Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Gray a prisoner at HMP Humber on 17 January 2019

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.

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 Paul Gray died on 17 January 2019 of acute heart failure and ischaemic heart disease at HMP Humber. He was 56 years old. I offer my condolences to Mr Gray's family and friends.

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

However, the investigation identified a short delay in the emergency response because the radio network being blocked. I am also concerned that it took 21 minutes for an ambulance to arrive.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2019**

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Summary

Events

1. Mr Paul Gray was serving a life sentence and had been at HMP Humber since 2016.

2. Mr Gray had complex cardiac issues, for which he took appropriate medications. His medical history included a coronary artery bypass and two unsuccessful attempts to unblock his arteries. Mr Gray also had significant engagement with mental health services at Humber.

3. On 17 January 2019, about 2.00pm, Mr Gray told a wing officer that he was not going to work that day. He did not give a reason or complain of feeling unwell.

4. Ten minutes later, during a roll check, Mr Gray pressed his cell bell and an officer responded. Mr Gray was talking to the officer about his property when he suddenly went stiff and collapsed. The officer tried to call for assistance over her radio but the radio network was blocked. Another officer on the wing called a code blue emergency. The control room called an emergency ambulance immediately.

5. Officers attended and put Mr Gray in the recovery position. Two nurses arrived a few minutes later. Mr Gray was unconscious but breathing and he had an unstable pulse. A nurse applied oxygen, but Mr Gray's observations did not improve.

6. An Operational Support Grade (OSG) in the control room contacted the ambulance service for an update at 2.28pm and was told the estimated time of arrival was about 12 minutes.

7. At about 2.35pm, Mr Gray went into cardiac arrest. The nurses applied a defibrillator and started cardiopulmonary resuscitation (CPR). Paramedics arrived and took over Mr Gray's care.

8. Mr Gray's condition did not improve and at 3.20pm, a prison GP confirmed that Mr Gray had died.

9. A post-mortem report gave the cause of death as acute left ventricular failure and ischaemic heart disease.

Findings

10. Mr Gray's care from primary care services was good and the complex case process was used appropriately in accordance with National Institute for Clinical Excellence (NICE) guidelines. We agree with the clinical reviewer that the clinical care Mr Gray received while at Humber was equivalent to that which he could have expected to receive in the community.

11. There was a short delay in the emergency response because the officer who responded to Mr Gray's cell bell was unable to call for help on her radio because the network was blocked. Another officer was able to use his radio almost immediately.

12. After an ambulance was called, it was 21 minutes before the ambulance arrived.

Recommendations

- The Governor should:
    - ensure that individual radios are regularly tested and that the radio network is fully operational at all times so that staff can use their radios to make emergency calls; and
    - provide guidance to staff on alternative methods for raising the alarm in an emergency if radio communication fails.
- The Governor should review the operation of Humber's medical emergency response code protocol with the local healthcare commissioner and ambulance trust to ensure that ambulances are despatched without delay when a medical emergency code is called.

The Investigation Process

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

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

15. The investigator interviewed two members of staff at Humber on the telephone on 17 April.

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

17. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. We wrote to Mr Gray's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Gray's sister raised concerns that were not directly linked to the circumstances of Mr Gray's death. We have responded to her concerns in separate correspondence.

19. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. They provided an action plan which is annexed to this report.

20. We provided a copy of our initial report to Mr Gray's sister. She did not identify any factual inaccuracies.

Background Information

HMP Humber

21. HMP Humber is a medium security prison in Yorkshire that holds approximately 1,000 men. City Health Care Partnership provides healthcare services. There are healthcare staff on duty at all times.

22. In August 2018, Humber was selected to be part of the "10 Prisons Project" which seeks to improve safety, security and decency in the prisons involved. The project focuses on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Humber was in December 2017. Inspectors reported clinical leadership was strong and enthusiastic. Inspectors saw good examples of joint working and positive relationships between managers.

24. Health services provided appropriate treatment for most prisoners, and access to them was generally adequate. Some elements of operational management were weak; for example, emergency equipment was not routinely checked, and there was a significant backlog of unanswered health care complaints.

25. Prisoners with long-term conditions and complex health needs were overseen by nurses who liaised with the GP to ensure a coordinated approach. Prisoners were involved in the creation of their individual care plans, which were good, supported continuity of care and were based on national clinical guidance.

Independent Monitoring Board

26. 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 December 2018 (published in May 2019), the IMB reported clinical rooms were clean and well equipped, but poorly ventilated. The attendance rate for GP appointments was 85% and nurse led clinics was 73%. The healthcare complaints system had been reviewed and was more efficient at responding in a timely manner. Psychoactive substance use was a major issue and the number of prisoners requiring mental health support was putting the mental health team under considerable pressure.

