Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Bramble a prisoner at HMP Wormwood Scrubs on 16 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*

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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 Keith Bramble died of heart disease caused by a severe narrowing of the arteries of the heart on 16 January 2019 at HMP Wormwood Scrubs. Mr Bramble had a urinary tract infection, high blood pressure and high cholesterol which contributed to but did not cause his death. He was 59 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that the healthcare that Mr Bramble received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community. However, I am concerned that healthcare staff did not follow up an outstanding medical appointment, Mr Bramble's complex medications were not linked to a diagnosis and he did not have a hypertension care plan in place.

When Mr Bramble was found unresponsive, prison and healthcare staff responded promptly and carried out CPR before paramedics arrived and took over. Prison staff did not offer adequate support to a prisoner who was involved in the emergency response.

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 **July 2019**

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Summary

Events

1. Mr Keith Bramble was sentenced to 10 years and six months in prison in 2012 and released on licence in 2017. He was recalled on 28 April 2018, and sent to HMP Wormwood Scrubs.

2. On 28 April, a nurse completed Mr Bramble’s initial health screen and noted an outstanding medical appointment. A prison GP reviewed Mr Bramble and noted that he had a heart flutter (heart palpitations) and hypertension (high blood pressure). The GP re-prescribed Mr Bramble’s medication. On 29 April, when the nurse completed Mr Bramble’s second health screen, he did not note the outstanding appointment and did not arrange for a care plan to be created for Mr Bramble’s hypertension.

3. On 1 May, healthcare staff asked Mr Bramble’s community GP for his medical records. These were provided promptly but did not explain why Mr Bramble had been prescribed all his medication. Healthcare staff took no further action at that time.

4. On 18 June, a prison GP discussed Mr Bramble at a multidisciplinary team meeting. The GP decided that he should have weekly blood pressure checks but this did not happen from September to December.

5. Mr Bramble was prescribed apixaban (a blood-thinning drug). A prison dentist, who saw Mr Bramble on 24 December, asked for a blood test to see how thin his blood was and how long it took to clot. A nurse, who reviewed the results, could not link a diagnosis to his prescription of apixaban and arranged for staff to contact Mr Bramble’s GP practice to find out why he was prescribed this drug. They did so on 7 January 2019 but the GP practice provided no further information.

6. At 8.00am on 16 January, Mr Bramble went to the gymnasium. At 9.30am, a prisoner saw him lying on a bench, unwell. At about 10.00am, a physical education instructor escorted the prisoners, including Mr Bramble, back to the wing. Mr Bramble told another prisoner that he had chest pains. Neither Mr Bramble nor the prisoner told staff about this.

7. Between 9.40am and 10.00am, an officer spoke to Mr Bramble who was lying on his bed in his cell. He told the officer that he had a pain in his leg and was unable to walk downstairs to see the nurse. The officer went to find a nurse but was told that there were none on the wing. Having sought advice from a supervising officer, the officer returned to Mr Bramble’s cell. Mr Bramble told him that he felt better and wanted to rest.

8. At 11.11am, the officer was handing out lunch with a prisoner. When he opened Mr Bramble’s cell door, the officer saw that he was lying on his side on his bed, with a blanket covering his shoulders and back and with his back to the door. The officer and prisoner shouted into the cell but got no response.

9. Another prisoner went into the cell and saw that Mr Bramble was not breathing. At 11.23am, the officer pressed the general alarm bell. Officers immediately went to the cell and a senior officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). The control room called for an ambulance at 11.25am.

10. A prisoner started cardiopulmonary resuscitation (CPR) before officers took over resuscitation attempts. A nurse, a prison GP and a healthcare support worker promptly went to Mr Bramble's cell and continued resuscitation attempts until paramedics arrived and took over. Shortly afterwards, they pronounced that Mr Bramble had died. The post-mortem examination established that he died of heart disease.

Findings

Clinical care

11. The clinical reviewer said that the care that Mr Bramble received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community.

12. However, Mr Bramble's outstanding medical appointment was not followed up at his second health screen and he did not attend the appointment.

13. Mr Bramble had seven prescribed medications. It was not clear why he was prescribed all his medication. Healthcare staff should have promptly checked with his community GP and when they could not establish a diagnosis, they should have escalated the matter to a prison GP to progress promptly. This did not happen.

14. Mr Bramble should have had a care plan for hypertension at Wormwood Scrubs.

15. There is no record that healthcare staff checked that Mr Bramble was taking his medication properly. Since Mr Bramble's death, Wormwood Scrubs has introduced a system to check prisoners' compliance.

