Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Penny, a prisoner at HMP Bristol, on 11 September 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 Simon Penny died at HMP Bristol on 11 September 2019. His death was due to severe blood loss from a large stomach ulcer. He was 35 years old. I offer my condolences to Mr Penny's family and friends.

Mr Penny was unwell throughout his seven days at Bristol. Healthcare staff tried to assess and monitor him, but his clinical management was impaired by his difficult behaviour and refusal to cooperate.

I am concerned that prison doctors were twice unable to examine Mr Penny, due to a lack of wing staff to open his cell and poor facilities in the treatment room. I am also concerned that there is no record of a request for him to be examined on the afternoon of his death.

When Mr Penny's condition worsened, staff did not comply with the emergency response procedures, leading to delays in requesting an ambulance, giving essential information and getting the correct resuscitation equipment. Additionally, they were not fully aware of the circumstances in which they can enter a cell at night.

The clinical reviewer considered that Mr Penny's clinical care was equivalent to that which he could have expected to receive in the community. While I am satisfied that the deficiencies in his management did not affect the outcome, I am concerned that, on several occasions, operational problems impacted on the ability of healthcare staff to deliver optimal care.

I commend the prison's family liaison officer for her committed and compassionate support to Mr Penny's family. I am also pleased to note the visible personal engagement by the Governor in the aftermath of Mr Penny's death.

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 **November 2020**

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Summary

Events

1. On 4 September, Mr Simon Penny was sentenced to 14 weeks imprisonment. At court, he was unwell, but paramedics considered him fit to be detained.

2. Symptoms of abdominal pain and vomiting continued after Mr Penny arrived at HMP Bristol and staff attributed this mainly to drug withdrawal. Mr Penny declined reception health assessments. (He refused to engage with subsequent attempts to monitor and examine him. He was often aggressive and abusive to healthcare staff.)

3. A prison GP assessed Mr Penny at his cell door, on 5 September. The GP could not examine him, as there were no wing staff available to unlock his cell, so he arranged to check him at the evening clinic. Mr Penny did not attend.

4. On 8 September, a healthcare assistant was only able to carry out visual observations of Mr Penny due to staffing problems caused by the limited weekend regime and incidents on the wing.

5. On 9 September, a prison GP reviewed Mr Penny, but could not conduct a physical examination as there was no washbasin or privacy blinds in the medical room. However, she prescribed medication to help relieve his stomach problems and pain. She also requested urgent blood tests, which later revealed no abnormalities.

6. During the afternoon of 11 September, Mr Penny was found in a staff toilet. He was in pain and appeared to have vomited blood. A prison officer reported this to healthcare staff, who said they could not see him immediately as it was not an emergency, but they would do so as soon as possible. There is no evidence that Mr Penny was examined following this incident.

7. At around 9.20pm on 11 September, Mr Penny's cellmate became concerned about him and summoned help. Mr Penny initially seemed to be conscious, but became unresponsive just after nurses and officers arrived. Resuscitation attempts were unsuccessful and paramedics confirmed his death at 10.48pm.

Findings

8. The clinical reviewer considered that Mr Penny's clinical care was equivalent to that which he could have expected to receive in the community. Healthcare staff monitored his vital signs and reviewed his symptoms as best they could. However, we believe that his standard of care was diminished by operational failings.

9. The day after Mr Penny arrived at Bristol, a prison GP could not physically examine him, as there were no wing staff available to unlock his cell door.

10. The GP who reviewed Mr Penny on 9 September, was unable to carry out an internal examination, as the medical room had no sink or privacy curtains.

11. An officer said that she had asked for healthcare staff to assess Mr Penny on the afternoon of his death when he appeared to have vomited blood. There is no record of the request, or the healthcare response.

12. The person who answered the cell bell on the night of 11 September did not know how to request non-urgent medical help at night and had not been trained in first aid. Bristol has introduced mandatory first aid training for all operational support staff. Nearly half of them have already received this.

13. Staff did not follow some of the mandatory procedures during an emergency and their knowledge of the policy on entering cells at night was inaccurate. No emergency code was used to inform the control room of the nature of the incident and there was a delay in requesting an ambulance. Although Bristol has a local protocol setting out the basic information required by the ambulance service, it took several minutes for staff to provide this.

14. Essential items were missing from the emergency bag and a significant amount of time was spent collecting additional equipment during the resuscitation process. The bag should have been checked daily, but there was no evidence that it had been checked in the previous 48 hours.

