Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Neil, a prisoner at HMP North Sea Camp, on 19 April 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Neil died on 19 April 2019 of hypoxic brain injury following a cardiac arrest, while a prisoner at HMP North Sea Camp. Mr Neil was 72 years old. I offer my condolences to Mr Neil's family and friends.

Mr Neil received a good level of clinical care while at North Sea Camp which was equivalent to that which he could have expected to receive in the community.

We found failings in the emergency response when Mr Neil was found unresponsive in his cell. Although this did not affect the outcome for Mr Neil, it could be critical in other emergency situations.

The Governor should commend the staff involved in the cardiopulmonary resuscitation attempt. They were successful in resuscitating Mr Neil, which is not often achievable, and gave him the chance to receive treatment at 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 **January 2020**

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Summary

Events

1. Mr John Neil was serving an indeterminate sentence for public protection for sexual offences and had been at HMP North Sea Camp since 22 February 2018. Mr Neil had a number of pre-existing medical conditions including chronic obstructive pulmonary disease (COPD, also known as lung disease), which was diagnosed in 2014.

2. Healthcare staff appropriately monitored and managed Mr Neil's COPD using a respiratory care plan. Mr Neil continued to smoke despite advice from healthcare professionals of the serious implications of this.

On 11 April, a nurse examined Mr Neil and noted his COPD was well controlled. Mr Neil needed another review in three months' time. He did not report any health concerns to staff in the weeks prior to his death.

3. At about 12.20am on 18 April, Mr Neil collapsed on his bed. His cellmate went to the wing office and told an officer. The officer went to Mr Neil's cell and saw he was unresponsive but breathing.

4. The officer made a radio call for a senior officer to attend Mr Neil's cell. Two minutes later, the officer said an ambulance was needed. Another officer requested an ambulance immediately.

5. The officer ran to the wing office to get the defibrillator and when he got back, he put Mr Neil in the recovery position. Mr Neil was still breathing.

6. A senior officer and another officer arrived two minutes later and Mr Neil had stopped breathing. The officers immediately started cardiopulmonary resuscitation (CPR) and attached the defibrillator.

7. The first responder arrived at the prison at 12.35am. The officers moved Mr Neil to the landing and continued CPR. Two paramedics arrived at 12.42am, and took over Mr Neil's care. Mr Neil remained unconscious but the defibrillator detected activity from his heart.

8. The paramedics took Mr Neil to hospital at 1.18am. He was placed on a life support machine in the intensive care unit. His condition did not improve and at 4.50pm, on 19 April, a hospital doctor removed the life support. At 9.15pm, a hospital doctor confirmed that Mr Neil had died.

9. The coroner gave Mr Neil's cause of death as hypoxic brain injury following a cardiac arrest, in keeping with infective exacerbation of COPD.

Findings

10. The clinical reviewer concluded that the clinical care Mr Neil received at North Sea Camp was equivalent to that which he could have expected to receive in the community. The management of his COPD was good and an effective care plan ensured his condition was monitored regularly and his basic observations recorded.

11. We are concerned that the member of staff who saw Mr Neil unresponsive on 18 April did not use an emergency medical code when radioing for assistance. This meant staff did not know what they were responding to or the urgency of the situation. Although this did not appear to cause a significant delay, or affect the outcome for Mr Neil, the failure to use the correct emergency code could be critical in future cases.

12. We agree with the clinical reviewer that the staff should be commended for the resuscitation attempt. Resuscitation is not often successful and Mr Neil was able to be taken to hospital for further medical intervention.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code or calling an ambulance

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the two officers who carried out CPR on Mr Neil so that they are aware of the Ombudsman's findings.

The Investigation Process

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

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

15. The investigator interviewed three members of staff and a prisoner at North Sea Camp on 19 June 2019.

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

17. We informed HM Coroner for Central and West Lincolnshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. We wrote to Mr Neil's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

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

Background Information

HMP North Sea Camp

20. HMP North Sea Camp is an open (Category D) prison, holding approximately 400 men. Accommodation is provided in five residential units. There are also 66 beds in four detached houses, known as the Jubilee Units, which are used for long-term prisoners living independently.

