

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Imtinan Uppal, a prisoner at HMP Risley, on 14 September 2019

A report by the Prisons and Probation Ombudsman

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*



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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 Imtinan Uppal died in hospital on 14 September 2019 of bronchopneumonia, while a prisoner at HMP Risley. He was 66 years old. I offer my condolences to Mr Uppal's family and friends.

The clinical reviewer found that Mr Uppal's long-term health conditions were well-managed at Risley and that his care was equivalent to that he could have expected to receive in the community.

She identified some failings after Mr Uppal was taken ill on 27 August, including that the nurse who assessed him that morning did not request an urgent review by a GP. However, he was seen by a GP around an hour later and sent to hospital. The clinical reviewer was satisfied that none of the failings affected the eventual outcome for Mr Uppal.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

April 2020

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Summary

Events

1. On 8 November 2017, Mr Imtinan Uppal was sentenced to four years imprisonment for sexual offences and sent to HMP Forest Bank. He was moved to HMP Risley on 20 December 2018.
2. Mr Uppal had several long-term conditions including chronic obstructive pulmonary disease (COPD – a group of serious lung conditions), diabetes and hypertension. Staff put appropriate care plans in place and regularly monitored his conditions.
3. Around 9.45am on 27 August 2019, a nurse saw Mr Uppal after he complained of chest pain. The nurse assessed him and calculated a National Early Warning Score (NEWS) of six (which indicates an urgent review should be requested and the patient should be monitored hourly). The nurse noted that she had told a prison GP, who would see him in the afternoon. In the event, a prison GP saw Mr Uppal around an hour later, when he continued to feel unwell, and decided to send him to hospital.
4. Hospital staff initially suspected Mr Uppal may have tuberculosis (TB), but this was ruled out and he was treated for a chest infection.
5. Mr Uppal's condition deteriorated and at 5.55pm on 14 September, he died in hospital.
6. The post-mortem examination found that he died from bronchopneumonia. COPD and heart disease were listed as contributory factors.

Findings

7. The clinical reviewer found that Mr Uppal's long-term conditions were well-managed at Risley and his care was equivalent to that he could have expected to receive in the community. However, she found some failings after Mr Uppal was taken ill on 27 August.
8. The nurse who assessed Mr Uppal on 27 August did not arrange for an urgent review by a GP as she should have done. Staff did not make a full entry in the medical record when the decision to call an ambulance was made. Also, staff did not obtain regular updates from the hospital. The clinical reviewer was satisfied, however, that none of these failings affected the outcome for Mr Uppal.

Recommendations

- The Head of Healthcare should ensure all staff understand how to use the NEWS tool and use the correct escalation procedures.
- The Head of Healthcare should ensure that staff make a comprehensive entry in the medical record when a decision is taken to send a prisoner to hospital.
- The Head of Healthcare should ensure that staff obtain regular updates and update the prisoner's medical record when a prisoner is admitted to hospital.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Uppal's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Uppal's clinical care at the prison.
12. We informed HM Coroner for Cheshire, Halton and Warrington of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Uppal's wife to explain the investigation and ask if she wished to raise any issues. Mr Uppal's wife raised questions about the standard of healthcare Mr Uppal had received, which are addressed in our report. She raised other issues which have been addressed through separate correspondence.
14. Mr Uppal's family received a copy of the initial report. They pointed out some factual inaccuracies with the clinical review. This report and the clinical review have been amended accordingly.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Risley

16. HMP Risley is a medium security training prison, which holds over 1,000 convicted men. Bridgewater Community Healthcare NHS Trust and Greater Manchester West Mental Health Trust provide healthcare services in the prison. There is 24-hour healthcare cover. There is a doctor in the prison during the day and at night there are nurses on duty. Prisoners who need inpatient treatment are referred to other prisons (usually HMP Preston) or to hospital.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Risley was in June 2016. Inspectors reported that health services were reasonable, but governance and oversight were underdeveloped. The range of primary care services was adequate, although prisoners waited too long to see a GP.

Independent Monitoring Board

18. 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 2018, the IMB reported that the healthcare building was clean and well equipped, and the feedback from a prisoner survey had been good. A Healthcare Improvement Advisor frequently attended to offer well-being services to staff and prisoners.

Previous deaths at HMP Risley

19. Mr Uppal was the ninth prisoner to die at HMP Risley since September 2017. Of the previous deaths, three were from natural causes, two were self-inflicted, one was drug-related, one a homicide and one awaits classification. We have previously made recommendations about use of the NEWS tool and obtaining regular updates on prisoners taken to hospital.

