Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vahit Tezgel, a prisoner at HMP Stoke Heath, on 30 September 2020

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 Vahit Tezgel died in hospital from a heart attack on 30 September 2020, while a prisoner at HMP Stoke Heath. He was 61 years old. I offer my condolences to Mr Tezgel's family and friends.

The clinical reviewer was satisfied that the standard of care Mr Tezgel received was equivalent to that which he could have expected to receive in the community.

I am concerned, however, that when two officers found Mr Tezgel unresponsive in his cell, neither started cardiopulmonary resuscitation (CPR). There was a delay of over 90 seconds before healthcare staff arrived and started CPR. They managed to regain a pulse. Paramedics arrived soon after and took over CPR. They took Mr Tezgel to hospital, but he died a short time later.

We cannot say if the outcome for Mr Tezgel may have been different if CPR been started sooner, but we know that in a medical emergency a delay of a few minutes may be critical.

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 **May 2021**

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Summary

Events

1. On 13 September 2019, Mr Vahit Tezgel was sentenced to two years and three months in prison for wounding. On 18 September, he was moved to HMP Stoke Heath.

2. Mr Tezgel had a heart condition and was prescribed appropriate medication.

3. On 16 July 2020, Mr Tezgel told a nurse that he had a crushing pain in his chest. The nurse sent him to hospital. At the hospital Mr Tezgel had blood tests and an electrocardiogram (ECG). The results were normal so Mr Tezgel was sent back to prison the same day.

4. On 30 September, an officer found Mr Tezgel lying in his bed unresponsive. He called to another officer to assist. They checked for a pulse and when they could not find one, they called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties).

5. Healthcare staff responded to the code blue and started cardiopulmonary resuscitation (CPR). They regained a pulse and continued CPR until paramedics arrived and took over. Mr Tezgel was taken by ambulance to hospital.

6. When Mr Tezgel got to hospital, he had another cardiac arrest and was pronounced dead at 11.35am. A hospital doctor gave the cause of death as a heart attack cause by heart disease.

Findings

7. The clinical reviewer found that the standard of care Mr Tezgel received was equivalent to that he could have expected to receive in the community.

8. However, she was concerned that there were no care plans in place to manage Mr Tezgel's heart disease. She was also concerned that Mr Tezgel's first and second reception health screens were offered on the same day, which is not in line with National Institute for Health and Care Excellence (NICE) guidelines.

9. We are concerned that when officers found Mr Tezgel unresponsive, they did not start CPR. There was a delay of 90 seconds before healthcare staff arrived and started CPR. We cannot say if the outcome for Mr Tezgel may have been different if CPR been started sooner, but we know that in a medical emergency a delay of a few minutes may be critical.

10. We are also concerned that the prison did not offer Mr Tezgel's family any help with repatriation or funeral costs as they should have done.

Recommendations

- The Head of Healthcare should ensure that all prisoners with identified long-term conditions have a specific personalised management plan in place, in line with NICE guidelines.

- The Head of Healthcare should review the process of reception screening to ensure that first and second reception screens are not offered on the same day.
- The Governor should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity, and that staff first on the scene of an emergency provide basic life support until qualified health professionals arrive.
- The Governor should share this report with Officer A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Governor should ensure that:
    - following a death in custody of a foreign national prisoner, the prison offers up to £3,000 towards reasonable funeral expenses and a separate amount for reasonable repatriation costs; and
    - the prison now offers to pay reasonable funeral and repatriation expenses to Mr Tezgel's family.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Stoke Heath informing them of the investigation and asked anyone with relevant information to contact her. No one responded

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

13. NHS England commissioned a clinical reviewer to review Mr Tezgel's clinical care at the prison. The investigator and clinical reviewer jointly interviewed a nurse. The investigator interviewed two prison officers. Due to coronavirus restrictions all interviews were conducted by telephone.

14. We informed HM Coroner for Shropshire, Telford and Wrekin of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Tezgel's daughter to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She did not respond.