Previous deaths at HMP Humber

27. Mr Gray was the eighth prisoner, to die at Humber since January 2017, and the third prisoner to die of natural causes. There are no similarities with those deaths.

Key Events

28. Mr Paul Gray was serving a life sentence for theft and assault. He had been in prison since 1998. On 2 December 2016, Mr Gray was transferred to HMP Humber.

29. Mr Gray had complex cardiac issues, which included angina, ischaemic heart disease, a coronary artery bypass in 2009, reduced blood flow to his heart and high blood pressure.

30. Healthcare staff and a hospital consultant appropriately managed Mr Gray's conditions. He took a number of medications for his cardiac conditions, which healthcare staff reviewed appropriately.

31. Mr Gray had chronic occlusion (a build-up of plaque) in his heart vessels. In 2017, Mr Gray underwent two angioplasty procedures (a technique to unblock narrow arteries), both of which were unsuccessful.

32. Mr Gray was a prolific self-harmer and had significant engagement with the prison's mental health team. He would self-isolate himself from his peers because of paranoia and spent most of his time in his cell. Mr Gray told wing staff that he was being bullied for his medications. As a result, Mr Gray's cell was unlocked before the rest of the wing so that he could collect his medications. Officers took Mr Gray's meals to him sealed, because he was concerned about his food being tampered with.

33. On 23 August, staff started suicide and self-harm procedures known as ACCT, to provide additional support to Mr Gray. Mr Gray was supported by ACCT for nearly five months. When Mr Gray said he was feeling the best he had done for some time, the ACCT was closed. A Challenge, Support and Intervention Plan was opened to continue to support Mr Gray while he continued to self-isolate.

34. Mr Gray had recurrent episodes of angina and chest pain. On 6 November 2018, Mr Gray had a scan of his heart. The scan showed he had right sided heart failure.

35. On 13 December, Mr Gray went to hospital after complaining of chest pain. A scan of his heart showed an impairment of the left side of the heart.

Events of 17 January 2019

36. On 17 January, an officer took Mr Gray's lunch to his cell. No concerns were raised about Mr Gray's wellbeing.

37. At about 2.00pm, an officer spoke to Mr Gray in his cell. Mr Gray said that he was not going to work, but did not complain of feeling unwell.

38. At about 2.10pm, an officer was conducting a roll check. She noticed that Mr Gray's cell bell was on and went to his cell. Mr Gray was complaining that the trainers in his cell were not his. He said that his cardigan was missing, then he opened a bag and found it and continued to look through his belongings. Mr Gray then suddenly went stiff and rigid.

39. The officer tried to call for assistance over her radio but the radio would not transmit (which appeared to be a network issue). She shouted to another officer and a Senior Officer (SO) to radio a medical emergency code and he was able to do so.

40. The communications log shows a code blue was called at 2.17pm. (A code blue indicates a medical emergency where the prisoner is unconscious or not breathing.) The control room called an emergency ambulance immediately and said that Mr Gray was unresponsive and had known heart issues.

41. Officers arrived and entered Mr Gray's cell. They put him in the recovery position and started to check for signs of breathing and a pulse. Two nurses from the healthcare team arrived a few minutes later. Mr Gray was unconscious but breathing but had an unstable pulse. A nurse applied oxygen, but Mr Gray's observations did not improve.

42. An operational support grade (OSG) said that he was on the phone to the ambulance service for about ten minutes while he waited for an update from healthcare staff. At 2.28pm, the OSG telephoned the ambulance service back for a reference code and information about the paramedics who were attending. The OSG was told the estimated time of arrival was about 12 minutes.

43. At about 2.35pm, Mr Gray went into cardiac arrest and the nurses started CPR. A nurse applied a defibrillator. The OSG called the ambulance service to update them on Mr Gray's condition. He said that as he was talking to them, the ambulance arrived at the gate.

44. The ambulance arrived at the prison at 2.38pm and arrived at Mr Gray's cell two minutes later. The paramedics moved Mr Gray to the wing landing so that they had more space to provide treatment. The defibrillator delivered numerous shocks to Mr Gray, but his vital signs did not improve. The nurses and paramedics continued to give Mr Gray CPR.

45. At 3.20pm, a prison GP confirmed that Mr Gray had died.

Liaison with Mr Gray's family

46. At 3.05pm on 17 January, a prison manager telephoned Mr Gray's next of kin, his sister, to inform her that Mr Gray was seriously unwell and was being resuscitated. She made the telephone call because Mr Gray's sister lived a few hours away and she wanted to give her the opportunity to start travelling in case Mr Gray could be resuscitated. She said she would update Mr Gray's sister in 30 minutes.

