Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Puttock a prisoner at HMP Oakwood on 7 May 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*

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 Puttock died of a left coronary artery atheromatous occlusion (a critical blockage of a blood vessel supplying blood to his heart muscle) in hospital on 7 May while a prisoner at HMP Oakwood. He was 43 years old. We offer our condolences to his family and friends.

Mr Puttock had limited contact with the healthcare departments in prison. Although he was at risk of heart problems, his blood pressure was in a healthy range two months before his death. We are satisfied that Mr Puttock's care was equivalent to that which he could have expected to receive in the community. We are, though, concerned that Oakwood did not record Mr Puttock's next of kin when he arrived at prison, which led to a significant delay in making contact following his death.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **March 2018**

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Summary

Events

1. On 17 May 2016, Mr Mark Puttock was sentenced to three years and five months in prison for sexually assaulting a child. He was sent to HMP Leicester.

2. Mr Puttock had a history of depression and said he had used new psychoactive substances (NPS). He was prescribed medication to manage his depression and was referred to a drugs worker but declined intervention.

3. Mr Puttock had little contact with the healthcare team, except for an appointment with a psychiatrist on 27 May after he was seen behaving unusually. The psychiatrist noted that his behaviour was consistent with using NPS.

4. On 31 May, Mr Puttock was transferred to HMP Oakwood. He was assessed as fit to live on a standard wing and to attend the gym. Nursing staff administered Mr Puttock's medication twice daily.

5. There are no significant entries in Mr Puttock's medical record until 6 March 2017 when a routine test recorded Mr Puttock's blood pressure as being within a healthy range.

6. On 14 March, Mr Puttock's blood was tested (although records do not say why). The results were normal, except for his cholesterol and white blood cell count which were slightly raised. A repeat test was taken on 5 April. There was no change from the previous results and staff took no further action.

7. On 7 May, Mr Puttock told an officer that he was not feeling well, and thought he might have taken the wrong medication earlier that day. After reassuring the officer that he was okay, Mr Puttock returned to his cell and at 10.30am, the officer went to speak to healthcare staff. As there was no urgency, they advised the officer to bring Mr Puttock back 20 minutes later when they had finished their duties. The officer told Mr Puttock this when she returned to the wing. When she went to collect him 15 minutes later, she found him unresponsive in his cell.

8. The officer called a medical emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing), and both prison and healthcare staff tried to resuscitate Mr Puttock while they waited for paramedics to attend. Paramedics were with Mr Puttock by 11.03am, and at 11.40am, he was transferred to hospital, where he died of a heart attack at 12.12pm.

Findings

Clinical care

9. We are satisfied that Mr Puttock received a good standard of care at HMP Oakwood, equivalent to that which he could have expected to receive in the community. The emergency response was appropriate and timely.

Family liaison

10. Oakwood did not record clear details for Mr Puttock's next of kin. This caused a lengthy delay in the prison making contact with his father. Staff failed to consider whether Mr Puttock's father was the appropriate contact as he had given the number of a friend to contact in case of emergency.

Recommendation

- The Director should ensure that next of kin contact details are completed, kept up to date and are readily available in the event that a prisoner becomes seriously ill.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Oakwood, informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners contacted the investigator.

12. The investigator visited HMP Oakwood on 21 June 2017. She interviewed one member of staff and spoke to three prisoners. She subsequently spoke to a nurse by telephone.

13. NHS England commissioned a doctor to review Mr Puttock's clinical care at the prison.

14. We informed HM Coroner for South Staffordshire District of the investigation who provided toxicology and post-mortem results. We have sent the coroner a copy of this report.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Oakwood

16. HMP Oakwood opened in 2012. It is near Wolverhampton and managed by G4S. Oakwood is one of the largest prisons in England and Wales, providing places for up to 1,605 Category C male prisoners.

17. Care UK provides healthcare services, including a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Oakwood was in December 2014. Inspectors reported that health services had much improved since the last inspection, including care for older prisoners. There were some chronic staff shortages in the healthcare team which affected some areas of delivery. Agency staff were used to fill the shortages. Care planning was well developed and clinical records were good.

Independent Monitoring Board

19. 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 March 2017, the IMB reported that they were satisfied that Health Services were provided to all patients/prisoners as required and that Care UK had introduced clinics led by nurses on some wings and this had been well received as had the nurse triage and dispensing of medication.