16. It is unclear after Mr Bramble felt unwell why a nurse did not see him before he died. However, as Mr Bramble told an officer that he was feeling better and wanted to rest, it is reasonable that staff did not seek urgent medical assistance when a wing nurse was not available.

Support for prisoners and staff

17. A prisoner who was involved in the emergency response said that he was not offered support after the incident. On 22 January, an inreach nurse saw him but said that he was not distressed. She advised him to contact the inreach team, Listeners, the Samaritans or the chaplaincy and told him that the safer custody team would visit him. The prisoner told us that the safer custody team visited four or five weeks after the incident.

Recommendations

- The Head of Healthcare should ensure that healthcare staff follow up external medical appointments identified at initial health screens during second health screens.
- The Head of Healthcare should ensure that when prisoners have multiple prescriptions:
  - healthcare staff check that each medication is linked to a specific diagnosis and recorded in prisoners' medical records; and
  - where it is not possible to link a diagnosis, healthcare staff promptly bring it to the attention of a prison GP and discuss the case at a primary care complex case meeting.
- The Head of Healthcare should ensure that staff implement a care plan to manage prisoners with hypertension soon after their arrival at Wormwood Scrubs or soon after diagnosis.
- The Governor should ensure that prisoners who have been present at a death receive appropriate support.

The Investigation Process

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

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

20. NHS England commissioned a clinical reviewer to review Mr Bramble's clinical care at the prison. The investigator jointly interviewed six members of staff and one prisoner with the clinical reviewer at Wormwood Scrubs on 20 February.

21. We informed HM Coroner for West London District of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

22. The PPO's family liaison officer, contacted Mr Bramble's ex-partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no specific questions. She received a copy of the initial report and made no comments.

23. We shared the initial report with the Prison Service. There were three factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Wormwood Scrubs

24. HMP Wormwood Scrubs is a local prison in West London, holding nearly 1,300 prisoners who are on remand from West London courts and London prisoners serving short sentences or nearing the end of long sentences. Care UK is contracted to provide primary care and several other health services at Wormwood Scrubs.

25. In August 2018, Wormwood Scrubs was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Wormwood Scrubs was in July 2017. Inspectors reported that because of severe staff shortages, there were significant staff redeployments and a failure to deliver basic services. They noted that groups of relatively junior staff managed large, challenging wings, and some lacked the confidence to challenge the men in their care adequately. They concluded that healthcare provision was reasonably good although the restricted prison regime had an impact on the effective delivery of some services. Inspectors found that healthcare staffing difficulties had begun to improve as a result of an ongoing recruitment campaign and use of regular agency staff. They noted that although prisoners could see a nurse each day on the wings, it was for a limited time due to the restricted time out of their cells. Inspectors reported that overall, it was an extremely concerning picture, and they could see no justification for why this poor situation had persisted since 2014.

Independent Monitoring Board

27. 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 May 2018, the IMB reported that until July 2017, staff shortages meant that many daily routines could only function by diverting staff from other tasks. However, they noted that by January 2018, the staffing situation began to improve as new staff were recruited. They found that the standard of healthcare remained generally acceptable but there were problems getting prisoners to appointments. They noted that Wormwood Scrubs did not always provide the same level of access to healthcare that would be available in the community.

Previous deaths at HMP Wormwood Scrubs

28. Mr Bramble was the ninth prisoner to die at Wormwood Scrubs since January 2017. Three of the previous deaths were from natural causes and five were self-inflicted. There were no significant similarities with the previous deaths.

Key Events

29. On 15 June 2012, Mr Keith Bramble was sentenced to 10 years and six months in prison for robbery and possession of a weapon. On 2 March 2017, Mr Bramble was released on licence and on 28 April 2018, he was recalled to custody and sent to HMP Wormwood Scrubs.

30. On 28 April, a nurse completed Mr Bramble's initial health screen. He noted that Mr Bramble had an outstanding medical appointment on 5 May but there were no other details about this. He noted that Mr Bramble was overweight, with a body mass index (BMI) of 26.8. His blood pressure (120/72) and pulse rate (80 beats per minute) were normal. He noted that Mr Bramble said that he did not drink alcohol and had never smoked (although he had previously said that he was a smoker).

31. A prison GP reviewed Mr Bramble and noted that he had a heart flutter and hypertension. He re-prescribed the seven medications that he took in the community. These were generally prescribed for heart disease, high blood pressure, heart failure and to prevent blood clots. Healthcare staff allowed him to keep his medications in his cell and administer them himself.

