Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Cartwright, a prisoner at HMP Oakwood, on 13 November 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 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 we oversee can improve their work in the future.

Mr Peter Cartwright died on 13 November of a heart attack caused by ischaemic heart disease while a prisoner at HMP Oakwood. He was 72 years old. I offer my condolences to Mr Cartwright's family and friends.

I am satisfied that the care Mr Cartwright received for his diabetes was equivalent to that which he could have expected to receive in the community.

However, I am concerned that there was a delay in conducting tests at HMP Hewell and HMP Oakwood which could have confirmed Mr Cartwright's diagnosis of heart problems sooner. I am not satisfied that this aspect of Mr Cartwright's care was equivalent to that which he could have expected to receive in the community.

I am also concerned that there were no care plans documented in Mr Cartwright's medical record and that healthcare staff at Oakwood did not increase his medication for his heart problems as recommended by his hospital consultant.

The clinical reviewer could not say if these failings affected the outcome for Mr Cartwright.

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 **June 2020**

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Summary

Events

1. On 23 March 2019, Mr Peter Cartwright was remanded to HMP Hewell. On 16 May 2019, he was sentenced to five years in prison for sexual offences. On 29 May 2019, Mr Cartwright was transferred to HMP Oakwood.

2. Mr Cartwright had a history of heart disease, high blood pressure, high cholesterol, chronic kidney disease and type 2 diabetes. He took prescribed medication to manage and treat his conditions. A GP at Hewell examined Mr Cartwright and requested diagnostic tests. Healthcare staff reviewed him regularly.

3. Following his transfer to Oakwood, Mr Cartwright was seen regularly by prison GPs and healthcare staff. They monitored his diabetes and cardiac conditions. In July, a prison GP referred him to a cardiology consultant. Tests found a probable previous heart attack and a problem with Mr Cartwright's heart, which had lost its ability to pump properly. The consultant recommended changes to Mr Cartwright's medication.

4. On 10 November, Mr Cartwright was diagnosed with a urine infection and was prescribed antibiotics. The infection made him feel dizzy, faint and unsteady on his feet and on 12 November, he had two falls. On both occasions, an officer radioed a medical emergency code and a prison paramedic attended.

5. At 11.30pm, Mr Cartwright's cellmate rang the cell bell because Mr Cartwright had fainted and banged his head. Officers responded and entered the cell and cleaned a cut on the back of Mr Cartwright's head. They helped him back to bed and monitored him throughout the night.

6. On 13 November at 7.00am, Mr Cartwright's cellmate rang the cell bell again. An officer responded and found Mr Cartwright unresponsive. He did not appear to be breathing. The officer radioed a code blue medical emergency and was joined by a second officer almost immediately. They entered the cell and began cardiopulmonary resuscitation (CPR). Control staff called an emergency ambulance.

7. Healthcare staff arrived quickly and continued with CPR. They gave Mr Cartwright oxygen and attached a defibrillator to his chest. No shock was advised.

8. Paramedics arrived after approximately 30 minutes and began advanced life support. A slight pulse was detected and at 8.10am, Mr Cartwright was taken to hospital. He was escorted by two officers but he was not restrained.

9. At 9.08am, on arrival at hospital, a doctor confirmed that Mr Cartwright had died.

10. The Coroner gave Mr Cartwright's cause of death as a heart attack caused by ischaemic heart disease.

Findings

11. The clinical reviewer concluded that the care Mr Cartwright received for his diabetes was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

12. However, the clinical reviewer found that there were delays at HMP Hewell and at HMP Oakwood in completing diagnostic tests for Mr Cartwright's heart problems, including an electrocardiogram and blood tests, which, if completed sooner, could have reduced the time taken to confirm Mr Cartwright's diagnosis. The clinical reviewer concluded that this aspect of Mr Cartwright's care was not equivalent to that which he could have expected to receive in the community.

13. Also, there were no documented care plans at Hewell or Oakwood relating to Mr Cartwright's care and there was a delay in increasing his medication for his heart problems at Oakwood as recommended by his cardiology consultant.