Previous deaths at HMP Oakwood

20. Mr Puttock was the seventh prisoner to die at HMP Oakwood since January 2016. There are no significant similarities with previous deaths.

Key Events

21. On 17 May 2016, Mr Mark Puttock was sentenced to three years and five months in prison for sexually assaulting a child and was sent to HMP Leicester.

22. That day, a nurse completed Mr Puttock's initial health screen and recorded that he had a history of depression, had previously tried to harm himself and take his life. Mr Puttock told staff he had a history of using New Psychoactive Substances (NPS - 'legal highs' designed to produce the same, or similar effects, to drugs such as cannabis, cocaine and ecstasy) and the nurse referred him to the substance misuse services. He was prescribed fluoxetine (antidepressant) and amitriptyline (to help with sleep). He was a smoker and was offered smoking cessation advice which he declined.

23. On 18 May, Mr Puttock saw a drugs worker but declined the opportunity to address his substance misuse.

24. Mr Puttock had no further contact with healthcare services, except for seeing a prison psychiatrist on 27 May after wing staff saw him behaving unusually. The psychiatrist recorded that his behaviour was consistent with that of someone using NPS.

25. On 31 May, Mr Puttock was transferred to HMP Oakwood. A nurse completed an initial health screen. He told her that he had taken illicit substances, including cannabis and NPS in the previous two months. The nurse recorded that while Mr Puttock was not suitable to hold his own medication, he was fit to live on a standard wing and to attend the gym. Mr Puttock told her that he had regular headaches caused by a historic brain haemorrhage. A prison GP prescribed medication to manage his depression. There is no record that staff took his blood pressure as part of the routine healthscreen.

26. Nursing staff continued to administer fluoxetine and amitriptyline to Mr Puttock twice daily.

27. There are no significant entries in Mr Puttock's medical record until 6 March 2017 when, as part of a routine NHS health check, a healthcare assistant took Mr Puttock's observations and recorded his blood pressure as138/91mmHg, which was within a normal range. No further action was therefore needed. Mr Puttock was again offered smoking cessation, which he declined.

28. On 14 March, a prison GP tested Mr Puttock's blood. There is no record to explain why. His results were normal for the prostate and thyroid gland, folic acid, vitamin B12, ferritin, glucose, liver function and kidney function although Mr Puttock's cholesterol (at 7.1mmol/L) and his white blood cell count (the cells to fight infection) were slightly raised, and doctors asked for a repeat test to be completed.

29. On 5 April, a nurse tested Mr Puttock's blood. As there was no change from the results of 14 March, no further action was taken.

Events of 7 May 2017

30. On the morning of 7 May, a nurse saw Mr Puttock when he was collecting his medication. She described him as 'fine and cheery', with no cause for concern.

31. A prisoner from the same wing as Mr Puttock told the investigator that, at approximately 10.24am, he overheard Mr Puttock tell an officer that he had chest pains and felt sweaty. He said that Mr Puttock told him he was 'okay' when he asked how he was.

32. The officer said that Mr Puttock approached her and described feeling hot. She said that he rubbed the area just below his collar bone and said that it hurt. The officer said that Mr Puttock told her that he thought he had taken the wrong medication, and that this might be the cause of his pain. When the officer asked Mr Puttock if he was okay to walk, she said that he said he was fine, but just did not 'feel right'. The officer said that she advised him to go and sit in his cell while she asked the healthcare team to examine him.

33. The nurse said that the officer approached her as she was leaving the dispensary at approximately 10.30am. She told the nurse that Mr Puttock was unwell and in pain, but did not specify where the pain was. The nurse said that as the officer's request was not an emergency she suggested that she bring Mr Puttock to the healthcare hub (next to A wing) to assess him thoroughly. As she had further tasks to complete, the nurse asked that Mr Puttock be brought to the hub in 15-20 minutes.

34. The officer said she returned to the wing at approximately 10.35am, and went to Mr Puttock's cell to check on him. She told him that she would take him to see a nurse in approximately 20 minutes, and asked if he could wait that long. The officer said that Mr Puttock looked 'under the weather' and said he had vomited but was feeling better.