15. The prison's family liaison officer provided a high standard of support and the Governor was personally involved at key stages following Mr Penny's death.

Recommendations

- The Governor should ensure that healthcare staff are given access to prisoners who need to be medically examined in their cells.
- The Head of Healthcare should ensure that healthcare staff understand that they can insist on being able to examine a prisoner in person if they consider it clinically necessary, and that that there is a clear escalation path if this is denied.
- The Governor and Head of Healthcare should ensure that clinical treatment and examination rooms are appropriately furnished and that a sink and privacy curtains are installed in the room on C3.
- The Governor should ensure that all staff know how to request medical assistance at night when the prisoner's condition is not considered to be life-threatening.
- The Governor should ensure that staff understand the policy on opening cells at night, notably that subject to a personal risk assessment, they are permitted to enter a cell in an emergency when there is potentially a risk to life.
- The Governor and Head of Healthcare should ensure that all prison staff understand PSI 03/2013, as well as local instructions and their responsibilities during medical emergencies, including:
    - using the appropriate emergency code to effectively communicate the nature of a medical emergency and enable staff to take the relevant equipment to an emergency;
    - calling an ambulance immediately in an emergency; and

    - promptly providing the information expected in the Secondary Emergency Notification of Dispatch (SEND) protocol, when requesting an ambulance.
- The Head of Healthcare should ensure that emergency bags are fully equipped and checked in line with the healthcare policy and that checks are documented.
- The Governor and Head of Healthcare should ensure that staff fully document requests, significant interactions and decisions relating to prisoners.
- The Governor should ensure that this report is shared with the prison's family liaison officer so that she is aware of the Ombudsman's comments.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her.

17. The investigator visited Bristol on 26 September 2019. She spoke to the Governor, members of the safer custody team and three prisoners, including Mr Penny's cellmate and a close, longstanding friend. She also met Mr Penny's mother, who visited the prison that day. The investigator obtained copies of relevant extracts from Mr Penny's prison records.

18. NHS England commissioned a clinical reviewer to review Mr Penny's clinical care at the prison. The clinical reviewer and the investigator interviewed six members of staff at Bristol on 13 November. The investigator and the clinical reviewer later interviewed two further members of staff individually, by telephone.

19. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Penny's mother, his next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. Mr Penny's mother asked whether Mr Penny was assessed properly when he arrived at Bristol and why he had been placed on a normal wing, given his drug dependency? She later appointed a solicitor to act on her behalf. We have addressed her questions in this report.

21. Our investigation was suspended while waiting for the cause of death and clinical review. This has delayed the initial report.

22. The solicitors acting for Mr Penny's mother received a copy of our initial report. No comments were received.

23. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan is annexed to this report.

Background Information

HMP Bristol

24. HMP Bristol serves the local courts and holds up to 614 adult men over the age of 18 years old. HM Prisons and Probation Service placed it under special measures in 2018 as they considered that it needed additional specialist support to improve performance.

25. At the time of Mr Penny's death, healthcare services at Bristol were managed by Inspire Better Health, a partnership of eight providers led by Bristol Community Health and Hanham Health, a GP partnership. Since April 2020, healthcare has been provided by Avon and Wiltshire Mental Health Partnership and Hanham Health. The prison has no inpatient facilities.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Bristol was in May and June 2019. HM Chief Inspector of Prisons invoked the Urgent Notification process on 11 June, informing the Secretary of State for Justice of significant concerns about the treatment and conditions of prisoners.

27. Inspectors reported that healthcare provision had improved since the previous inspection in 2017. It was well-managed, with an appropriate range of services, and strong clinical leadership. Substance misuse services were particularly impressive, with effective partnership working. However, the inspection found that the C wing drug recovery landing was 'squalid and degrading' and some of the residential wing treatment rooms were in a poor state. An infection prevention and control audit had been carried out in May 2019 and an audit programme was in place, but there was a backlog of improvement works.

Independent Monitoring Board

28. 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. The IMB's latest annual report has yet to be published, but in the report for the year to July 2018, the Board reported that the healthcare department was under increasing pressure due to the ageing prison population, the number of prisoners with long-term conditions, the prevalence of illicit drug use and high levels of self-harm. They also noted frequent verbal abuse and intimidation towards nurses.

Previous deaths at HMP Bristol

29. Mr Penny was the fourth prisoner to die at Bristol since September 2017. Two of the previous deaths were from natural causes and one was self-inflicted. There have been two further self-inflicted deaths.