14. The clinical reviewer could not say if these delays affected the outcome for Mr Cartwright.

Recommendations

- The Head of Healthcare at HMP Hewell and HMP Oakwood should ensure that diagnostic tests requested by a GP are completed in a timely manner and that the GP is informed of any delays or if the tests cannot be completed.
- The Head of Healthcare at HMP Hewell and HMP Oakwood should ensure that staff create and document care plans for all prisoners with heart disease, high blood pressure, chronic kidney disease and type 2 diabetes, in line with national guidelines.
- The Head of Healthcare at HMP Oakwood should ensure that changes to medication recommended by specialists are introduced as instructed.

The Investigation Process

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

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

17. NHS England commissioned an independent clinical reviewer to review Mr Cartwright's clinical care at the prison.

18. We informed HM Coroner for South Staffordshire District of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Cartwright's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Cartwright's son did not respond to our letter.

20. The initial report was shared with HMPPS. They did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Oakwood

21. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

22. The last inspection of HMP Oakwood was in February and March 2018. Inspectors reported that health services had improved considerably since their last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans. However, there were often delays in arranging external hospital appointments because of the high demand and insufficient escort staff.

Independent Monitoring Board

23. 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 March 2019, the IMB reported that the introduction of pharmacy technicians had resulted in an improvement in the management of medication. There had been a reduction in the number of missed healthcare appointments and the ongoing use of prison based paramedics continued to provide benefits. The Board expressed concern that some prisoners attending visits were unable to collect medication on their return as they had missed their appointment.

Previous deaths at HMP Oakwood

24. Mr Cartwright was the fourteenth prisoner to die at Oakwood since November 2017. Of the previous deaths, 11 were from natural causes and two were drug-related. We have highlighted delays in completing diagnostic tests and the lack of recorded care planning in previous investigations.

Key Events

25. On 23 March 2019, Mr Peter Cartwright was remanded to HMP Hewell charged with sexual offences. On 16 May, he was sentenced to five years in prison.

26. Mr Cartwright had a history of heart disease, high blood pressure, high cholesterol, chronic kidney disease and type 2 diabetes. He had previously had a cardiac stent fitted (a short wire-mesh tube that acts like a scaffold, inserted to help keep an artery open). Mr Cartwright took aspirin, atorvastatin, bisoprolol and enalapril for heart and kidney disease and linagliptin for diabetes.

HMP Hewell

27. At his initial health screen, Mr Cartwright told healthcare staff that his previous GP was in Spain. This led to some initial difficulties in prescribing his medication. On 28 March, Mr Cartwright told a prison GP that he did not know the name or the doses of the medication that he took. The next day, the prison contacted Mr Cartwright's friend who lived in Spain and obtained a copy of Mr Cartwright's repeat prescriptions.

28. On 4 April, a prison GP saw Mr Cartwright for a follow up review. Mr Cartwright said that he was due to see a cardiologist in Spain on 3 May 2019, because he had an enlarged heart. Mr Cartwright also had a dry scaly rash on his face and back, which he said was psoriasis and which he treated with over the counter cream.

29. The GP examined Mr Cartwright's chest and noted normal heart sounds. His pulse was 'rhythm regular' and he did not identify any concerns. The GP arranged for several tests to be completed including blood tests, an electrocardiogram (ECG, a simple test that is used to check the heart's rhythm and electrical activity) and an echocardiogram (a scan used to look at the heart and nearby blood vessels). The GP also recommended that Mr Cartwright's skin condition be monitored.

30. On 15 April, Mr Cartwright attended the health clinic for his blood test. Some blood tests, but not all, were completed. The, NT-proBNP test (used to identify systolic heart failure) that the GP had asked to be conducted was not completed. Mr Cartwright's ECG was also not completed. A nurse recorded in the medical record, 'unable to do ECG, no stickers for tracing'. The nurse examined Mr Cartwright's skin.

31. On 10 May, Mr Cartwright was reviewed by a locum GP. The GP recorded that Mr Cartwright had hypertensive disease but appeared alert and well and his blood pressure was well controlled. The GP noted that Mr Cartwright was waiting for an ECG and requested further bloods tests to be completed including the NT-proBNP test. There is no evidence to indicate that these tests were completed before Mr Cartwright transferred to Oakwood on 29 May.

HMP Oakwood

32. At his initial health screen on 29 May, a nurse recorded Mr Cartwright's pre-existing conditions and medication. Mr Cartwright refused to have a blood test

for his diabetes. He told the nurse that he took medication to control his diabetes and that his blood test results were usually fine. The nurse noted that Mr Cartwright was awaiting an ECG and sent a 'task' to have this arranged.