32. On 29 April, a nurse completed Mr Bramble's second health screen. There is no evidence that the nurse asked him about his hypertension (high blood pressure), the medication that he was taking or his outstanding medical appointment.

33. On 1 May, a pharmacy technician asked Mr Bramble's community GP for his medical records and on 7 May, a pharmacy officer reviewed them. She noted Mr Bramble's medication history.

34. On 24 May, a nurse manager referred Mr Bramble to a gym class for those over the age of 50 years.

35. On 6 June, a prison GP noted that Mr Bramble's blood tests were overdue. They were scheduled for 12 June but were not completed. The records do not explain why not. The blood tests were rebooked for 20 June.

36. On 18 June, a prison GP manager noted that Mr Bramble was discussed at a multidisciplinary team meeting. He planned for baseline blood tests and for healthcare staff to check Mr Bramble's blood pressure weekly.

37. On 20 June, Mr Bramble refused to have his blood tests because he said that "he only had this done once a year and saw no reason to have this done again". He again refused to have the blood tests on 4 July, and did not allow his blood pressure to be taken on 12 July.

38. On 30 July, a nurse reviewed whether Mr Bramble could continue to keep and administer his own medication. She decided that he could, and gave him a dosette box to help him monitor which medications he had taken. On 1 August, the nurse checked his blood pressure (137/85) and pulse rate (79 beats per minute) which were both normal.

39. On 8 August, a senior nurse checked Mr Bramble's blood pressure (130/85) and pulse rate (86 beats per minute) which remained in in the normal range. There is

no record that Mr Bramble had his blood pressure or pulse rate taken from September to December.

40. On 24 December, Mr Bramble saw a prison dentist, who asked for him to complete an international normalised ratio (INR) blood test (a blood-clotting test). This is required for some blood-thinning drugs, and Mr Bramble was prescribed and took apixaban, a blood-thinning medication. On 27 December, a nurse completed a blood test for Mr Bramble. A nurse reviewed it and noted that the advice from the British National Formulary (the authoritative source for prescribing in England and Wales) was that an INR is neither required nor accurate in monitoring apixaban. She found that there was no diagnosis linked to Mr Bramble's prescription of apixaban in his medical records and sent a request to the pharmacy team to check with Mr Bramble's GP why he was prescribed apixaban.

41. On 31 December, a prison GP manager reviewed Mr Bramble's medication and noted that his blood pressure and pulse should be monitored. On 2 January 2019, a pharmacist asked for the information from Mr Bramble's community GP. On 7 January, a pharmacy technician, received a telephone call from Mr Bramble's community GP practice. They had no extra information about Mr Bramble's previous cardiology appointments or his hospital discharge sheets and there is no evidence that they provided any information about his diagnoses or the reason he was prescribed apixaban.

42. On 11 January, a nurse checked Mr Bramble's blood pressure (129/74) and pulse (72 beats per minute) which were both in the normal range.

Events of 16 January 2019

43. At 8.00am on 16 January, Mr Bramble went to the gym for exercise. At 9.30am, a prisoner saw Mr Bramble lying on a bench and saw that he did not look well. He asked Mr Bramble if he was alright but he did not answer.

44. When the class ended at about 10.00am, a physical education instructor escorted the prisoners, including Mr Bramble, back to their wing. She said that she knew Mr Bramble as a gym user but did not recall that he looked unwell that day or if he had told any members of staff at the gym that he felt ill.

45. A prisoner said that he spoke to Mr Bramble after he came back from the gymnasium. Mr Bramble told him that he had chest pains. He did not report this to staff.

46. Between 9.40am and 10.00am, a newly-recruited officer who was on probation, saw that the emergency call bell light was on outside Mr Bramble's cell (which was on the third landing). The officer did not know why the light was on because all the cell doors were unlocked and open. He looked into the cell and saw Mr Bramble, lying on the bed. He told the officer that he had a pain in his leg and was unable to walk downstairs to see the nurse.

47. The officer went to the ground floor of the wing to find a nurse. He spoke to a member of healthcare, who said that there was no nurse on duty on the wing so he went to see a Supervising Officer (SO). We were unable to interview the officer because he has not returned to work since Mr Bramble's death but in his

written statement, he said that the SO told him to return to Mr Bramble's cell and check on his welfare and that a prison nurse would be contacted to attend the wing. The SO told the investigator that when the officer told him that Mr Bramble felt unwell, he told him to ask the wing nurse when she was coming back or if she could visit Mr Bramble.