47. At 3.30pm, the prison manager telephoned Mr Gray's sister and told her that Mr Gray had died. As she had already telephoned Mr Gray's sister, she considered that she had to follow up the telephone call as soon as possible and it would not have been appropriate to wait for someone to deliver the news in person.

48. The prison's managing chaplain was appointed as the prison's family liaison officer (FLO) that afternoon. He telephoned Mr Gray's sister at 5.20pm. He introduced himself as the FLO and offered his condolences. He explained what would happen next and provided his contact details.

49. The FLO provided ongoing support to Mr Gray's sister. He arranged for Mr Gray's sister and brother to visit the prison and for a memorial service to be held the same day.

50. Mr Gray's funeral was on 5 February. The prison offered a financial contribution towards the costs of the funeral in line with national guidance,

Support for prisoners and staff

51. After Mr Gray's death, the prison 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.

52. Later in the afternoon of 17 January, a SO and the FLO informed the prisoners on Mr Gray's wing that he had died and offered support. The prison posted notices informing other prisoners of Mr Gray'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 Gray's death.

53. The prison held a memorial service on 23 January.

Post-mortem report

54. The post-mortem report gave Mr Gray's cause of death as acute left ventricular disease and ischaemic heart disease.

55. There was evidence that Mr Gray had used a psychoactive substance at some time prior to his death. However, there is no indication that this contributed to his death in any way. The pathologist recorded Mr Gray's death as due to natural causes.

Findings

Clinical care

56. Mr Gray had a significant medical history of complex heart issues. During his time at Humber, he was monitored closely and appropriately referred to hospital when needed. Healthcare staff put care plans in place for his ongoing needs. His medications were appropriate at all times. Mr Gray had significant engagement with primary care services and the complex case process was used appropriately to ensure a 'joined-up' approach to Mr Gray's care. This was in accordance with National Institute for Clinical Excellence (NICE) guidelines.

57. The clinical reviewer concluded that the clinical care Mr Gray received while at Humber was equivalent to that which he could have expected to receive in the community. We agree.

Emergency response

Communications network

58. Prison Service Instruction (PSI) 03/2013 sets out the procedures for calling a medical emergency over the radio network in all public and contracted prisons. It states, "The intention is to ensure timely, appropriate and effective response to medical emergencies and thereby to maximise the likelihood of a positive outcome for the patient."

59. HMP Humber does not have a local policy or guidance for staff setting out best practice in a medical emergency when either an individual radio or the radio network is not working. The investigator was told that staff would have been told in officer training that they can use the general alarm, a telephone, or call for help in an emergency if their radio does not work.

60. When the officer saw Mr Gray go stiff and collapse, she immediately tried to call for assistance on her radio but the radio network transmission was blocked. She shouted to other officers on the wing to call an emergency code. In the absence of CCTV, we do not know how much time elapsed between the officer trying to radio a code blue and a code blue being called successfully. It is unlikely that this delay had any impact on the eventual outcome for Mr Gray. However, any delay in future cases could be critical.

61. In addition, we are concerned that staff do not have the assurance that they can always use their radios in an emergency. If radio communication fails, staff should be aware of alternatives such as pressing the general alarm or using their personal alarms in order to summon immediate help in an emergency. We make the following recommendation:

The Governor should:

- **ensure that individual radios are regularly tested and the radio network is fully operational at all times so that staff can use their radios to make emergency calls; and**

- **provide guidance to staff on alternative methods for raising the alarm in an emergency if radio communication fails.**

Ambulance response

62. The control room called an ambulance at 2.17pm and the ambulance arrived at 2.38pm. We are concerned that it took so long for the ambulance to arrive. Ambulance response times are outside the Ombudsman's remit. However, we note that the OSG said that he was on the phone to the ambulance service for about ten minutes while he waited for an update from healthcare staff. This may suggest that the ambulance was not despatched until the OSG had obtained and provided details of Mr Gray's condition.

63. Under PSI 03/2013 each prison is required to have a medical emergency response protocol agreed in conjunction with the local healthcare commissioner and the local ambulance trust. This should normally provide that, in recognition of the special circumstances of prisons, an ambulance will be despatched immediately in response to a medical emergency code without the need to wait for detailed information about the precise nature of the emergency (beyond the broad outlines provided by code red or code blue). We recommend:

The Governor should review the operation of Humber's medical emergency response code protocol with the local healthcare commissioner and ambulance trust to ensure that ambulances are despatched without delay when a medical emergency code is called.

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