Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Finnegan a prisoner at HMP Hewell on 16 September 2018

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 Joseph Finnegan died of coronary artery thrombosis (a blood clot which restricts blood flow within the heart) caused by coronary artery atheroma (a build-up of fatty deposits on the arteries around the heart) on 16 September 2018 in hospital, while a prisoner at HMP Hewell. Heart disease and diabetes also contributed to, but did not cause, Mr Finnegan's death. He was 70 years old. I offer my condolences to his family and friends.

There were deficiencies in the way that staff managed Mr Finnegan's medication and diabetic care, and he should not have been restrained when he was taken to hospital.

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 **April 2019**

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Summary

Events

1. On 31 August 2018, Mr Joseph Finnegan was remanded to HMP Hewell, charged with sex offences. He had a number of chronic diseases, including Type 2 diabetes (controlled with medication), sleep apnoea (difficulty breathing at night), Arnold-Chiari malformation (issues with the spinal cord affecting the base of the brain), hypothyroidism (an underactive thyroid controlled with medication), angina (chest pains), hearing loss and two strokes. He had reduced mobility and used a wheelchair.

2. Healthcare staff did not check the correct dosage for Mr Finnegan's diabetes medication or monitor his blood sugar levels. He became unwell and staff then realised that his diabetic medication was incorrect. This was rectified but staff failed to monitor him adequately.

3. On 15 September, Mr Finnegan told a nurse that he felt unwell. He had vomited and had breathing difficulties. She called for an ambulance. Paramedics took Mr Finnegan to hospital. Two officers escorted him and they restrained him, using an escort chain. At the request of hospital staff, they removed the escort chain for treatment.

4. In hospital, Mr Finnegan's condition deteriorated and he died at 11.05pm on 16 September 2018.

Findings

5. Mr Finnegan's diabetes care at the prison was not equivalent to the level of care that he could have expected to receive in the community. There were unnecessary delays in obtaining medical information which led to inadequate care planning.

6. Mr Finnegan was restrained when he went to hospital although he was elderly, in very poor health and used a wheelchair. The prison manager who authorised the use of restraints placed too much emphasis on the details of Mr Finnegan's alleged offence and did not reflect the impact of Mr Finnegan's condition on his risk of escape.

Recommendations

- The Head of Healthcare should ensure that community GP records are urgently passed to prison GPs for a clinical assessment to ensure continuity of healthcare.
- The Head of Healthcare and prison GPs should work together to ensure that a review of diabetic care and prescribing practices is conducted.
- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification when prisoners are restrained.

The Investigation Process

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

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

9. NHS England commissioned a clinical reviewer to review Mr Finnegan's clinical care at the prison. They jointly interviewed three members of staff at HMP Hewell on 25 October 2018.

10. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The investigator contacted Mr Finnegan's wife to explain the investigation and to ask if she had any matters that she wanted us to consider. She had no comments but asked for a copy of our report.

12. Mr Finnegan's wife received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Hewell

14. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Care UK provide health services and there is a 20-bed inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported that the prison had many challenges and areas of serious concern. Inspectors acknowledged that Care UK had inherited a poor healthcare service which needed significant further improvement. They noted that healthcare staff shortages had significantly affected service delivery, and that agency staff had been recruited to cover shortages while recruitment campaigns were run to fill vacancies. Inspectors found that areas in the healthcare unit, including the inpatient area, were dirty and poorly ventilated. They noted that the waiting area for vulnerable prisoners had prominent racist and violent graffiti and what appeared to be blood on the walls. They said that the high rate of 'failure to attend' healthcare appointments had recently improved.

Independent Monitoring Board

16. 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 30 September 2017, the IMB noted that the staffing levels were insufficient to meet the needs of the prison. They said that there were high levels of staff sickness, along with vacancies which exacerbated staffing difficulties. They said that board members had made frequent healthcare visits during which they had seen appropriate interaction between staff and prisoners.

Previous deaths at HMP Hewell

17. Mr Finnegan was the seventeenth prisoner to die at Hewell since September 2015, including eight prisoners who died from natural causes. There have been two deaths since Mr Finnegan's' death. We have made previous recommendations about the improper use of restraints which Hewell agreed to implement. We are disappointed that restraints are again an issue in this case.

Key Events

18. On 31 August 2018, Mr Joseph Finnegan was remanded to HMP Hewell, charged with sex offences and sent to HMP Hewell. Mr Finnegan had a history of Type 2 diabetes (controlled with medication), sleep apnoea (difficulty breathing at night), Arnold-Chiari malformation (issues with the spinal cord affecting the base of the brain), hypothyroidism (an underactive thyroid controlled with medication), angina (chest pains), hearing loss (which he used hearing aids for) and he had had two strokes.

