Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Abrahams a prisoner at HMP Onley on 10 January 2018

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr John Abrahams died in hospital on 10 January 2018 of pneumonia, following a head injury sustained in a fall at HMP Onley. Mr Abrahams was 74 years old. I offer my condolences to Mr Abrahams' family and friends.

I am satisfied that the care Mr Abrahams received at Onley was equivalent to that which he could have expected to receive in the community.

However, I am concerned that he was restrained when he initially went to hospital, and that he remained restrained for a further day, despite his serious injuries. It is not the first time that we have criticised the prison for this.

I am also concerned about the delay in his body being released for the funeral.

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 **August 2017**

Contents

Summary

Events

1. On 15 September 2017, Mr John Abrahams was sentenced to four years imprisonment for fraud. He was initially sent to HMP Thameside and was transferred to HMP Onley on 13 October.

2. A health screen on reception revealed Mr Abrahams' history of hypertension (high blood pressure). He had an outstanding eye appointment and borderline diabetes. Otherwise, Mr Abrahams had no significant health concerns.

3. On 23 October, a prison GP reviewed Mr Abrahams. He referred him to an eye specialist, and placed him on the dentist's waiting list.

4. On the morning of 2 January 2018, a prison GP reviewed Mr Abrahams for a problem with his foot. He noted that Mr Abrahams appeared well and happy. Shortly afterwards, Mr Abrahams collapsed in the healthcare waiting room, hitting his head as he fell. A nurse working nearby attended to him immediately and noted that he was breathing and had a pulse. The nurse requested assistance and an ambulance was called.

5. A few minutes later, the prison GP assessed Mr Abrahams. He suspected that he had a severe brain injury. When the ambulance first responder arrived, the prison GP requested the call be escalated to one for an emergency ambulance.

6. Mr Abrahams was taken to hospital restrained with an escort chain. A hospital registrar advised that he had fractures to his skull, bleeding on the brain and was in a life-threatening condition. The next day the escort chain was removed.

7. On 4 January, Mr Abrahams had surgery on his brain. His condition deteriorated and, on 9 January, the decision was taken to withdraw life support. On 10 January at 3.59pm, Mr Abrahams was pronounced dead.

Findings

Emergency response

8. We are satisfied that the prison responded to Mr Abrahams' fall appropriately and in line with the prison service instructions.

Clinical care

9. The clinical reviewer concluded that the care Mr Abrahams received was equivalent to that which he could have expected to receive in the community. His health issues were appropriately managed by healthcare staff at Onley.

Contact with Mr Abrahams' family

10. We are satisfied that the prison acted appropriately in its contact with Mr Abrahams family. The family liaison officer maintained good contact throughout. He also tried to ensure the prompt release of Mr Abrahams' body for burial to avoid unnecessary distress.

11. However, we are concerned about the delay in releasing Mr Abrahams' body, and consider that the prison should improve its protocols with the local coroner.

Restraints, security and escorts

12. We are concerned that Mr Abrahams was restrained when he was taken to the hospital, and that these restraints were not removed for another day.

Recommendations

- The Governor should liaise with the local coroner and the police to establish appropriate and effective protocols for deaths in custody.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Prison Group Director for East Midlands Group should ensure that effective action is taken to implement this repeat recommendation about the inappropriate use of restraints at HMP Onley.

The Investigation Process

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

14. The investigator visited Onley on 22 January 2018. He obtained copies of relevant extracts from Mr Abrahams' prison and medical records.

15. The investigator interviewed one member of staff and a prisoner at Onley on 22 January.

16. NHS England commissioned a clinical reviewer to review Mr Abrahams' clinical care at the prison.

17. We informed HM Coroner for Northamptonshire of the investigation. The coroner gave us the results of the post-mortem examination, and we have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Abrahams' wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked us to consider:

    - what was done for her husband after he collapsed;
    - what clinical support Mr Abrahams was given for his other healthcare problems; and
    - whether Mr Abrahams was aware of the procedures for booking medical appointments.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

20. Mr Abrahams' wife received a copy of the initial report and indicated that she was satisfied with the findings. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Onley

21. HMP Onley is a resettlement prison serving the Greater London area. It holds approximately 742 adult male prisoners. Northamptonshire Healthcare NHS Foundation Trust provides health services including primary care, mental health and substance misuses services. A GP is on duty during normal working hours. Onley falls under the jurisdiction of HM Coroner for Northampton.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Onley was conducted between July and August 2016. Inspectors reported that there had been a dramatic decline in standards since their last inspection in 2012, particularly in relation to safety and drug management. They noted that, since the last inspection, Onley had been designated as a resettlement prison for London, and that this change in role had undoubtedly had a significant impact on the prison.