30. We have previously made a recommendation about emergency response procedures.

Key Events

31. On 4 September 2019, Mr Simon Penny was sentenced to 14 weeks in prison. He had breached both a community order and a suspended sentence given for theft and possession of psychoactive substances (PS). Mr Penny had a long history of substance misuse. At court, Mr Penny was unwell, agitated and angry and said he was withdrawing from PS. Paramedics completed an acute care referral form, but concluded that he was medically fit to be taken to prison and he was taken to HMP Bristol.

32. Prison reception staff noted that he had threatened to hang himself if sent to prison and that he was withdrawing from drugs "in a very bad way". He was therefore managed under the Assessment, Care in Custody, Teamwork (ACCT) procedures - the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm, until 6 September.

33. Mr Penny refused an initial health screen and medical examination, but demanded methadone. There was no doctor in the prison at that time. As Mr Penny felt so ill, staff were unable to carry out the first night procedures and assessments, but noted key information from his previous periods at the prison.

34. Prisoners with opiate dependence are monitored closely for the first five days. During the night, Mr Penny continued to vomit. He refused to be examined, but accepted anti-sickness medication.

35. On 5 September, a nurse tried to complete Mr Penny's health assessment, but he remained under his blanket and would only talk about his drug withdrawal. She referred him to the substance misuse service for psychosocial intervention. A urine test was positive for opiates and cocaine.

36. In the afternoon, Mr Penny was moved to a cell on C3, the detoxification unit. A prison GP assessed Mr Penny, standing outside his cell door, as no officers were available to unlock him. He noted that Mr Penny was sweating and in discomfort from abdominal pain. The GP prescribed methadone and planned a thorough check in the evening. Mr Penny refused to go to the evening clinic, so the GP asked the nurses to monitor him.

37. During observations in the early hours of 7 September, Mr Penny twice reported abdominal pain and vomiting bile. He refused to allow nurses to carry out clinical observations and became abusive when a nurse advised that, due to his symptoms, he should take paracetamol, not ibuprofen.

38. Later that morning, Mr Penny refused to engage with a member of the substance misuse service. He was aggressive and abusive to healthcare staff but apologised afterwards. He continued to show signs of withdrawal but would not attend for clinical checks in the afternoon. (Over the next few days, further attempts to complete a substance misuse assessment also failed, as Mr Penny was too unwell, or refused to engage.)

39. On 8 September, a healthcare assistant noted that she had only carried out clinical checks visually due to a shortage of staff, the weekend regime and incidents on the landing. Later, at the medication hatch, Mr Penny appeared

agitated and was unhappy with the dosage of methadone. He threatened to call the hospital from his cell if he did not see the doctor.

40. On 9 September, Mr Penny was assessed by the medical director and clinical lead at Bristol. He said that he had suffered abdominal pain since he arrived at the prison and that it did not feel the same as the pain associated with withdrawal, as he had been addicted to heroin since the age of nine and knew the symptoms. He was very angry about his treatment and threatened to set fire to his cell if he was not sent to hospital for investigation. Mr Penny's observations were within normal ranges, although he told the medical director and clinical lead, they were usually normal, even when he was very unwell.

41. The medical director and clinical lead at Bristol was unable to perform an internal examination, as there was no washbasin or privacy blinds in the medical room. She arranged for urgent blood tests, weekly weight checks and prescribed medication to help bowel movements and pain, together with a nutritional supplement. She planned to see Mr Penny again in a few days. (The nurse who took the blood sample noted that Mr Penny had claimed to have an ulcer that was about to burst. There is no reference in his medical records to suggest he had an ulcer.) The blood tests showed no abnormalities.

42. On the same day, Mr Penny moved to a residential wing. Nothing significant was recorded on 10 September.

Events of 11 September

43. On 11 September, Mr Penny refused a clinical assessment and five-day detoxification review. When a member of healthcare went to his cell, he shouted abuse and blocked the observation panel. He also refused to participate in his first session with his key worker and threatened to assault staff.

44. Sometime after 4.00pm, Mr Penny was found in a staff toilet and an officer attended. He was hunched over the toilet bowl and, from a distance, the officer saw dark red/black vomit, which she assumed was blood. At interview, the officer said she radioed healthcare and was told that someone would see Mr Penny as soon as possible, but they could not attend immediately as it was not an emergency. Mr Penny became aggressive, so the officer radioed for help. A Custodial Manager (CM) and Supervising Officer (SO) de-escalated the situation and staff escorted him back to his cell. Mr Penny said that he had coughed up blood.