48. The officer did not speak to the on-duty prison nurse but in his statement, he said he did as the SO advised, he went back to Mr Bramble's cell to tell him that a nurse would come to see him. Mr Bramble told him that he felt better and asked him to close the cell door slightly so that he could rest. About 15 minutes later, the officer checked on Mr Bramble again. He said that Mr Bramble told him that he was fine and just wanted to rest. There is no evidence that a nurse was contacted to see Mr Bramble.

49. At 11.11am, the officer was handing out lunch with a prisoner. The fire marshall, was nearby checking on fire alarms. When he opened Mr Bramble's cell door, the officer saw him lying on his side on his bed, with a blanket over his shoulders and back and with his back to the door. The officer and the prisoner shouted into the cell but got no response from Mr Bramble.

50. The fire marshall went into the cell and saw that Mr Bramble was not breathing. He tried but could not find a pulse on his neck. He told the officer that Mr Bramble was not breathing. The fire marshall and another prisoner lifted Mr Bramble onto the floor.

51. At 11.23am, the officer pressed the general alarm bell. Officers promptly went to the cell, the SO radioed a medical emergency code blue and the control room called for an ambulance at 11.25am.

52. The fire marshall started cardiopulmonary resuscitation (CPR). An officer and the SO took over CPR from the fire marshall. A nurse took over chest compressions and assessed him. A prison GP inserted a tube into Mr Bramble's airway.

53. A healthcare support worker and a nurse then took over chest compressions.

54. At 11.32am, an ambulance arrived at the prison and officers escorted the paramedics promptly to the cell where they took over resuscitation efforts.

Contact with Mr Bramble's family

55. On 16 January, the Head of Safer Custody appointed, a public protection lead, as the family liaison officer (FLO) and an officer as the deputy family liaison officer.

56. Mr Bramble's prison records did not list a next of kin. He had not made a telephone call or had a prison visit since April 2018. Police records listed his ex-partner as his next of kin and on 19 January, a police officer told Mr Bramble's ex-partner that he had died. She telephoned Wormwood Scrubs and spoke to The FLO who offered her support. On 30 January, the FLO visited Mr Bramble's ex-partner and offered her condolences.

57. Mr Bramble's funeral took place on 18 February, and Wormwood Scrubs contributed to its cost in line with national instructions.

Support for prisoners and staff

58. After Mr Bramble's death, a custodial manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

59. The prison posted notices informing other prisoners of Mr Bramble'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 Bramble's death.

60. The fire marshall said that after the incident, prison staff did not support him, or offer support. He said that the SO spoke to him soon after the incident and thanked him for his help, and that an officer from the safer custody department saw him four to five weeks after the incident. The fire marshall said that the officer thought that he wanted to speak to someone from the safer custody team but he had wanted to see the mental health team.

61. On 22 January, a nurse from the inreach team saw the fire marshall. He said that the fire marshall was not distressed and he had told him to speak to the inreach team, Listeners, the Samaritans or the chaplaincy and that officers from the safer custody team would visit him.

Post-mortem report

62. A post-mortem examination established that Mr Bramble died of ischaemic heart disease caused by severe coronary artery atheroma (a narrowing of the arteries of the heart). It concluded that he had a urinary tract infection, hypertension (high blood pressure) and hypercholesterolaemia (high cholesterol) which contributed to but did not cause his death.

Findings

Clinical care

63. The clinical reviewer, said that overall, the care that Mr Bramble received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community.

64. Mr Bramble had a number of risk factors for coronary heart disease. He had hypertension, a history of smoking and he was overweight. However, the clinical reviewer noted that he took medication to lower his blood pressure, to reduce cholesterol and to thin his blood.

65. However, we are concerned that there were a number of deficiencies in his healthcare. Mr Bramble said at his initial health screen that he had an outstanding medical appointment on 5 May. Staff did not follow this up at his second health screen, as they should have, and he did not attend his appointment. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff follow up external medical appointments identified at initial health screens during second health screens.

66. Mr Bramble was prescribed seven medications in the community. The clinical reviewer said that the community medical records did not have enough detail to understand why Mr Bramble was prescribed his medications, how they were linked to a diagnosis and whether there were any follow-up plans. However, she noted that the drugs prescribed to him in the community needed to be continued at Wormwood Scrubs, even though they were not all linked to a diagnosis because they would have reduced his risk of heart disease. Although prison staff received information about Mr Bramble's prescriptions promptly, it was unclear why he was prescribed two beta blockers and a blood-thinning medication.