23. Inspectors noted that healthcare provision was reasonably good overall, with good access to GP services. However, they observed that the waiting times for some services were too long, and too many external medical appointments had to be rescheduled due to the lack of available escort staff. Inspectors noted that there were staffing difficulties, but this was mitigated by using agency staff.

Independent Monitoring Board

24. 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 2017, the IMB reported that access to medical care was broadly comparable to that outside prison, and that waiting times for appointments had reduced. The Board observed that waiting times for ambulances had been a cause for concern over the past year, with unacceptable delays occurring several times.

Previous deaths at HMP Onley

25. Mr Abrahams was the fifth prisoner to die at Onley since January 2015, and the third to die from natural causes during that time. We have previously made recommendations about the inappropriate use of restraints.

Key Events

26. On 15 September 2017, Mr John Abrahams was sentenced to four years imprisonment for fraud and sent to HMP Thameside.

27. A nurse reviewed Mr Abrahams at a health screen on his reception at Thameside. He had a history of hypertension and borderline diabetes. Mr Abrahams was prescribed atorvastatin, amlodipine and ramipril (to treat his hypertension). The nurse observed that Mr Abrahams had a bloodshot eye, and he said that he had been advised to make an appointment at the Royal Cornwall Hospital for an eye scan. Mr Abrahams was assessed as being suitable for in-possession medication and continued with his prescription.

28. On 13 October, Mr Abrahams was transferred to HMP Onley. A nurse reviewed him at a reception health screen. She recorded that 20 years earlier he had had an epilepsy seizure but that he no longer required medication for this. Mr Abrahams continued to receive his hypertension medication as before.

29. On 23 October, a prison GP reviewed Mr Abrahams and noted his history of hypertension. The prison GP recorded that his blood pressure was fine at the time. Mr Abrahams told the GP that at an emergency eye clinic in September, he had been advised to have a follow-up six-to-eight weeks later because of his risk of developing glaucoma (damage to the optic nerve). Mr Abrahams also told the prison GP that he had lost a tooth but denied that this was the result of an assault. The prison GP examined Mr Abrahams and noted that both his eyes appeared fine, he had no pain or discomfort, and no double or blurred vision. He recorded that Mr Abrahams' cranial nerves were normal, he had no facial asymmetry, and had normal sensation and power in all four limbs. The prison GP added Mr Abrahams to the dentist's waiting list, and referred him to the ophthalmologist (eye specialist).

30. On 3 November, an optician reviewed Mr Abrahams and prescribed him new spectacles.

31. On 14 December, a second prison GP reviewed blood and urine tests for Mr Abrahams. The results were all satisfactory or borderline, and no further action was required. The following day, the second GP recorded that Mr Abrahams' QRISK2 cardiovascular score was 30.76%. (QRISK2 is a predictive algorithm which assesses a patient's risk of cardiovascular disease.) Mr Abrahams' score reflected a 30% chance of a cardiovascular incident within the next 10 years. The National Institute for Care Excellence (NICE) recommends that statins should be prescribed for patients with this risk. A second prison GP confirmed that Mr Abrahams was already prescribed the recommended dose of statins, so he took no further action.

32. On 27 December, a healthcare assistant recorded Mr Abrahams' blood pressure as 151/89, which was above the hypertension threshold.

Events of 2 January 2018

33. On the morning of 2 January 2018, a prison GP saw Mr Abrahams in surgery. In interview he said that Mr Abrahams was "smiling, laughing and joking and

appeared to be in good spirits." He discussed Mr Abrahams' blood test results with him. He confirmed in interview that there were some issues that required repeat tests but he was not unduly concerned. Mr Abrahams informed him that he had reduced sensation in his right foot but he had no pain and was able to run on it. The prison GP noted that he would place Mr Abrahams on the waiting list to see a podiatrist (a foot specialist). He also tasked the administration team to chase up the referral to the ophthalmologist he had requested the previous October.

