

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Harrhy a prisoner at HMP Usk on 20 September 2018

A report by the Prisons and Probation Ombudsman

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.

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 Christopher Harrhy died on 20 September 2018 of heart disease at HMP Usk. He was 57 years old. I offer my condolences to Mr Harrhy's family and friends.

The investigation found that Mr Harrhy received an appropriate standard of clinical care at the prison, equivalent to that which he could have expected to receive in the community. His referral to a hospital specialist was timely and healthcare staff appropriately managed his heart condition.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2019

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Summary

Events

1. Mr Christopher Harrhy was serving a life sentence for sexual offences and had been at HMP Usk since November 2017. He was obese and had high blood pressure. Prison GPs prescribed medication for hypertension and regularly monitored his condition.
2. Initial health screen tests at Usk showed that Mr Harrhy had an irregular pulse. Mr Harrhy had an electrocardiogram (ECG - a test that checks the heart's rhythm) and a prison GP diagnosed atrial fibrillation (a heart condition that causes an irregular and fast heart rate). A prison GP made a referral to a cardiologist (heart specialist).
3. On 14 March 2018, Mr Harrhy had an echocardiogram (an ultrasound of the heart). The cardiologist confirmed the diagnosis of atrial fibrillation and an enlarged heart. Mr Harrhy was prescribed medication for heart disease.
4. Mr Harrhy's blood pressure remained high and he experienced chest pains. On 13 June, a prison GP prescribed additional medication for hypertension and glyceryl trinitrate spray (GTN - used to relieve angina). This relieved his symptoms.
5. At approximately 7.35am on 20 September, an officer found Mr Harrhy unresponsive in his cell. He radioed an emergency code blue (which indicates that a prisoner is unconscious or not breathing) and the control room immediately called an ambulance.
6. Staff decided not to start cardiopulmonary resuscitation (CPR) because Mr Harrhy's appearance indicated he had been dead for some time. Paramedics arrived at 7.45am and said that the condition of Mr Harrhy's body indicated that he had died during the night.
7. The post-mortem examination showed that Mr Harrhy died from coronary heart disease and coronary artery atheroma (build-up of fatty deposits on the walls of the arteries around the heart, restricting the flow of blood to the heart muscle).

Findings

8. The clinical reviewer concluded that Mr Harrhy received an appropriate standard of clinical care at Usk, equivalent to that which he could have expected to receive in the community. Prison GPs referred Mr Harrhy to a hospital specialist when necessary and appropriately managed his heart condition.
9. We make no recommendations.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Usk informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Horry's prison and medical records.
12. Healthcare Inspectorate Wales (HIW) reviewed Mr Horry's clinical care at the prison.
13. We informed HM Coroner for Wales Gwent District of the investigation. The coroner informed us of the cause of death. We have sent the coroner a copy of this report.
14. The investigator wrote to Mr Horry's cousin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
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

HMP Usk and Prescoed

16. HMP Usk holds up to 273 men convicted of sexual offences. The prison is managed jointly with nearby HMP Prescoed. The Aneurin Bevan University Health Board delivers healthcare services at Usk. Nurses are on duty from 8.00am to 4.30pm, Mondays to Fridays. There is a GP surgery every weekday morning and doctors are on call until 6.30pm each weekday. Out of hours and weekend services are provided through the Gwent Out of Hours Cover, which provides telephone triage by a nurse or doctor.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Usk was in October 2017. Inspectors noted that governance of health care was satisfactory and leadership was good. Prisoners were very positive about their access to and the quality of GP and nursing care. The health care environment was clean. The population at Usk contained a high proportion of older men. Despite the environment's limitations, good work was undertaken to support them, including the best provision relating to the Care Act inspectors had seen. Healthcare provision overall was reasonably good.

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 31 March 2018, the IMB reported that there was now a full complement of staff in healthcare. It was still busy but provided a good service.

Previous deaths at HMP Usk

19. Mr Harray was the fifth prisoner at Usk to die since September 2015. All were from natural causes. There were no similarities between Mr Harray's death and previous deaths at Usk.

Key Events

20. On 4 March 2004, Mr Christopher Harray was remanded in custody for sexual offences and sent to HMP Parc. On 1 April 2005, he was sentenced to life in prison. Mr Harray spent time in several prisons before being moved to HMP Usk on 21 November 2017.
21. A prison nurse completed Mr Harray's reception health screen when he arrived at Usk. Mr Harray had a history of hypertension and osteoarthritis and was prescribed medication which he kept in his possession. The nurse recorded Mr Harray's weight as 159.8kg and his BMI (body mass index – a measure of whether a person is a healthy weight) as 52.7 (a BMI over 40 is classified as morbidly obese). The nurse noted that Mr Harray's pulse was irregular (80bpm) and his blood pressure was high (155/105 mmHg). She made a referral to a prison GP for further investigation into his irregular pulse. Nurses created a hypertension care plan which included weekly monitoring of Mr Harray's blood pressure. Mr Harray's blood pressure remained raised throughout his time at Usk.
22. On 24 November, a prison GP examined Mr Harray and diagnosed atrial fibrillation (a heart condition that causes an irregular and fast heart rate). The diagnosis was confirmed by the results of an electrocardiogram (ECG – a test to check the heart's rhythm). The prison GP prescribed Mr Harray an anticoagulant (used to prevent blood clots) and made a referral to the cardiology department at Nevill Hall Hospital for an echocardiogram (an ultrasound scan of the heart).
23. On 22 February 2018, the hospital cancelled Mr Harray's appointment because of a problem with the echocardiogram machine. The appointment took place on 14 March.
24. On 1 May, Mr Harray saw a cardiologist (heart specialist) to discuss the results of the echocardiogram. The cardiologist said the results showed that Mr Harray had an enlarged heart and atrial fibrillation. He told Mr Harray he would send a recommended treatment plan to the prison. This was received by the prison's healthcare department on 3 June.
25. On 4 June, a prison GP saw Mr Harray to discuss the diagnosis of atrial fibrillation and the cardiologist's recommendations. She prescribed bisoprolol for heart disease and said the dose would be increased if his condition did not improve. The prison GP said the cardiologist had arranged for Mr Harray to have a heart monitor fitted on 17 July.
26. On 14 June, Mr Harray complained of overnight chest pain. A prison nurse recorded his pulse as irregular (69bpm) and his blood pressure as raised (160/90mmHg). Mr Harray had an ECG which showed no acute changes. A prison GP arranged for a taxi to take Mr Harray to Nevill Hall Hospital. Hospital doctors assessed Mr Harray and did not find further damage to his heart. They diagnosed Mr Harray with gastro-oesophageal disease.
27. On 16 June, a prison nurse recorded Mr Harray's pulse as irregular (65bpm) and noted that his blood pressure had improved (142/86mmhg). She advised Mr Harray to contact healthcare staff if he felt unwell.