19. A nurse completed a thorough reception health assessment. He noted Mr Finnegan's medical conditions and that he used a wheelchair. The nurse arranged for Mr Finnegan to be admitted to Hewell's inpatient unit and for a prison GP to review him. Later that evening, a nurse settled Mr Finnegan into his cell in the inpatient unit. She noted that he was diabetic, used a machine at night to help with his sleep apnoea, wore a hearing aid and used a GTN spray for his cardiac problems. She created care plans to manage his conditions.

20. The next day, a locum prison GP completed a review and noted that the prison needed to obtain full details about Mr Finnegan's medication from his community GP. He prescribed metformin (diabetes medication) to be taken twice a day, pending the receipt of information from Mr Finnegan's community GP. No blood tests were arranged. The healthcare team received information from the community GP on 4 September and added it to Mr Finnegan's medical records but there is no evidence that anyone reviewed it.

21. Due to Mr Finnegan's limited mobility, he had a personal emergency evacuation plan (PEEP) so staff could help him in the case of an emergency evacuation.

22. On 8 September, a nurse checked on Mr Finnegan as part of his care plan and noted that, unusually, he was struggling to get out of bed and had been incontinent of urine. She checked his blood glucose level (32.0 mmol/l), blood pressure (144/59), respiration rate (18), pulse (95), oxygen saturation level (95%) and temperature (38.3). As these were high, she told Mr Finnegan not to eat any sweets or chocolate. A few hours later, she rechecked Mr Finnegan's glucose levels and noted that they remained high. She checked his medical notes and realised that there was a discrepancy in his metformin dosage as he should have received his metformin medication three times a day. She booked an urgent GP review. She suspected that he had a urine infection so she discussed the case with a locum prison GP who said that Mr Finnegan needed a ketones test (a urine test to check insulin levels).

23. The locum prison GP examined Mr Finnegan just over an hour later. He noted that Mr Finnegan was alert and that the ketones test was positive. He diagnosed a lower urinary tract infection and said that if his condition deteriorated, staff would need to arrange for him to be admitted to hospital. He reviewed the community GP letter and prescribed antibiotics and a change in the metformin dosage to three times a day (in line with the dosage that Mr Finnegan's community GP had prescribed). He also noted that nurses should encourage Mr Finnegan to increase his fluid intake and that they should monitor his blood sugar

levels. (He did not say how often this should be done.) Nurses frequently checked on Mr Finnegan but did not monitor his blood sugar levels.

24. On 11 September, a prison GP reviewed Mr Finnegan's medical records. (This appeared as a task so Mr Finnegan was not present.) He noted that his blood sugar levels had been high and tasked the nurses to check his full blood count, blood sugar, kidney, liver, thyroid, lipids, iron, magnesium and vitamins B and D levels and to take a further urine sample to check his ketones. The blood sample was collected on 12 September. However, a nurse who provided clinical support, noted that it was difficult to obtain a sample and she was unable to do so for his full blood count. There is no record that a urine sample was taken. The next day, the hospital laboratory completed a report, and noted that the blood sample could not be analysed as it had been mislabelled. (The request form included Mr Finnegan's name but the blood sample did not.) There is no record of another sample being taken and sent to the laboratory.

25. During the evening of 15 September, Mr Finnegan told a nurse that he felt unwell. He had vomited, was very pale and sweating. She checked his observations. His blood pressure was low at 93/45 and his oxygen saturation level was low at 68%. She arranged for an ambulance to take him to hospital. Two prison officers escorted him and restrained him, using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

26. When he arrived at hospital, Mr Finnegan had a high temperature, breathing difficulties and coughed up blood. At 10.48pm, a hospital doctor asked the escort staff to remove the handcuffs in case they needed to use a defibrillator to resuscitate Mr Finnegan. The escorts contacted the prison and a prison manager, authorised the removal of the handcuffs. They were never reapplied. Mr Finnegan's condition deteriorated and he died at 11.05pm on 16 September at hospital.

Contact with Mr Finnegan's family

27. On 16 September, the prison appointed as the family liaison officer (FLO). Mr Finnegan did not have a nominated next of kin. After Mr Finnegan died, the FLO contacted staff at HMP Dartmoor (the nearest prison) and asked them to visit Mr Finnegan's family. Two prison officers visited Mrs Finnegan to break the news of her husband's death and offer their condolences and support. Hewell arranged and paid for Mr Finnegan's funeral, which was held on 15 October 2018.

Support for prisoners and staff

28. After Mr Finnegan's death, a prison manager debriefed the staff involved in the hospital bedwatch to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

29. The prison posted notices informing other prisoners of Mr Finnegan'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 his death.