34. Following this consultation, Mr Abrahams returned to the healthcare waiting area. At approximately 10am, a nurse, who was working nearby, heard a noise from the waiting area. He attended immediately and saw Mr Abrahams lying "flat out on the floor". Other prisoners told the nurse that Mr Abrahams had stood up and fallen, hitting his head on the wall as he did so. The nurse noted that there was no sign of any assault, and no indication of any disturbance in the area, only concern for Mr Abrahams. He observed that Mr Abrahams "had a pulse, shallow breathing, and was not responding to voice. He had a lump to the side of head at least 5cm – from the fall". With the assistance of prisoners and officers, the nurse moved Mr Abrahams to the examination couch in the treatment room, and requested medical assistance and an ambulance. The nurse did not call a code blue because Mr Abrahams was breathing and had a pulse. (A code blue is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.) The control log records the ambulance being requested at 9.57am.

35. Shortly afterwards, a second nurse arrived, quickly followed by the prison GP. In interview, the prison GP said that he was told about Mr Abrahams' fall, and arrived a few minutes later. He added that this was about 15-20 minutes after Mr Abrahams had left his surgery. The GP noted that Mr Abrahams had a large swelling on the side of his head, measuring 7cm. In interview, the GP said, "that he was not responding to speech" but "was breathing by himself and had a cardiac output." The GP noted that Mr Abrahams had a GCS score of 4. (The Glasgow Coma Scale (GCS) defines a person's level of consciousness – a score of 8 or less equates to a severe brain injury.) The second nurse, who came after the fall, did not record her involvement in Mr Abrahams' medical notes.

36. The prison GP said that after a few minutes Mr Abrahams had gained strength, could move all of his limbs and responded to touch. He said that he suspected a brain injury, and noted that he would need a scan at the hospital. The control room log records that the paramedic arrived at 10.14am. The prison GP handed over the care to the first responder and recorded that Mr Abrahams' GCS score was 8 at that time. The first responder assessed Mr Abrahams and requested an ambulance crew, but the prison GP asked them to make sure this was an emergency ambulance.

37. The control room log records that the ambulance arrived at 11.28. Mr Abrahams was taken to University Hospital Coventry and Warwick, escorted by two officers and restrained with an escort chain.

38. CCTV footage taken from area where Mr Abrahams fell, confirmed that there was no suggestion of any assault.

Mr Abrahams' time in hospital

39. On arrival at the hospital, Mr Abrahams was assessed before being located on a neurology wing. The hospital registrar advised prison staff that Mr Abrahams had fractures to his skull, bleeding on the brain and was in a life-threatening condition. The following day, Mr Abrahams had a scan and tests. A doctor at the hospital asked for Mr Abrahams' escort chain to be removed and, at 3.30pm, officers removed this after a new escort risk assessment was completed.

40. During the morning of 4 January, Mr Abrahams had surgery on his brain, and was relocated in the intensive care unit. Mr Abrahams never regained consciousness and on 9 January his condition deteriorated. On the morning of 10 January, the decision was taken to withdraw life support.

41. On 10 January at 3.59pm, Mr Abrahams was pronounced dead.

Contact with Mr Abrahams' family

42. Mr Abrahams' next of kin was his wife, although his son and daughter were also listed.

43. On 2 January, the prison appointed a prison chaplain as Mr Abrahams' family liaison officer. The chaplain spoke to a prison GP, who advised that Mr Abrahams' family should attend the hospital. At 2.20pm, he informed Mr Abrahams' wife of her husband's condition. Three hours later, the chaplain met Mr Abrahams' wife, son and daughter at the hospital, and took them to see Mr Abrahams.

44. The chaplain, as the Mr Abrahams family liaison officer, continued to liaise with Mr Abrahams' family and to update them with any changes. A prison governor gave permission for Mr Abrahams' family to visit whenever they wanted, without seeking authorisation. Mr Abrahams' family were with him when he died.

45. Mr Abrahams was Jewish. The Jewish faith requires a funeral to be held as soon as possible following a death, ideally within 24 hours.

46. Early on 11 January, the family liaison officer spoke to HM Coroner for Northampton who has jurisdiction for Onley. The coroner told him that because Mr Abrahams died in hospital in Coventry, his death fell under the jurisdiction of the coroner for Coventry. The family liaison officer contacted HM Coroner for Coventry immediately, who said that he was yet to decide whether to transfer the case to Northampton.