33. On 9 June, Mr Cartwright had what was recorded as a 'routine' ECG. A prison GP examined him the next day but could not find the results of the ECG in his medical record. The GP highlighted Mr Cartwright's ongoing shortness of breath. He requested blood tests including NT-proBNP.

34. On 24 June, a prison GP reviewed Mr Cartwright. His NT-proBNP blood test had still not been completed. The GP examined Mr Cartwright and recorded 'heart sounds normal, no pitting oedema (swelling due to fluid accumulation), chest clear, clinically not in failure'. He requested further blood tests and a chest X-ray.

35. On 26 June, Mr Cartwright had blood tests completed but not the NT-proBNP. This was eventually done on 2 July. Three results from the NT-proBNP are recorded in the medical record. Two of the results were recorded as normal but the third reads 'Abnormal, looks to have heart failure'. A prison GP referred Mr Cartwright to the heart failure clinic. On 18 July, Mr Cartwright was given an appointment for 11 September at the Heart Assessment Clinic at New Cross Hospital.

36. On 27 June, Mr Cartwright had a diabetic retinal screen (offered to diabetics who, because of the disease, are more susceptible to eyesight issues) and a follow up assessment on 23 July. The results identified bilateral cataracts. The optician referred Mr Cartwright to the hospital's ophthalmology department for surgery.

37. On 11 September, Mr Cartwright attended New Cross hospital for his cardiology appointment. He was accompanied by two officers and handcuffed to one of them. (Although he was elderly, Mr Cartwright was mobile and was assessed as a high risk to children.)

38. Mr Cartwright had an ECG. The results showed a probable previous heart attack, and the echocardiogram results identified severe left ventricular systolic dysfunction (where the heart loses the ability to pump properly).

39. In the consultant's letter that followed, he recommended increasing Mr Cartwright's heart failure medications and adding spironolactone (used to treat heart failure, high blood pressure, fluid retention and certain types of kidney disorder), initially by 12.5mgs daily but increasing to 25mgs daily after a week, if his kidney function was stable. The consultant also requested an MRI scan (a type of scan that uses magnetic fields and radio waves to produce a detailed image of the inside of the body). A prison GP prescribed the initial dose immediately but healthcare staff did not increase any further doses until 3 October 2019, just over three weeks later.

40. Mr Cartwright continued to have blood tests to monitor his condition. On 24 September, the results showed raised potassium levels. A prison GP asked for the tests be repeated and on 25 September and a nurse took and submitted a blood sample for urgent examination. The results showed that the potassium levels had reduced and were towards the normal range. On 26 September, the GP prescribed Mr Cartwright atorvastatin (to help lower cholesterol levels).

41. On 8 October, a podiatrist examined Mr Cartwright as part of his diabetes monitoring. The assessment identified patchy nerve damage to both feet but Mr Cartwright did not have any other symptoms. He told the podiatrist that his diabetes was well controlled. Mr Cartwright's blood pressure and pulse were recorded and they were within the normal range.

42. On 11 October, the prison received a medical letter confirming the date for Mr Cartwright's MRI scan which was scheduled for 29 October. However, on 23 October, the appointment was cancelled because the prison did not have enough escort staff available on that day. A new appointment was made for 12 December.

43. On 17 October, a prison GP reviewed Mr Cartwright and requested blood and urine samples. At a follow-up review two days later, the GP recorded that Mr Cartwright had chronic kidney disease.

44. On 23 October, at the prison's wellman clinic, Mr Cartwright told a nurse that he felt generally unwell. He said that he was eating and drinking well, urinating and opening his bowels regularly, but that his stools were hard. His vital signs were within the normal range. The nurse advised him to drink more and to contact healthcare staff if he became less 'regular'.

45. On 29 October, the prison received confirmation of Mr Cartwright's ophthalmology appointment which was scheduled for 9 November. However, the prison was unable to provide escort staff at weekends so the appointment was cancelled. Mr Cartwright went on the waiting list for a Monday–Friday appointment.

46. On 5 November, the prison received a new date, for Mr Cartwright's ophthalmology appointment, which was scheduled for 17 November. Again, this was on a weekend so was cancelled. A new date of Friday 27 December was eventually arranged.

47. On 10 November, a nurse examined Mr Cartwright. He said that he felt disorientated. His clinical observations were normal except for his blood sugars, which were raised. Mr Cartwright told the nurse that he had eaten a box of Jaffa cakes.