67. When the prison dentist asked for an INR blood test, this prompted further discussion with Mr Bramble's community GP about his blood-thinning medication, apixaban. There is no record of a detailed conversation with Mr Bramble to find out why he had been prescribed apixaban and what diagnoses he had. We appreciate that healthcare staff made some attempts to understand why he was prescribed his medication and the prison GP manager said that there was a plan to see Mr Bramble to discuss his diagnoses and medication. However, in complex prescribing cases such as Mr Bramble's, healthcare staff should do more - and promptly - to understand a prisoner's prescriptions. We make the following recommendation:

    The Head of Healthcare should ensure that when prisoners have multiple prescriptions:

    - **Healthcare staff check that each medication is linked to a specific diagnosis and recorded in prisoners' medical records; and**

- **where it is not possible to link a diagnosis, healthcare staff promptly bring it to the attention of a prison GP and discuss the case at a primary care complex case meeting.**

When Mr Bramble refused to have his blood pressure and pulse rate checked, healthcare staff completed a refusal form but did not discuss his case with a prison GP or at a multidisciplinary team meeting. Mr Bramble had had a hypertension care plan in place since 2012 but it was not continued at Wormwood Scrubs. There is no evidence to explain why not. The clinical reviewer recommended that the Head of Healthcare develops a clear pathway to manage prisoners with hypertension. We make the following recommendation:

The Head of Healthcare should ensure that staff implement a care plan to manage prisoners with hypertension soon after their arrival at Wormwood Scrubs or soon after diagnosis.

68. While we recognise that Mr Bramble was allowed to keep and administer his own medication and that staff gave him a dosette box to manage his intake of medication, there is no record that healthcare staff checked with Mr Bramble that he was taking his medication properly. The police found an almost full dosette box in Mr Bramble's cell which indicates that Mr Bramble was not complying with the medication regime. The system for checking compliance at the time did not include a return system so that boxes returned could be replaced with new ones, or spot checks to confirm compliance. Wormwood Scrubs have since introduced this and we therefore do not make a recommendation about this.

Events of 16 January 2019

69. Mr Bramble was feeling unwell on the morning of 16 January. He reported chest pains to a prisoner but staff did not know this before Mr Bramble's death. He also reported leg pain to an officer. Between 9.40am and 10.00am, an officer saw Mr Bramble in his cell and tried to find a wing nurse but there were none available.

70. The officer was a newly-recruited officer on probation and it was reasonable that he asked his supervising officer for advice about what to do when a wing nurse was unavailable. The officer's account of what advice the SO gave him differs from the SO's account. The officer statement said that the SO told him to check on Mr Bramble and to tell him that a nurse would visit, whereas the SO's version is that he told the officer to find out when the wing nurse was coming back and ask if the nurse could visit Mr Bramble. In the absence of any other evidence about this, we cannot know exactly what the SO told the officer to do. However, when the officer returned twice to check on Mr Bramble, he (Mr Bramble) told him on both occasions that he was feeling better and wanted to rest. Although with hindsight, it might have changed the outcome for Mr Bramble if a nurse had been called, there was no emergency at the time – Mr Bramble had initially complained of leg pains to staff but then twice said that he felt better. In these circumstances, it is reasonable that staff did not call for urgent medical assistance but tried to monitor the situation by checking twice on Mr Bramble.

71. While we recognise that the officer, who found Mr Bramble unresponsive, was new to the Prison Service and on probation and that he found himself in a challenging situation, he should have gone into the cell and radioed a code blue immediately. The officer has not returned to work since the incident and we have therefore not been able to interview him about this. We cannot explain therefore why he did not enter the cell and why he pressed the general alarm bell rather than radioing a code blue.

72. However, we are satisfied that in this case, it did not make a difference to the outcome for Mr Bramble as the supervising officer who arrived at the cell in response to the alarm called a code blue promptly and that officers and healthcare staff arrived quickly and appropriately took over resuscitation efforts. An ambulance was also promptly called and paramedics were with Mr Bramble within 14 minutes.

Support for prisoners and staff

73. The fire marshall said that after the incident, prison staff had not supported him and the mental health team had not seen him. He said that the incident had affected him because he had experienced two recent, similar events and had mental health problems.

74. A nurse from the inreach team saw the fire marshall on 22 January, six days after the incident. He gave him information about available support and told him that a member of the safer custody team would speak to him, which apparently happened four or five weeks later. There are no records to confirm exactly what happened and we were unable to identify the member of staff from the safer custody team who apparently visited him.

75. The fire marshall was involved in the emergency response and started CPR. He was affected by the incident and we consider that prison staff should have promptly checked on him and offered support as soon after the incident as possible. We make the following recommendation:

The Governor should ensure that prisoners who have been present at a death receive appropriate support.

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