21. Nottinghamshire Healthcare NHS Foundation Trust provide healthcare services at the prison.

HM Inspectorate of Prisons

22. The most recent inspection of HMP North Sea Camp was conducted in July 2017. Inspectors reported that clinical governance of healthcare was sound and good relationships had been established across the prison. A range of appropriate primary care services were provided and waiting lists for clinics were short, although a significant number of men were waiting too long for routine podiatry care.

23. Inspectors noted that the safer custody and healthcare teams had a complex needs register for prisoners identified as having adult social care needs. This allowed them to track referrals to, and responses from, adult social care. Men were assigned 'buddies' to assist them where appropriate. Men at risk were considered for a single room and a log documented the reason for allocating them one.

Independent Monitoring Board

24. 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 February 2018, the IMB highlighted the good physical and mental health care provided at North Sea Camp. However, there were some issues with the distance that prisoners had to travel for some treatments, especially those with disabilities.

Previous deaths at HMP North Sea Camp

25. Mr Neil is the fifth prisoner to die of natural causes at HMP North Sea Camp in the last two years. There are no similarities with those deaths.

Key Events

26. Mr John Neil had been in custody since 2007 and was serving an indeterminate sentence for public protection for sexual offences. He had been at HMP North Sea Camp since 22 February 2018. Mr Neil had a number of pre-existing medical conditions including depressive disorder, diagnosed in 2008, asthma, diagnosed in 2010, first degree heart block diagnosed in 2012 and chronic obstructive pulmonary disease (COPD), diagnosed in 2014.

27. Mr Neil had a respiratory care plan in place for his COPD and healthcare staff monitored his basic observations, such as oxygen saturations and blood pressure, regularly and they were within the normal range. Prison GPs prescribed appropriate medication, which Mr Neil took as prescribed. He continued to smoke despite advice from healthcare professionals of the serious implications of this.

28. On 10 April, a nurse reviewed Mr Neil after he fell. He was unsure how he fell but said he had been feeling dizzy 'for months'. He did not have any injuries. On examination, Mr Neil had low blood pressure and the nurse booked him for a respiratory review. She also sent a task to the prison GP to query implementing a plan to manage Mr Neil's low blood pressure.

29. On 11 April, Mr Neil attended a respiratory review with a nurse. Mr Neil said he was using a spacer with his inhalers and found it effective. As his COPD appeared to be well controlled, the nurse arranged for another review in three months.

30. On 17 April, Mr Neil told a nurse that he was eating porridge in the morning and evening, but was not eating any other food. The nurse advised him that he needed to eat more protein and nutrients to help increase his weight. The nurse planned to book a falls risk assessment for Mr Neil.

31. That day, Mr Neil went into Boston on day release. Mr Neil's cellmate said that when Mr Neil returned to the prison, he said he was tired and went to bed at about 8.30pm. His cellmate said that Mr Neil did not complain of feeling unwell and his condition did not appear worse than usual. Another prisoner went into their cell at about 9.30pm, and Mr Neil woke up. His cellmate said that Mr Neil did not go back to sleep but rested on his bed.

32. At about 12.20am on 18 April, Mr Neil went to the toilet and when he came back to his cell, he sat on his bed then he collapsed. His cellmate said that Mr Neil appeared to be fitting and was purple in the face and neck. He went to the wing office and told an officer that Mr Neil appeared to be fitting and his breathing did not sound right. The officer immediately went to Mr Neil's cell and saw that he appeared to be coming to the end of a fit. Mr Neil was unresponsive but breathing.

33. At 12.24am, the officer made a radio call to a Supervising Officer (SO) that he needed to attend North Unit. Two minutes later, the officer radioed the SO again and said that an ambulance was needed. The SO asked one of the officers in the prison to call an ambulance immediately (there is no communications

department in the prison overnight so the duty manager has to delegate communications to staff).

