third at 00:15am.

33. Paramedics decided to transfer Mr Moorman to hospital, and they left the prison at approximately 1.15am. Staff did not apply restraints although he was accompanied by two escorts and the prison released him on a temporary licence.

34. Mr Moorman did not recover and life was maintained via a life support machine. Hospital staff withdrew treatment on 28 August and Mr Moorman was pronounced dead at 3.12pm.

Contact with Mr Moorman's family

35. On 26 August, prison manager contacted Mr Moorman's stepmother at 2.45am to tell her Mr Moorman had been admitted to hospital. She was grateful for the information and said she would pass it on to his birth mother, who lived in America. Mr Moorman's mother flew to England that day and the prison's family liaison officer arranged for her to be picked up from the airport by a taxi and taken straight to the hospital. The officer met her on the morning of 27 August and stayed in contact with her and Mr Moorman's stepmother to offer advice and support.

36. Mr Moorman's funeral was held on 2 November and the deputy governor and a chaplain from the prison attended. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

37. After Mr Moorman's death the duty 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.

38. The prison posted notices informing other prisoners of Mr Moorman's death and offered support.

Post-mortem report

39. The coroner provided a copy of the post-mortem and toxicology report. The post-mortem gave the cause of death as complications of prolonged respiratory arrest due to exacerbation of asthma/chronic obstructive pulmonary disease. The toxicology results were negative for illicit substances.

Findings

Clinical Care

40. The clinical reviewer concluded that the care Mr Moorman received was equivalent to that he could have expected to receive in the community but he had some concerns.

41. On 9 August 2016 Mr Moorman had a severe asthma attack. Although he was assessed by paramedics and a healthcare nurse, he had been told to attend an asthma review on 17 August. Mr Moorman cancelled this appointment and there is no record of the reason why, although another appointment was made. The clinical reviewer advises that staff should record all reasons for non-attendance of appointments in prisoner's notes along with records of discussions about the importance of turning up for them. We draw this to the head of healthcare's attention. As Mr Moorman had been reviewed thoroughly on 9 August and a replacement appointment was made for him, we make no recommendation.

The Emergency Response

42. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that when a medical emergency is called over the radio network, an ambulance must be called immediately and local procedures should ensure this. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.

43. Officer A phoned the communications room and asked for an ambulance rather than call a code over the radio because he said he knew he would have to explain why he wanted an ambulance and thought it would be easier to provide the details over the phone. When he spoke to the SO, she asked him to for more information. He had to provide more information and report it to her before she called an ambulance.

44. This is not consistent with the PSI and caused an unnecessary delay in calling for emergency care when there was no on-site healthcare support available. The prison's protocol is quite clear which emergency codes apply to what kinds of medical situation (blue for chest pains and breathing difficulties and red for severe blood loss) and that an ambulance should be called immediately when one is broadcast. Although an officer was aware that an ambulance was needed at approximately 11.00pm no ambulance was called until 11.23pm. 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 and ensures the control room calls an ambulance immediately when an emergency code is used.

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