Key Events

20. On 8 November 2017, Mr Imtinan Uppal was sentenced to four years imprisonment for sexual offences and sent to HMP Forest Bank. He was moved to HMP Risley on 20 December 2018.
21. A nurse completed Mr Uppal's reception health screen when he arrived at Risley. She noted he had hypertension (high blood pressure), diabetes and chronic obstructive pulmonary disease (COPD – a group of serious lung conditions including chronic bronchitis and emphysema). The next day, a prison GP ensured Mr Uppal's medication record was in order.
22. On 27 December, Mr Uppal had a secondary health screen and was referred to the long-term conditions clinic for review.
23. On 22 January 2019, a prison GP completed Mr Uppal's COPD annual review. He noted nothing unusual.
24. On 5 February, a nurse saw Mr Uppal in the long-term conditions clinic and completed an annual review of his diabetes and hypertension. She created care plans to ensure these conditions continued to be managed.
25. A QRisk2 Cardiovascular Disease ten-year score test was also carried out and indicated that Mr Uppal was at high risk of developing cardiovascular disease within the next ten years. He was already taking appropriate medication and the nurse created a cardiovascular disease care plan.
26. Blood tests were taken as part of Mr Uppal's long-term conditions review. On 8 February, the results became available, although his potassium levels had not been tested. He did not attend for a retest appointment on 12 February and it was not until 1 March that he was retested and results showed extremely high potassium levels. (Hyperkalaemia is characterised by high potassium levels. Potassium has a critical impact on nerve and muscle cells including those in the heart.)
27. Mr Uppal was immediately transferred to the accident and emergency department at Warrington General Hospital. He was discharged back to Risley the next day after his potassium levels had reduced.
28. Prison healthcare staff took daily blood tests to monitor Mr Uppal's potassium levels and he was prescribed medication to help keep levels within normal parameters.
29. On 13 March, Mr Uppal was transferred to Warrington General Hospital again when his potassium levels rose to unacceptable levels. The hospital gave him intravenous fluids. He was returned to Risley on 17 March. Doctors discontinued his lisinopril medication (for high blood pressure) as this was thought to be causing his raised potassium levels.
30. On 13 August, Mr Uppal was admitted to Warrington General Hospital until 16 August where he was treated for exacerbation of his COPD.

31. At 9.46am on 27 August, a nurse recorded that she had seen Mr Uppal because he had complained of chest pain. The nurse took observations and calculated a National Early Warning Score (NEWS) of six. (A NEWS is calculated by giving points to a range of physical observations. The score tells staff whether further intervention is needed and helps staff identify whether a patient is improving or deteriorating. A score of six indicates that an urgent assessment should be requested and the patient should be monitored hourly.) After the nurse had seen Mr Uppal, she recorded that she had asked a prison GP to see him that afternoon.
32. An hour later, at 10.46am, a prison GP recorded that Mr Uppal felt unwell and he had decided to send him to hospital. A nurse recorded that he was paler than earlier and said he felt weak. According to the prison's escort documentation, the ambulance left Risleigh at approximately 1.40pm. Mr Uppal was restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
33. Hospital staff initially suspected Mr Uppal had tuberculosis (TB - a serious bacterial infection that mainly affects the lungs). On 31 August, hospital staff advised the prison that the escort chain could increase the escorting officers' chances of infection. The deputy governor authorised its removal. When TB was ruled out, restraints were not reapplied as Mr Uppal's condition had deteriorated.
34. On 1 September, a nurse called the hospital ward but could not get through. She managed to speak to one of the escort officers who told her that Mr Uppal was being treated for a chest infection with antibiotics and oxygen. She called again on 4 September and was told there was no change. A nurse called the hospital on 6 September but was unable to speak to a member of hospital staff. She called again on 8 September and was told that Mr Uppal was still on antibiotics and high flow oxygen, but they were going to try to wean him off the high flow oxygen. On 13 September, a nurse called the hospital and was told that Mr Uppal's recovery looked uncertain.
35. Mr Uppal died in hospital at 5.55pm on 14 September 2019.

Contact with Mr Uppal's family

36. On 15 September, the prison appointed a family liaison officer and she telephoned the next of kin to offer advice and support. Mr Uppal's family had previously been made aware that he was in hospital and were with him when he died on 14 September. Mr Uppal's funeral was held on 20 September. The family did not want anyone from the prison to attend and did not accept the prison's offer to pay funeral costs.

Support for prisoners and staff

37. After Mr Uppal's death, the, duty governor visited the hospital and debriefed the escorting staff. The staff care team also contacted the officers and offered support.
38. The prison posted notices informing other prisoners of Mr Uppal 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 Uppal's death.

Post-mortem report

39. The post-mortem report concluded that Mr Uppal died of bronchopneumonia. COPD and heart disease were listed as contributory factors.

Findings

Clinical care

40. The clinical reviewer found that the care Mr Uppal received at HMP Risley was equivalent to that he could have expected to receive in the community. She found that the care for his long-term conditions was in line with guidance. She did, however, identify some areas for improvement.

41. On 27 August, after Mr Uppal complained of chest pain, a nurse calculated a NEWS of six. She noted that she had told a GP who would see him that afternoon. There should have been a more urgent escalation. In the event, Mr Uppal was seen by a GP later that morning, who sent him to hospital, and the clinical reviewer was satisfied that the oversight did not affect the outcome. However, staff need to be reminded of the correct escalation procedures when using the NEWS tool. We make the following recommendation:

The Head of Healthcare should ensure all staff understand how to use the NEWS tool and use the correct escalation procedures.

42. Although healthcare staff decided to call an ambulance at some point on 27 August, the medical record does not show exactly when the ambulance was called, whether it was an emergency ambulance, when it arrived or when it left with Mr Uppal. We make the following recommendation:

The Head of Healthcare should ensure that staff make a comprehensive entry in the medical record when a decision is taken to send a prisoner to hospital.

43. Mr Uppal was taken to hospital on 27 August, but prison healthcare staff did not call the hospital for an update until 1 September. Also, they did not call for an update between 8 and 13 September. While this did not affect the outcome for Mr Uppal, it is important that prison healthcare staff obtain regular updates from the hospital as it could affect continuity of care. We make the following recommendation:

The Head of Healthcare should ensure that staff obtain regular updates and update the prisoner's medical record when a prisoner is admitted to hospital.

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