Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alexander Hurley, a prisoner at HMP The Mount, on 26 December 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.

The Ombudsman's 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 Alexander Hurley died of an acute myocardial infarction (heart attack) on 26 December 2019 at HMP The Mount. He was 62 years old. I offer my condolences to Mr Hurley's family and friends.

Prior to his arrival at The Mount in 2015, Mr Hurley had been diagnosed with ischaemic heart disease. Care plans were created to manage his care and Mr Hurley was regularly reviewed by healthcare staff, but he chose not to attend healthcare appointments or take his medications as prescribed.

On 23 December, Mr Hurley was taken to hospital by emergency ambulance with the symptoms of heart failure. Around midnight on 25/26 December, he discharged himself from hospital against medical advice and returned to The Mount. He collapsed in his cell a few hours later after reporting chest pains.

The clinical reviewer found that despite Mr Hurley's reluctance to engage with healthcare staff, they provided prompt investigations and referrals to secondary care providers in order to diagnose, treat and manage Mr Hurley's condition. She was satisfied that Mr Hurley received a good standard of care equivalent to that which he could have expected to receive in the community.

I am, however, concerned that prison staff did not monitor Mr Hurley regularly when he returned to prison on 26 December and that a medical emergency code was not called immediately when he reported chest pains.

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 2020**

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Summary

Events

1. On 22 August 1998, Mr Alexander Hurley was sentenced to life imprisonment for manslaughter. He was released on licence on 12 September 2013. On 15 January 2015, Mr Hurley was recalled to prison for assaulting a member of staff at the approved premises where he lived. He was sent to HMP The Mount.

2. During his initial health screen at The Mount, a prison nurse noted that Mr Hurley had received a previous diagnosis of ischaemic heart disease. A care plan was created to manage his condition and he was reviewed regularly by healthcare staff.

3. Throughout his time in prison, Mr Hurley chose not to attend his appointments to monitor and manage his ongoing heart conditions. He consistently refused to comply with the advice of healthcare staff or take his prescribed medications. Mr Hurley was assessed as having the mental capacity to make decisions about his care and treatment, and fully understood the consequences of not doing so.

4. On 23 December 2019, a prison GP reviewed Mr Hurley and diagnosed worsening heart failure. Mr Hurley was taken to hospital by emergency ambulance for further review and was admitted as an inpatient.

5. Around midnight on 25/26 December, Mr Hurley discharged himself from hospital. He arrived back to The Mount at approximately 12.30am, and was taken to his cell.

6. At 4.05am, Mr Hurley pressed his cell bell. An Operational Support Grade (OSG) went to his cell to check on him. Mr Hurley told him that he was experiencing chest pain and that he felt unsteady on his feet. He asked to speak with the Night Orderly Officer (NOO). The OSG asked the NOO to attend Mr Hurley's cell. However, when the OSG returned to the cell to check on his well-being, he found Mr Hurley unresponsive.

7. Staff arrived at Mr Hurley's cell and called a code blue emergency and began cardiopulmonary resuscitation (CPR).

8. At 4.37am, paramedics arrived and continued with CPR. At 5.24am, the paramedics confirmed that Mr Hurley had died.

9. The post-mortem gave the cause of death as heart attack caused by a reduction of blood flow to the heart, ischaemic heart disease and congestive cardiac failure.

Findings

Clinical care

10. The clinical reviewer concluded that the care Mr Hurley received at The Mount was equivalent to that which he could have expected to receive in the community. Despite Mr Hurley repeatedly refusing to listen to the advice from both healthcare staff and hospital staff, the clinical reviewer is satisfied that that healthcare staff

appropriately reviewed him, and where necessary referred him to secondary care providers.

11. The clinical reviewer was also satisfied that healthcare staff made good efforts to encourage Mr Hurley to comply with their advice. They assessed his mental capacity on several occasions, and concluded that he had the mental capacity to make decisions about his care and treatment. He fully understood the consequences of his persistent refusal to fully engage with healthcare staff and to take his medications as prescribed.