28. On 13 July, Mr Harrhy complained of chest pain which mainly occurred during the night. A prison GP noted Mr Harrhy's family history of heart disease and recorded his blood pressure as raised (164/95mmhg). She prescribed doxazosin (to treat hypertension) and made a referral to a cardiologist. She also prescribed glyceryl trinitrate (GTN - a spray used to relieve angina).
29. On 17 July, Mr Harrhy had a heart monitor fitted at Nevill Hall Hospital to measure his heart's activity over 24 hours. This was removed on 18 July.
30. On 22 August, a prison GP examined Mr Harrhy and noted that his chest was clear. She noted that the results of the 24-hour heart monitor were unavailable and Mr Harrhy had a cardiologist appointment on 27 September. She referred Mr Harrhy for a chest X-ray and increased his bisoprolol dose. The X-ray results were received on 24 August with normal results.
31. On 29 August, Mr Harrhy told a prison GP his chest pain had improved and was usually relieved by the GTN spray. He declined to have his bisoprolol dose increased because he was anxious about side effects and said he would discuss this with the cardiologist. A prison GP told Mr Harrhy to contact healthcare staff if he experienced any further episodes of chest pain.

Events of 20 September

32. At approximately 7.35am, a prison officer found Mr Harrhy unresponsive on his bed with his face pressed into his pillow. He radioed an emergency code blue (which indicates a prisoner has breathing difficulties or is unconscious) for assistance from healthcare and prison staff. The control room immediately called an ambulance. Two prison officers and a custodial manager arrived and entered Mr Harrhy's cell.
33. At 7.40am, two prison nurses arrived. A nurse noted that Mr Harrhy was pale, his lower limbs were mottled and stiff and there were no obvious signs of life. A prison officer said staff should not start cardiopulmonary resuscitation (CPR) to preserve Mr Harrhy's dignity.
34. The prison nurses felt they should start CPR until the paramedics arrived. The prison officer did not agree and the nurses left Mr Harrhy's cell.
35. The paramedics arrived at 7.45am and took over Mr Harrhy's care. They did not start CPR and tests did not reveal any signs of life. The paramedics said the condition of Mr Harrhy's body indicated that he died during the night.

Contact with Mr Harrhy's family

36. On 20 September, the prison appointed a prison officer as family liaison officer (FLO). At 9.30am, the FLO and a prison manager, visited Mr Harrhy's cousin, his nominated next of kin, and informed her of Mr Harrhy's death. They offered Mr Harrhy's cousin their condolences and support.
37. Mr Harrhy's funeral was held on 5 October. The prison contributed to the cost in line with Prison Service policy.

Support for prisoners and staff

38. After Mr Harrhy's death, a prison 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.
39. The prison posted notices informing other prisoners of Mr Harrhy'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 Harrhy's death.

Post-mortem report

40. The post-mortem examination found that Mr Harrhy's cause of death was coronary heart disease and coronary artery atheroma (build-up of fatty deposits on the walls of the arteries around the heart, restricting the flow of blood to the heart muscle).

Findings

Clinical care

41. Mr Harry was obese and had high blood pressure. On his arrival at Usk, an initial reception health screen showed that Mr Harry had an irregular pulse. A prison GP quickly referred Mr Harry for further investigations and diagnosed him with atrial fibrillation. The GP made an appropriate referral to a cardiologist. The clinical reviewer found that prison GPs prescribed appropriate medication for heart disease and managed Mr Harry's heart condition appropriately.
42. When Mr Harry complained of chest pain, a prison GP ensured he was immediately taken to hospital for further investigation. On his return to Usk, prison GPs gave Mr Harry information about his condition, care and future treatment plan.
43. The clinical reviewer noted that prison officers and nurses disagreed over the decision not to commence CPR when they found Mr Harry unresponsive in his cell. A prison nurse told the clinical reviewer that Mr Harry had no obvious signs of life and his appearance indicated that he had died, specifically the mottled appearance of his legs. The prison nurse acknowledged that the decision not to commence CPR was correct. The clinical reviewer has made a recommendation about this issue for the Head of Healthcare at Usk to address.
44. The clinical reviewer considered that Mr Harry received an appropriate standard of care at Usk which was equivalent to that which he could have expected to receive in the community.

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