35. Approximately 15 minutes later, the officer went to Mr Puttock's cell. She said that he was on his bed and described his position as looking as though he had fallen backwards. The officer went into the cell, shouted to Mr Puttock and shook him, but got no response. She immediately called a code blue (a code indicating difficulties in breathing). The code blue was received by the control room at 10.48am, and an ambulance was called promptly. A prison manager went immediately to Mr Puttock's cell and staff tried to place Mr Puttock in the recovery position as he was still breathing. His breathing became laboured and the prison manager began cardiopulmonary resuscitation.

36. Two prison managers arrived at Mr Puttock's cell, instructed the officer to collect the defibrillator, and took over resuscitation efforts. At 10.49am, two nurses arrived at Mr Puttock's cell and the officer simultaneously returned with the defibrillator. One of the prison managers and one of the nurses continued cardiopulmonary resuscitation.

37. At 11.00am the first response ambulance arrived at the prison gates. Paramedics were with Mr Puttock by 11.03am. A second ambulance arrived at 11.20am. Paramedics continued resuscitation efforts and Mr Puttock was diagnosed with Pulseless Electrical Activity (PEA – a heart sound is present but

with no detectable cardiac output). At 11.40am, Mr Puttock was transferred, without restraints, to hospital, where he died at 12.12pm.

Contact with Mr Puttock's family

38. On 7 May, a prison manager appointed an officer as the family liaison officer and another as the deputy family liaison officer.

39. That day, the deputy family liaison officer recorded in the family liaison log that he looked through Mr Puttock's prison records as there was no clear next of kin. He found an address in Mr Puttock's records and confirmed on the electoral register that it was his father's address.

40. At 3.00pm, the family liaison officer and the deputy family liaison officer visited Mr Puttock's father's home. When they arrived, they were told that he was no longer at the property and they had no forwarding address. That day, the family liaison officer contacted the Leicestershire Police, Mr Puttock's solicitor and Leicestershire Probation to help locate Mr Puttock's father.

41. The family liaison officer recorded in the family liaison log at 10.30am on 8 May that Mr Puttock's first night records indicated that his father was not aware that he was in prison and that Mr Puttock had provided contact details for a friend whom the prison should call in case of an emergency. The family liaison officer did not contact Mr Puttock's friend, but noted in the family liaison log that she would await the advice of the police.

42. At 2.15pm on 8 May, the family liaison officer received a call from the police who confirmed that they had located Mr Puttock's father and that officers were informing him of his son's death. They agreed that she would wait for them to update her about the outcome before she would make contact with Mr Puttock's father. The family liaison officer spoke Mr Puttock's father on 10 May after the police updated her. She apologised for not contacting him earlier and offered her condolences and support. Oakwood contributed to the cost of Mr Puttock's funeral in line with national instructions.

Support for prisoners and staff

43. After Mr Puttock'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. The prison posted notices informing other prisoners of Mr Puttock's death, and offering support.

Post-mortem report

44. A post-mortem examination established that Mr Puttock died from a left coronary artery atheromatous occlusion (a critical blockage of a blood vessel supplying blood to his heart muscle). Toxicology results identified therapeutic levels of amitriptyline and fluoxetine in Mr Puttock's system but did not detect NPS.

Findings

Clinical care

45. We agree with the clinical reviewer that the healthcare that Mr Puttock received in prison was equivalent to that which he could have expected to receive in the community. Mr Puttock had risk factors for cardiovascular disease: he was a smoker, his cholesterol was raised and he admitted using NPS which can affect people in a number of ways, including increasing heart rate, raising blood pressure and reducing blood supply to the heart. Despite this, when Mr Puttock's blood pressure was taken two months before his death, it was not raised. Mr Puttock's death was sudden and unexpected and healthcare staff could not have prevented it. The clinical reviewer further comments that resuscitation was prompt and healthcare staff were in attendance with a defibrillator within seven minutes, which is faster than the community response time of eight minutes.

Family liaison

46. When Mr Puttock arrived at HMP Oakwood, prison staff should have clarified who his next of kin was and recorded their contact details. This did not happen and this resulted in a delay of over 24 hours in making contact with his father. It is also questionable whether this was appropriate as Mr Puttock had given details of a friend to contact in case of an emergency. We are therefore concerned that after the police had contacted his father, no one took steps to notify Mr Puttock's stated next of kin, his friend, of his death. We make the following recommendation:

    The Director should ensure that next of kin contact details are completed, kept up to date and are readily available in the event that a prisoner becomes seriously ill.

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