Post-mortem report

30. The post-mortem report noted that Mr Finnegan died from coronary artery thrombosis (a blood clot which restricts blood flow within the heart) which was caused by coronary artery atheroma (a build-up of fatty deposits on the arteries around the heart). Hypertensive heart disease (a heart condition caused by high blood pressure) and non-insulin dependent diabetes mellitus contributed to his death but did not cause it.

Findings

Clinical care

31. The clinical reviewer found that Hewell's management of Mr Finnegan's diabetes fell below that expected in the community and did not meet the National Institute for Health and Care Excellence (NICE) guidelines on managing Type 2 diabetes.

32. Healthcare staff did not review the information from Mr Finnegan's community GP record when it arrived which meant that they did not notice that his metformin dosage was incorrect until he became unwell.

33. Prison Service Order (PSO) 3050 sets out the importance of continuity of healthcare for prisoners. The healthcare team received details of Mr Finnegan's health history and medication from his community GP but there was no continuity of care. We are concerned that when Hewell received his community medical record, it did not trigger staff activity. No one took action to review Mr Finnegan's medication or escalate the need for him to see a GP. We therefore recommend that:

    The Head of Healthcare should ensure that community GP records are urgently passed to prison GPs for a clinical assessment to ensure continuity of healthcare.

34. The clinical reviewer concluded that there was inadequate care planning for testing Mr Finnegan's blood sugar levels. On arrival at Hewell, staff knew that he was diabetic and created a diabetic care plan. However, this was never updated and they did not arrange blood tests until eight days after his arrival when he became ill with a urinary tract infection. The clinical reviewer noted that a finger prick blood test could have been completed on the first day and this would have provided immediate information to assess and manage Mr Finnegan's diabetes. Even when the test was completed on 8 September and showed high levels, it was not repeated until 15 September when Mr Finnegan told staff that he felt unwell.

35. The clinical reviewer noted that the NICE guidelines said that in order to manage diabetes and prescribe the correct medication, staff needed to take blood tests to check Mr Finnegan's kidney function. He said that urgent tests could have been completed the day after Mr Finnegan arrived at Hewell, and results would have been available that day. He noted that even if routine tests had been taken, results would have been available in four or five days. However, the blood tests were not requested until eleven days after Mr Finnegan arrived and the sample was mislabelled which meant that the tests were never completed. The Head of Healthcare acknowledged this and said that arrangements had already been made to introduce a label printing machine.

36. The clinical reviewer has made a number of recommendations which the Head of Healthcare will need to address, and we make the following recommendation about Hewell's general approach to diabetes care:

    The Head of Healthcare and prison GPs should work together to ensure that a review of diabetic care and prescribing practices is conducted.

Restraints, security and escorts

37. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

38. When Mr Finnegan left court and was escorted to Hewell on 31 August, he was not restrained. However, fifteen days later, when his health declined and he needed to go to hospital urgently, he was restrained with an escort chain.

39. The escort risk assessment was fully completed, and included medical information about Mr Finnegan's medical issues, including that he had had previous strokes and had low blood pressure, diabetes, angina, an overactive thyroid, no feeling in his legs, used a hearing aid, had an active PEEP and used a wheelchair. It was appropriately noted that all his risk factors to the public and prison staff were low. The security assessment noted that the authorising manager may wish to consider not restraining him, taking into account his poor health and limited mobility.

40. Contrary to the risk assessment, Mr Finnegan's Person Escort Record (PER) noted that as an unsentenced prisoner, he should be double handcuffed (where the prisoner's hands are handcuffed together and a second pair of handcuffs are attached to the prisoner and a prison officer). However, due to his severe mobility difficulties, the escort contacted the duty manager, who instructed that an escort chain should be used at all times, unless Mr Finnegan's behaviour changed, in which case double handcuffs should be used. The duty manager added a note to the PER that there were double handcuffs in the emergency bag which could be applied, if needed.

41. At interview, the duty manager said that she had spoken to a nurse about Mr Finnegan's condition and his transfer to hospital. (She could not recall who she spoke to and did not note this on the escort risk assessment.) She said that when she authorised the use of restraints, she took into account the nature of the offence and the fact that Mr Finnegan was on remand.

42. There is no evidence that she considered Mr Finnegan's health and lack of mobility at the time, and their impact on his risk of escape. His escort risk assessment was completed, with comprehensive medical input at the time of departure. He needed help for all his care needs and had difficulty getting out of bed. We are concerned that staff appear not to understand a fundamental aspect of the High Court judgement – the need to take into account a medically-informed assessment of the impact of the prisoner's condition on their risk of escape and, in the event of their escape, the risk to the public. We repeat the recommendation which Hewell agreed to implement last year:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification when prisoners are restrained.

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