47. On 15 January, the family liaison officer spoke to HM Coroner for Coventry again. He said he had transferred the case to Northampton which had not yet decided to accept it. The family liaison officer informed Mr Abrahams' wife of these developments. The next morning, the Northampton Coroner accepted the case. The police advised that a forensic post-mortem would be required, and that Mr Abrahams would need to be formally identified prior to this. The family liaison officer informed Mr Abrahams' wife that he would do this. On 22 January, the

formal identification and post-mortem took place. On 27 January an interim death certificate was sent to Mr Abrahams' wife.

48. Mr Abrahams' funeral was held on 30 January. The prison offered to contribute to the costs of this in line with national guidance but this offer was declined.

Support for prisoners and staff

49. After Mr Abrahams' death, there was no formal debrief for the staff involved in the emergency response because he had been at hospital for some time. The escort staff at the hospital were offered support and given the opportunity to discuss any issues arising.

50. The prison posted notices informing other prisoners of Mr Abrahams' 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 Abrahams' death.

Post-mortem report

51. The post mortem concluded that Mr Abrahams died from pneumonia consequent on the head injury he sustained when he collapsed on 2 January 2018.

Findings

Emergency response

52. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. In more serious cases, a code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.

53. The nurse who heard Mr Abrahams fall, did not call a code blue when he first attended to Mr Abrahams, because he was still breathing and had a pulse. According to the strict wording of PSI 03/2013, this was the right thing to do at the time, given how Mr Abrahams presented. When a prison GP assessed Mr Abrahams shortly afterwards, he quickly realised that his injuries were serious. He noted that his GCS score of 4 equated to a severe brain injury. The GP asked the first responder to upgrade the call to request an emergency ambulance.

54. We are satisfied that the prison responded to Mr Abrahams' fall appropriately and in line with the PSI.

Clinical care

55. We agree with the clinical reviewer that the care Mr Abrahams received at Onley was equivalent to that which he could have expected to receive in the community. He was appropriately managed for his existing health concerns, and referred to specialists where necessary. We recognise that these appointments were delayed but note that they were chased up by the GP at Onley. We are satisfied that Mr Abrahams' fall could not reasonably have been foreseen by healthcare staff, and note that he appeared well and healthy only a short time before this happened.

Contact with Mr Abrahams' family

56. We are satisfied that the prison acted appropriately in its contact with Mr Abrahams' family. The family liaison officer liaised with his wife and kept her informed throughout. The Governor facilitated unrestricted access to enable Mr Abrahams' family to visit him whenever they wanted, without requiring specific authorisation. We also recognise that the prison family liaison officer did all he reasonably could to speed up the process of having Mr Abrahams' body released to his family for burial.

57. However, we are concerned about the confusion over which coroner should have had jurisdiction over this case. This resulted in a delay of nearly three weeks before Mr Abrahams' family was able to hold his funeral. This no doubt caused added distress, especially as the Jewish tradition requires a funeral to take place as soon as possible. While we accept that the prison was not responsible for these delays, we would have expected it to have clearly established protocols with the coroner for deaths in its custody already in place.

The Governor should liaise with the local coroner and the police to establish appropriate and effective protocols for deaths in custody.

Restraints, security and escorts

58. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

59. We are concerned that Mr Abrahams was restrained with an escort chain when he was taken to the hospital on 2 January. We appreciate that the incident was an emergency which required rapid decisions, but we note that the prison GP recorded that Mr Abrahams had a GCS score of 8, which indicated that he was regarded as having a severe brain injury. However, there is no evidence of this judgement having informed the risk assessment of the need for restraints.

60. We are particularly concerned that, despite the very poor prognosis following Mr Abrahams' admission to hospital, the prison did not review its escort risk assessment until prompted to do so by the hospital, and that Mr Abrahams was still restrained until the afternoon following his admission.

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

61. We have previously made recommendations to Onley about the inappropriate use of restraints, all of which have been accepted. We therefore make this further recommendation:

The Prison Group Director for East Midlands Group should ensure that effective action is taken to implement this repeat recommendation about the inappropriate use of restraints at HMP Onley.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141