45. The officer said that Mr Penny was clearly in considerable discomfort with stomach pain, which he thought was due to septicaemia, and she had relayed this to the CM although she did not make a record of this. She understood from the SO that healthcare staff had later reviewed Mr Penny on the wing. There is no record that this took place.

Emergency response

46. An Operational Support Grade (OSG) started night duty at around 8.30pm and completed a count of prisoners shortly afterwards. At that time, Mr Penny and his cellmate were in bed.

47. M Penny's cellmate told the investigator that he later woke up and saw Mr Penny apparently fitting and pressed the cell call bell. (Records show the bell was activated at 9.18pm and answered a minute later.)

48. The OSG responded and looked through the observation panel. She saw Mr Penny on the floor at the back of the cell and asked Mr Penny's cellmate what had happened. He replied that Mr Penny had fallen out of bed and might have injured himself. The OSG asked several questions, including if Mr Penny was breathing all right and was told that he was but that his breathing seemed slightly different. She told the investigator that Mr Penny's cellmate did not say anything about Mr Penny fitting.

49. The OSG was unsure what to do. She felt that Mr Penny's condition was not serious enough to call a medical emergency, but she did not know how to get medical help at that time of night. She went to the landing above and asked an officer. On his advice, she radioed for nurses, the night manager and officers to attend. Meanwhile, Mr Penny climbed back into bed and coughed up blood.

50. Two officers joined the OSG at the cell and spoke to the men through the door. Although Mr Penny seemed conscious, he was unable to speak clearly and made indecipherable noises. One of the officers estimated that it was around five minutes before there were sufficient staff to open the cell door.

51. Another officer escorted two nurses to the cell. The nurses did not initially know the nature of the incident but, on the way, someone suggested it might be related to PS. When they reached the wing, one of the nurses went to the treatment room to get the observation bag, while the other nurse went to the cell. The bag was incomplete, so she took some items from the emergency bag.

52. When the nurse reached the cell, at around 9.30pm, the officers present then opened the door. Mr Penny's condition had worsened, and he was unresponsive. The other nurse then arrived and both nurses asked for an emergency ambulance, so an officer radioed the control room. An officer tried to see if there was anything blocking Mr Penny's airway, but his body was tense, and his teeth clenched. The officers then placed him on the floor. An officer performed chest compressions, in rotation with some of the other officers. Another officer fetched a defibrillator. When attached, it advised no shock.

53. Paramedics arrived at 9.42pm and took over the resuscitation attempts, including blood and plasma transfusions. They confirmed Mr Penny's death at 10.48pm.

Contact with Mr Penny's family

54. Mr Penny did not cooperate with the reception process, so his next of kin details had not been recorded. (A safer custody peer worker had later tried to obtain them.) At 12.15am, the police provided the details for Mr Penny's mother, who lived a considerable distance away.

55. The Governor and the prison's family liaison officer arrived at the home of Mr Penny's mother and sister at 3.10am. They broke the news of Mr Penny's death, gave relevant information and offered support. They ensured that a friend was with his mother before they left.

56. The prison's family liaison officer telephoned Mr Penny's mother later that morning, visited again the next day and kept in close contact over the following weeks. She drove and accompanied Mr Penny's mother to the chapel of rest and to the prison. She arranged for her to meet one of Mr Penny's longstanding friends at the prison and have a further detailed conversation with the Governor. She also liaised with the Coroner's officer and the funeral director. The prison's family liaison officer made another home visit to support Mr Penny's mother.

57. The Governor and the prison's family liaison officer attended Mr Penny's funeral, which was held on 3 October. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

58. After Mr Penny's death, the Governor 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. Staff interviewed during the investigation said that they felt well supported.

59. The Governor issued personalised notices informing other staff and prisoners of Mr Penny's death and offering support. He also outlined the investigative processes to follow and his personal commitment to ensure any lessons were learned. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm, in case they had been adversely affected by Mr Penny's death.

Post-mortem report

60. A post-mortem examination indicated that the cause of Mr Penny's death was an upper gastrointestinal haemorrhage, caused by a duodenal ulcer. The clinical reviewer explained this as "bleeding from his stomach or upper intestine, due to an area of ulceration (where the surface lining had been worn away) in his small intestine".

61. The post-mortem report noted that Mr Penny had a large ulcer which had probably caused a lot of discomfort, but diagnosis of his condition was possibly hindered by his withdrawal symptoms and refusal to engage with staff. It was likely that his bleed had started suddenly, rather than developing over several days.