Emergency response

12. As Mr Hurley had been in hospital with heart problems and had discharged himself in the middle of the night against medical advice, we consider that the Night Orderly Officer should have asked night staff to check on him regularly until he could be seen by healthcare staff in the morning.

13. Given the circumstances, we also consider that the OSG should have called a medical emergency code immediately when Mr Hurley reported chest pains, instead of going to the office to phone the night orderly officer.

Recommendations

- The Governor should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the need to call a medical emergency code promptly.
- The Governor should ensure that a copy of this report is shared with a CM and an OSG and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

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

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

16. NHS England commissioned Man independent clinical reviewer to review Mr Hurley's clinical care at the prison.

17. The investigator visited The Mount with the clinical reviewer on 3 March 2020, and carried out four interviews. Due to a malfunction with the voice recorder, only three interviews were transcribed.

18. We informed HM Coroner for Hertfordshire of the investigation. The coroner gave us Mr Hurley's cause of death. We have sent the coroner a copy of this report.

19. Mr Hurley did not have a named next of kin.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP The Mount

16. HMP The Mount in Hertfordshire is a medium security prison holding approximately 800 adult male prisoners.

17. Healthcare services are commissioned by Hertfordshire Community Care Trust. The healthcare centre is open from 8.00am to 6.30pm Monday to Friday and from 8.00am to 5.00pm at weekends. The Mount has a full-time GP, with the service augmented by locums as necessary. An out of hours service is provided through the Hertfordshire Urgent Care Services. There are no inpatient beds at The Mount.

HM Inspectorate of Prisons

18. The most recent inspection of HMP The Mount was in May 2018. Inspectors reported that there was evidence of strong leadership within the healthcare department, and that the healthcare team were enthusiastic and skilled. Healthcare staff told inspectors that they felt well supported by the management team.

19. Inspectors also noted that healthcare staff had excellent training opportunities in both triage, and non-medical prescribing courses. Staff received regular managerial and clinical supervision. The healthcare department was noted to be a bright, clean environment which met infection control standards. The waiting area was well ventilated and less crowded than on previous inspections.

Independent Monitoring Board

20. In their latest annual report, for the year to July 2019, the IMB reported that The Mount was, overall, a safe and decent establishment. The Board considered that healthcare services provided were at least as good as those available in the wider community.

21. The Board recognised there had been challenges for healthcare caused by staffing vacancies and equipment failure, but that both issues were being addressed. Although attempts to recruit a second GP at the prison have been unsuccessful, an advanced nurse practitioner had recently been appointed and a paramedic had recently joined the prison to act as a clinical lead.

Previous deaths at HMP The Mount

22. Mr Hurley was the second prisoner to die at The Mount since December 2017. The previous death was a drug-related death. There are no similarities between Mr Hurley's death and the previous death.

Key Events

23. On 22 August 1998, Mr Alexander Hurley was sentenced to life imprisonment for manslaughter. He was released on licence on 12 September 2013. On 15 January 2015, Mr Hurley was recalled to prison (The Mount) after getting drunk in the approved premises where he lived and assaulting a female member of staff with a chair.

24. During his initial health screen at The Mount, a prison nurse noted that Mr Hurley had received a previous diagnosis of ischaemic heart disease. A care plan was created to manage his condition and he was reviewed regularly by healthcare staff.

25. Between June 2016 and December 2018, Mr Hurley consistently refused to engage with healthcare services to monitor and manage his ongoing health conditions and provide ongoing support. He was diagnosed with severe depression and severe anxiety but despite the repeated best efforts of the prison's mental health inreach team (MHIRT), he refused to engage with the service. Healthcare staff explained the importance of having routine heart checks and blood tests but Mr Hurley said that while he understood the possible consequences of not following the advice given to him, he did not want to have any further tests.