34. The officer ran to the wing office to get the defibrillator. When he got back, he and Mr Neil's cellmate put Mr Neil in the recovery position. He was still breathing and the officer observed Mr Neil for any changes while he waited for staff to arrive.

35. An officer and the SO arrived about two minutes later. At this point, Mr Neil had stopped breathing. The two officers started CPR and attached the defibrillator which advised to continue with CPR. Mr Neil vomited some liquid, but he remained unresponsive. The officers continued with CPR.

36. At 12.35am, the first responder arrived. He asked the officers to move Mr Neil to the landing and to continue CPR while he administered adrenalin. The first responder had a CPR machine that took over the compressions. Two paramedics arrived at 12.42am, and took over from the officers. Mr Neil remained unconscious but the defibrillator detected activity from his heart.

37. The paramedics took Mr Neil to Pilgrim Hospital, Lincolnshire, at 1.18am. Mr Neil was placed on a life support machine in the intensive care unit.

38. Mr Neil's condition did not improve and at 4.50pm on 19 April, a hospital doctor removed the life support. At 9.15pm, a hospital doctor confirmed that Mr Neil had died.

Contact with Mr Neil's family

39. The prison appointed an officer as the family liaison officer (FLO). At 8.20am on 18 April, the FLO telephoned Mr Neil's brother to inform him that Mr Neil was in intensive care. The FLO met Mr Neil's brother at the hospital. She explained the FLO role and provided support.

40. Mr Neil's funeral was held on 14 June. The prison offered a financial contribution in line with national guidance.

Support for prisoners and staff

41. After Mr Neil's death, a prison manager spoke to the officer on the bedwatch and the SO about the events of 18 and 19 April.

42. The prison posted notices informing other prisoners of Mr Neil'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 Neil's death. Mr Neil's cellmate was offered support and told the investigator he knew how to access additional support if he needed it.

Post-mortem report

43. The coroner gave Mr Neil's cause of death as hypoxic brain injury (lack of oxygen to the brain) following a cardiac arrest, in keeping with infective exacerbation of COPD.

Findings

Clinical care

44. The clinical reviewer found that the management of Mr Neil's COPD was good. An effective care plan ensured his condition was monitored regularly and his basic observations recorded. Despite encouragement from healthcare professionals to stop smoking, Mr Neil made the decision to continue.

45. The clinical reviewer concluded that the clinical care Mr Neil received while at HMP North Sea Camp was equivalent to that which he could have expected to receive in the community. We agree.

Emergency response

46. PSI 03/2013, 'Medical Emergency Response Codes', says that all staff must be made aware of and understand their responsibilities during medical emergencies. The PSI requires staff to radio a medical emergency code to communicate the nature of a medical emergency efficiently. The code triggers staff to take the relevant equipment to the scene and to call an ambulance without delay.

47. When the officer arrived at Mr Neil's cell, he found Mr Neil unconscious and coming to the end of a fit. This medical emergency falls into the 'code blue' emergency code category. Although the officer and the SO told the investigator that the officer called a code blue, the communications log does not reflect this. The communications log says that the officer radioed for the SO to provide assistance. The communications log also recorded that two minutes later, the officer said an ambulance was needed. In addition, the Operational Support Grade in the control room said that when the initial call for assistance went out, he was unaware what the issue was. This would not have been the case if the officer had called a code blue.

48. Although failure to call an emergency code over the radio does not appear to have affected the eventual outcome for Mr Neil, it did cause a delay of two minutes before an ambulance was called. We are concerned that failure to use the correct emergency code could be critical in future emergency situations. We make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code or calling an ambulance.

49. The clinical reviewer said that resuscitation attempts are not often successful. However, the staff involved in the CPR managed to resuscitate Mr Neil who was then taken to hospital for treatment. We agree with the clinical reviewer that the resuscitation attempt was excellent and all staff involved should be commended.

    The Governor and Head of Healthcare should ensure that a copy of this report is shared with the two officers who carried out CPR on Mr Neil so that they are aware of the Ombudsman's findings.

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