48. Mr Cartwright said that he had been feeling dizzy and losing his balance. The nurse examined his ears, which were compacted. She prescribed ear drops. She took a urine sample. The results showed traces of nitrates and blood, most likely indicating a bacterial infection. A second sample was taken and sent for further testing.

49. On 11 November, a prison officer contacted the healthcare team because Mr Cartwright appeared disorientated and forgetful. A nurse examined him. Mr Cartwright showed no obvious disorientation or confusion. He told the nurse that he felt out of sorts but ok. The nurse noted that Mr Cartwright had been prescribed antibiotics for a urine infection. She advised him to contact healthcare staff if his symptoms did not settle.

50. On 12 November at 8.20am, Mr Cartwright became dizzy and fell. An officer radioed a code blue medical emergency (indicating a prisoner is unconscious or

having breathing difficulties). She put Mr Cartwright in the recovery position. A prison paramedic attended immediately. Mr Cartwright was conscious and alert and did not need further medical assistance.

51. The prison paramedic examined Mr Cartwright who had a full recollection of the incident but said that he became disorientated. His vital signs, including blood sugar levels and a neurological assessment (using the Glasgow Coma Scale, the most common scoring system used to describe the level of consciousness in a person following a traumatic brain injury) were all normal. The prison paramedic completed a falls risk assessment and gave Mr Cartwright a pendant alarm to call for assistance if needed.

52. At 9.50am, an officer radioed a second code blue after Mr Cartwright fell and reported feeling dizzy. The officer helped him to sit down and the prison paramedic attended. Mr Cartwright had a full recollection of the incident and was not injured. He was helped back to his feet and further assistance was cancelled.

53. At 11.30pm, Mr Cartwright's cellmate rang their cell bell after Mr Cartwright fainted and banged his head. An officer attended and could see Mr Cartwright sitting on the floor. He could talk but had blood on a tissue from a cut to the back of his head. The officer called for other officers to help him and a night manager and others attended. The officers entered the cell, cleaned the cut on Mr Cartwright's head, which they described as superficial, and helped him back into bed.

54. An officer completed welfare checks throughout the night. Mr Cartwright had moved onto the floor with his pillow under his head. His cellmate was sitting in a chair and the two were talking. The cell light was on all night so the officer could see them clearly. At 4.30am, when the officer did a roll count, Mr Cartwright was conscious and breathing and talking to his cellmate.

55. At 7.00am, on 13 November, Mr Cartwright's cellmate rang the cell bell after he woke up and could not get a response from Mr Cartwright. An officer attended and saw Mr Cartwright on the floor. His eyes were open but his skin looked grey and he did not appear to be breathing. The officer called a code blue and the control room called an emergency ambulance. An officer who was working on the floor below, joined the first officer and they entered the cell. One officer immediately began chest compressions while the other gave rescue breaths. They could not feel a pulse.

56. A nurse and other members of healthcare staff attended. They moved Mr Cartwright out of the cell and onto the landing and continued resuscitation. Mr Cartwright remained unconscious. Staff gave him oxygen and attached a defibrillator to his chest. No shock was advised. Mr Cartwright was still warm, his pupils were 'fixed' and he had been incontinent of urine.

57. Paramedics arrived after approximately 30 minutes and began advanced life support. A slight pulse was detected and at 8.10am, Mr Cartwright was taken to New Cross Hospital. Two officers escorted him but he was not restrained.

58. At 9.08am, on arrival at hospital, a hospital doctor confirmed that Mr Cartwright had died.

Contact with Mr Cartwright's family

59. At 9.00am, on 13 November, the prison appointed a family liaison officer (FLO). Mr Cartwright had not named a next of kin. His last known address was in Spain and from his prison records the FLO found the details of a friend in Spain.

60. The FLO spoke to Mr Cartwright's friend in Spain who gave him the telephone number of another friend. The FLO contacted the second friend who gave him a telephone number for Mr Cartwright's son. The FLO telephoned Mr Cartwright's son and left a message on his phone.

61. At 1.45pm, Mr Cartwright's son telephoned the prison and spoke to the Head of Safer Custody. She informed Mr Cartwright's son that his father had died. Mr Cartwright's son said that he would inform the rest of the family and would call back regarding the funeral arrangements.