26. Mr Hurley often experienced chest pain which he attributed to his decision to stop taking his prescribed medications. In April 2018, he told a prison GP that he was flushing his heart medication down the toilet. When the prison GP challenged him on this, Mr Hurley said that it was his decision and that he wanted to die in prison. The prison GP and other members of the healthcare team repeatedly encouraged Mr Hurley to take his medications and explained the importance of doing so to him, but he consistently refused. The prison GP considered that Mr Hurley had the mental capacity to make informed decisions about his care and treatment.

27. On 7 December, Mr Hurley attended the healthcare unit after complaining of shortness of breath and a pain in the left side of his chest. The prison GP reviewed him and told him that he needed to go to hospital for further review. Mr Hurley refused to accept the prison GP's advice and said that he fully understood that his decision was risking his life.

2019

28. On 10 April 2019, during a review with a nurse, Mr Hurley handed all his prescribed medications to her and said that he did not need them anymore. The nurse told him that doing so would be a risk to his health. Mr Hurley said that he understood, but had made the decision not to take them anymore. He also refused any further routine blood tests despite the nurse's best efforts to persuade him otherwise. Healthcare staff decided to continue prescribing Mr Hurley his medication in the hope that he would change his mind.

29. On 15 May, a nurse reviewed Mr Hurley after he was found to be unsteady on his feet and short of breath. She asked him if he had taken his medication. Mr Hurley told her that he could not find them. She considered that he was being

deliberately evasive. She referred him for a review by the MHIRT which was carried out on 5 June. Mr Hurley agreed to engage and underwent a mini mental state examination. The results concluded that there were no issues with his mental capacity or decision making which confirmed that he had the capacity to make decisions about his care and treatment.

30. On 12 June, a prison GP reviewed Mr Hurley who agreed to have a routine health check. The results indicated that his B-type natriuretic peptide level was high which indicated possible heart disease. He agreed to be referred to hospital for further review.

31. On 1 August, Mr Hurley attended the cardiology department at a hospital for his review. The cardiologist reviewed and amended his prescribed medications and reinforced the importance of taking his medications as prescribed. Mr Hurley told hospital staff that he would comply with their advice.

32. On 20 October, a nurse reviewed Mr Hurley after he complained of pain in the right side of his chest. He told her that he had not eaten all day or taken his medication. Mr Hurley recovered quickly when he had something to eat. The nurse told him to eat properly and take his medications as prescribed.

33. On 3 November, a nurse reviewed Mr Hurley because he was experiencing shortness of breath. He told her that he had not taken his medication. She reinforced to him the importance of taking his prescribed medications. Mr Hurley said that he fully understood the importance of taking his medication as advised, and he knew what would happen if he failed to do so. As previously, Mr Hurley refused to comply with her advice.

34. Between 3 and 12 December healthcare staff reviewed Mr Hurley on three further occasions. On each occasion, his symptoms were caused by his refusal to take his medications.

35. On 14 December, Mr Hurley was reviewed by a nurse after reporting shortness of breath. She noted he appeared to be generally unwell and considered he was suffering from a worsening of his heart disease. She referred him for a GP review.

36. On 16 December, a prison GP reviewed Mr Hurley. Mr Hurley told him that although he had been non-compliant with his prescribed medications, he would agree to take furosemide (used to treat high blood pressure). The prison GP noted a worsening lower leg oedema (an abnormal accumulation of fluid in the lower leg often caused by congestive heart disease). The prison GP planned to review Mr Hurley the following week.

37. On 23 December, the prison GP reviewed Mr Hurley as planned. The prison GP noted he appeared generally unwell, had difficulty mobilising and was very short of breath. He diagnosed worsening heart failure. Mr Hurley was taken to hospital by emergency ambulance for further review and he was admitted as an inpatient. Healthcare staff kept in regular contact with hospital staff and received updates on Mr Hurley's condition.

Events of 25/26 December

38. Around midnight on 25/26 December, against the advice of both hospital staff and the prison officers accompanying him, Mr Hurley discharged himself from hospital. The prison officers asked him to wait until after 8.00am when healthcare staff would be on duty in the prison, but he refused. He arrived back at The Mount at 12.30am and was taken to his cell.