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

Background Information

HMP Stoke Heath

17. HMP Stoke Heath is a medium secure prison in Shropshire that holds up to 766 adults and young adult men on eight residential wings. Healthcare is provided by Shropshire Community Health NHS Trust. The Forward Trust provides services and support for prisoners with substance misuse issues.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Stoke Heath was in November 2018. Inspectors reported that all healthcare staff were trained to provide basic life support, and resuscitation equipment was appropriate. However, there was only one resuscitation bag, which would have been difficult to deploy swiftly. (This concern was addressed during the inspection.) Most custody staff had received first aid training and had access to automated external defibrillators (AEDs), though some staff were unsure of their location.

19. Inspectors found that patients with long-term conditions were well supported by nurse practitioners with appropriate skills. Evidence-based care planning was used, and the Trust provided additional specialist support as required to help manage this population.

Independent Monitoring Board

20. 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 April 2020, the IMB reported that, overall, Stoke Heath was a well-run prison that continued to provide a safe and decent environment for prisoners, who were treated fairly and with respect.

21. The Board reported that healthcare staffing had improved greatly during the last 12 months and, for the first time in many years, a full team of Band 6 primary care nurses, both RMN and RGN, was in place. A new GP clinical lead had been appointed and was making significant improvements to quality, safety and care. Reception screening had been enhanced and there was a real focus on second screens and assessed needs on arrival.

Previous deaths at HMP Stoke Heath

22. Mr Tezgel was the first prisoner to die at Stoke Heath since October 2017.

Key Events

23. On 13 September 2019, Mr Vahit Tezgel, a Turkish national, was sentenced to two years and three months in prison for wounding. He was sent to HMP Dovegate.

24. On 18 September, Mr Tezgel was moved to HMP Stoke Heath. A nurse noted that she could not complete Mr Tezgel's initial screening because he was taken straight to the wing.

25. The following day, a nurse completed Mr Tezgel's reception screen. She used interpreter assistance because Mr Tezgel's English was limited. Mr Tezgel told the nurse that he had no underlying health conditions and was not taking any prescribed medication. On the same day, Mr Tezgel was offered a second reception screening, but he declined.

26. On 23 December, a prison GP saw Mr Tezgel. Mr Tezgel told the GP that he had previously been on medication for a heart condition.

27. On 8 January 2020, the prison GP reviewed Mr Tezgel's medical notes and noted that he had previously been on cardiac medication. The prison GP put Mr Tezgel back on the same medication and arranged blood tests. On 13 January, the blood tests came back as normal.

28. On 15 February, an officer responded to Mr Tezgel's emergency cell bell. Mr Tezgel said that he was short of breath and had a pain in his chest and arm. Prison staff called an ambulance and Mr Tezgel was taken to hospital. He was discharged from hospital and returned to prison the same day with a discharge letter that said healthcare staff needed to undertake follow up care.

29. On 20 February and 31 March, healthcare staff noted that they were still waiting for an appointment from the hospital about Mr Tezgel's cardiology referral.

30. On 16 July, a nurse saw Mr Tezgel because he said that he had a crushing pain in his chest. The nurse took Mr Tezgel's observations and assessed that he needed to go to hospital. At the hospital, Mr Tezgel had an electrocardiogram (ECG) and blood tests. The results were normal so Mr Tezgel was sent back to prison that evening.

31. On 30 September, at around 8.35am, Officer A went to Mr Tezgel's cell to unlock him for work. When Officer A opened the cell door, he saw that Mr Tezgel was lying on his bed. He called his name, but Mr Tezgel did not respond. Officer A called for his colleague, Officer B, to come and assist. Officer A checked for a pulse and when he could not find one, Officer B called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties). Both officers then waited outside the cell for healthcare staff to arrive.

32. Just over 90 seconds later, a nurse responded to the code blue. She assessed Mr Tezgel and immediately started cardiopulmonary resuscitation (CPR). Staff managed to regain a pulse. At 9.10am paramedics arrived and took over. They

left the prison to take Mr Tezgel to hospital at 9.35am. Mr Tezgel was accompanied by two prison officers, but no restraints were used.

33. When Mr Tezgel got to hospital, he had another cardiac arrest and was pronounced dead at 11.35am.

Contact with Mr Tezgel's family

34. On 30 September 2020, when Mr Tezgel was taken to hospital, the prison appointed an officer as the family liaison officer (FLO). Mr Tezgel's daughter was listed as his next of kin so a prison manager contacted her to tell her that Mr Tezgel was very unwell and was being taken to hospital. Mr Tezgel's daughter said that she would make her way to the hospital. However, Mr Tezgel died before she arrived at the hospital. The FLO called Mr Tezgel's daughter to tell her.