62. On 14 November, Mr Cartwright's son spoke to the FLO by telephone. He asked that the prison arrange the funeral. The FLO kept in regular contact with Mr Cartwright's son.

63. Mr Cartwright's funeral was held on 13 December. The prison contributed towards the costs in line with Prison Service instructions.

64. On 31 December, Mr Cartwright's son visited the prison to collect his father's ashes.

Support for prisoners and staff

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

66. The prison posted notices informing other prisoners of Mr Cartwright'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 Cartwright's death.

Cause of death

67. The Coroner did not request an autopsy and concluded that Mr Cartwright died from a myocardial infarction (a heart attack) caused by ischaemic heart disease. He also had Type 2 diabetes which did not cause but contributed to his death.

Findings

68. The clinical reviewer was satisfied that the care Mr Cartwright received for his diabetes was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

69. However, the clinical reviewer found that although Mr Cartwright was referred appropriately to the cardiology team for assessment, he was concerned about the time it had taken Hewell and Oakwood to complete diagnostic tests. If completed sooner, the tests could have reduced the time taken to confirm Mr Cartwright's diagnosis of heart problems. The clinical reviewer concluded that this aspect of Mr Cartwright care was not equivalent to that which he could have expected to receive in the community.

70. An ECG, initially requested at Hewell on 4 April, could not be done on 15 April as planned, because some equipment was not available. On 29 May, on arrival at Oakwood, a nurse identified that Mr Cartwright still needed an ECG and the medical records show that a 'routine' ECG was completed on 9 June. However, when a prison GP reviewed Mr Cartwright the next day, he could not find the results of the ECG.

71. Mr Cartwright eventually had an ECG when he attended New Cross Hospital for his cardiology appointment on 11 September. The results identified a probable previous heart attack.

72. A specific blood test (NT-proBNP, used to identify systolic heart failure), also requested on 4 April, was not done until 2 July, despite numerous opportunities to do it sooner. The results, appeared to be abnormal, suggesting heart failure.

73. The clinical reviewer could not say whether these delays affected the eventual outcome for Mr Cartwright. We make the following recommendation:

    The Head of Healthcare at HMP Hewell and HMP Oakwood should ensure that diagnostic tests requested by a GP are completed in a timely manner and that the GP is informed of any delays or if the tests cannot be completed.

74. Despite Mr Cartwright's numerous medical conditions there is no record in his medical notes of any care plans. The clinical reviewer is satisfied that the lack of recorded care planning did not necessarily affect the care that Mr Cartwright received, but said that documented care plans, as prescribed by the Royal College of Nursing, are essential to provide both the appropriate management of medical conditions and to support healthcare staff. We make the following recommendation,

    The Head of Healthcare at HMP Hewell and HMP Oakwood should ensure that staff create and document care plans for all prisoners with heart disease, high blood pressure, chronic kidney disease and type 2 diabetes, **in line with national guidelines**.

75. In the consultant's letter, received after Mr Cartwright's cardiology appointment in September 2019, the consultant recommended adding spironolactone to Mr Cartwright's medications. A prison GP prescribed the initial dose immediately, but the increased dose did not start until 3 October 2019, just over three weeks later.

76. The clinical reviewer found that Mr Cartwright's potassium levels had risen which could explain the reason for the delay, but there is nothing recorded in the medical record to indicate that this was the case.

77. The Head of Healthcare said that Mr Cartwright returned from his cardiology appointment with a prescription for spironolactone but no letter or instructions. A prison GP arranged for the medication to be issued immediately and requested blood tests, to be taken two weeks later. This is normal practice when this medication is prescribed, as increases are usually considered after two weeks, not one week.

78. The blood tests, taken on 26 September, indicated low glomerular filtration rate, (GFR, a test to show how well the kidneys are working). The blood tests were repeated on 1 October, and the increased dose was prescribed on 3 October.

79. The consultant's letter recommending increasing the dose after only one week was apparently received on 24 October, but none of this is clear from the medical records and ultimately there was a delay.

80. The clinical reviewer could not say what, if any, impact the delay had on Mr Cartwright but it is important that any medication changes recommended by specialists are introduced as directed. We make the following recommendation:

    The Head of Healthcare at HMP Oakwood should ensure that changes to medication recommended by specialists, are introduced as instructed.

81. The clinical reviewer has made number of additional recommendations which we do not repeat in this report but which the Head of Healthcare at Hewell and Oakwood will wish to address.

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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