39. At 4.05am, Mr Hurley rang his cell bell. An OSG responded immediately and went to his cell. Mr Hurley said that he was experiencing chest pain and felt unsteady on his feet. He asked to speak with the Night Orderly Officer (NOO), A Custodial Manager (CM). The OSG considered that as Mr Hurley was standing and holding a conversation with him it was not necessary to radio a code blue emergency. He left the cell and went to the wing office a short distance away and called The CM and asked him to attend Mr Hurley's cell to review him.

40. OSG immediately returned to Mr Hurley's cell to tell him that CM Leenders was on his way, but Mr Hurley had collapsed and was unresponsive. At that point, the CM and Assistant Night Orderly Officer (ANOO) a Prison Officer arrived. They immediately entered the cell and noted that although Mr Hurley was unresponsive, he was still breathing and had a shallow pulse. The CM immediately radioed a code blue emergency.

41. Two prison officers attended with an emergency response bag. An officer began chest compressions while the CM attached the defibrillator to Mr Hurley's chest. The defibrillator indicated that at that time there was no shockable rhythm. The officer continued with chest compressions.

42. Shortly afterwards, the defibrillator registered a shockable rhythm and administered a shock. There was no other shockable rhythm detected by the defibrillator.

43. At 4.37am, paramedics arrived. They moved Mr Hurley from his cell onto the landing and continued with CPR. However, they were unsuccessful and at 5.24am, they confirmed that Mr Hurley had died.

Post-mortem report

44. The post-mortem gave the cause of death as acute myocardial infarction (heart attack) caused by critical coronary artery stenosis (reduction in the blood flow to the heart), ischaemic heart disease and congestive cardiac failure.

Contact with Mr Hurley's Family

45. Mr Hurley had no contact with family or friends and had no one listed as a next of kin. He had previously asked a Reverend and (NAME), who were members of the chaplaincy team, to act as his next of kin.

46. Mr Hurley's funeral was held on 27 January 2020. Members of the chaplaincy team held a service for prisoners and staff in the prison chapel. In line with national guidance, the prison paid for the full cost of his funeral.

Support for prisoners and staff

47. The prison posted notices informing other prisoners of Mr Hurley'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 Hurley's death.

48. After Mr Hurley's death, an operations manager debriefed the staff who were involved giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

Findings

Clinical care

49. The clinical reviewer found that prison healthcare staff made prompt, appropriate referrals both to prison GPs and to secondary care providers, in order to diagnose, treat and manage Mr Hurley's condition.

50. The clinical reviewer also considered that healthcare staff tried to encourage Mr Hurley to take responsibility for the management of his health conditions, but that Mr Hurley consistently refused to comply with their advice. He often refused to take his prescribed medications and refused investigations and treatments, which were crucial to his well-being. Mr Hurley was consistently assessed as having the mental capacity to make decisions about his care and treatment, even if those decisions were not always in his best interests.

51. The clinical reviewer concluded that the care Mr Hurley received at The Mount was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She considers that Mr Hurley's death was not preventable.

Emergency response

52. Mr Hurley had been in hospital with heart problems and had discharged himself in the middle of the night against medical advice to a prison without 24-hour healthcare. In these circumstances, we consider that the Night Orderly Officer should have asked the night staff to check his welfare regularly until he could be seen by healthcare staff when they came on duty at 8.00am.

53. We also consider that when Mr Hurley rang his bell and told the OSG that he had chest pains, the OSG should have called a code blue emergency code immediately instead of going to the office to ask the Night Orderly Officer to attend. Given the circumstances, we consider that this should have been treated as a medical emergency.

54. We cannot say if this delay affected the outcome for Mr Hurley, but we know that a delay of even a few minutes can make a critical difference in a medical emergency.

55. We are satisfied that prison staff did their best to resuscitate Mr Hurley when he was found unresponsive.

56. We recommend:

The Governor should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the need to call a medical emergency code promptly.

The Governor should ensure that a copy of this report is shared with the CM and the OSG and that a senior manager discusses the Ombudsman's findings with them.

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