35. Mr Tezgel's body was repatriated back to Turkey where his funeral was held on 11 October. The prison did not offer to pay for the costs of repatriation in line with national instructions, nor did they contribute towards funeral expenses.

Support for prisoners and staff

36. After Mr Tezgel'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.

37. The prison posted notices informing other prisoners of Mr Tezgel's death and offering support.

Cause of death

38. No post-mortem examination was carried out as the coroner accepted the cause of death provided by a hospital doctor. The doctor gave Mr Tezgel's cause of death as a heart attack, caused by heart disease.

Findings

Clinical Care

39. The clinical reviewer concluded that overall, the clinical care Mr Tezgel received at Stoke Heath was equivalent to that which he could have expected to receive in the community.

40. When Mr Tezgel had his initial reception health screen, he did not tell the nurse that he had a heart condition. He did not tell anyone until three months later when he had an appointment with the prison GP. When the GP was made aware, he immediately followed it up and found out that Mr Tezgel had been diagnosed with ischaemic heart disease in 2013. The GP then prescribed Mr Tezgel with appropriate medication and arranged for blood tests.

41. The clinical reviewer was satisfied that Mr Tezgel's heart condition was managed well overall. However, she was concerned that there were no care plans in place to monitor Mr Tezgel's ischaemic heart disease, which is not in line with National Institute for Health and Care Excellence (NICE) guidelines. We recommend:

    The Head of Healthcare should ensure that all prisoners with identified long-term conditions have a specific personalised management plan in place in line with NICE guidelines.

42. The clinical reviewer was also concerned that when Mr Tezgel arrived at Stoke Heath his first and second health screen were offered at the same time. Mr Tezgel did not, therefore, receive the option to have a secondary screen after settling into the prison. This may have been a lost opportunity for him to discuss past medical history with a member of the healthcare team. Offering first and second reception screening at the same time is not in line with NICE guidelines. We therefore recommend:

    The Head of Healthcare should review the process of reception screening to ensure that first and second reception screenings are not offered on the same day.

Emergency response

43. We are concerned that when Officer A and Officer B saw that Mr Tezgel was unresponsive, they did not stay in the cell with Mr Tezgel and they did not provide any lifesaving treatment, including cardiopulmonary resuscitation (CPR). After calling a code blue, both officers waited outside the cell for healthcare staff to arrive.

44. Healthcare staff arrived at the cell in just over 90 seconds and started CPR straightaway. They managed to regain a pulse. When paramedics arrived, they continued CPR and then took Mr Tezgel to hospital.

45. We are concerned that the officers who found Mr Tezgel did not start CPR. We know that any delay in starting CPR can be crucial, and in this case, given that healthcare staff managed to regain a pulse for Mr Tezgel, it is possible that the outcome could have been different if CPR had been started sooner. We make the following recommendations:

The Governor should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity, and that staff first on the scene of an emergency provide basic life support until qualified health professionals arrive.

The Governor should share this report with Officer A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.

Funeral expenses

46. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the processes that should be followed when a prisoner dies. This includes that prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000 and must offer to pay reasonable repatriation costs for a deceased foreign national prisoner. The PSI says that the average cost of a simple repatriation is £1,200, excluding freight charges.

47. Mr Tezgel's body was repatriated from England to Turkey where his funeral was held on 11 October. The prison did not offer to pay any money towards it, and when asked why not, they said that Mr Tezgel's family did not ask.

48. PSI 64/2011 makes it clear that prisons must offer to pay a contribution towards funeral and repatriation costs. The prison should have offered Mr Tezgel's family financial help and should not have waited for them to ask. We therefore recommend:

The Governor should ensure that:

- **following a death in custody of a foreign national prisoner, the prison offers up to £3,000 towards reasonable funeral expenses and a separate amount for reasonable repatriation costs; and**
- **the prison now offers to pay reasonable funeral and repatriation expenses to Mr Tezgel's family.**

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