62. We note that toxicology tests on blood and urine showed that Mr Penny had methadone (which had been prescribed to him) and synthetic cannabinoids (PS) in his system at the time of his death, but these substances were not cited as a factor in his death.

Findings

Clinical care

63. Mr Penny's behaviour towards healthcare staff was challenging. He refused reception assessments and subsequent attempts to monitor his health. The clinical reviewer considered that this, as well as Mr Penny's withdrawal from drugs complicated the clinical assessment and management of his condition.

64. Mr Penny told a nurse that he thought he had an ulcer but there is no record to suggest this was the case in his previous medical records. The clinical reviewer noted that the fatal bleed probably started immediately before he died and the chance of successful resuscitation outside of hospital was unlikely. The clinical reviewer concluded that Mr Penny's clinical care was equivalent to that he could have expected to receive in the community.

65. We are concerned, however, that his clinical management was significantly impaired by operational weaknesses, which we outline below.

66. On 5 September, a prison GP was unable to physically examine Mr Penny, as no wing staff were available to unlock his cell door. A similar situation arose on 8 September. We make the following recommendations:

    The Governor should ensure that healthcare staff are given access to prisoners who need to be medically examined in their cells.

    The Head of Healthcare should ensure that healthcare staff understand that they can insist on being able to examine a prisoner in person if they consider it clinically necessary, and that that there is a clear escalation path if this is denied.

67. During the most recent inspection of Bristol, HM Chief Inspector of Prisons found that treatment rooms were in poor condition. A GP was unable to fully examine Mr Penny on 9 September, due to a lack of appropriate facilities. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that clinical treatment and examination rooms are appropriately furnished and that a sink and privacy curtains are installed in the room on C3.

The emergency response

68. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, and Bristol's Local Instruction 2.161 Healthcare Response Codes set out the actions staff should take in a medical emergency. The PSI includes mandatory instructions on efficiently communicating the nature of a medical emergency, to ensure staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It also explicitly states that all prison staff must be made aware of and understand the instruction and their responsibilities during medical emergencies. The investigation found several shortcomings in the handling of the emergency response.

Entering Mr Penny's cell and use of an emergency code

69. Prison Service Instruction (PSI) 24/2011, Management and Security of Nights, requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present, one of whom should be the night orderly officer. However, there is provision for prison staff to open cells at night without the authority of the night manager where there appears to be danger to life, subject to a dynamic risk assessment to ensure their safety. Bristol's local policy is consistent with the national policy and states there should be a minimum of two staff to open a cell at night.

70. Mr Penny was initially conscious. Although the OSG had noticed a slight change to his breathing, it did not seem severe enough to radio a medical emergency. This seems reasonable and we have no reason to second-guess her judgment. However, it is of concern that the OSG did not know how to get medical help at night.

71. At interview, the OSG said that three officers had to be present to go into the cell, "but as an OSG, I don't count". Another officer said that all five officers and the night manager had to be present to open a cell with two prisoners, at night. These statements show that their understanding of Prison Service and local policies on opening cells at night was wrong.

72. It is understandable that the prison officers exercised caution in unlocking the cell door, as Mr Penny was in a double cell, both men were awake and the severity of his condition was not immediately obvious. However, once Mr Penny became unconscious, staff should have used an emergency code, a mandatory requirement in these circumstances, so that the control room officer was in no doubt as to the nature and urgency of the request.

Requesting an ambulance

73. Bristol's Safer Custody Strategy and Local Operating Procedures includes a Memorandum of Understanding with the South West Ambulance Service Trust (SWAST), as well as a Secondary Emergency Notification of Dispatch (SEND) protocol. The protocol sets out the process for requesting an ambulance and the minimum information to be given to the call handler. A simple guide of the key points is displayed around the prison and in the control room.

74. There was a delay of at least five minutes between staff requesting an ambulance and the control room contacting the Ambulance Service. A further five minutes elapsed before the call handler received enough information to despatch an ambulance.

75. The investigator obtained a recording of the telephone call. For the first few minutes, neither the officer, nor the nurse who assisted with the call were able to answer basic questions, such as name, date of birth, whether Mr Penny was breathing, conscious, if he needed life-saving treatment and the prison's full address. When pressed on the details, some answers were contradictory and alternated between unconscious and awake. The despatcher was twice put on

hold while staff were consulted. At interview, a nurse said she was confused and uncertain when she spoke to the call handler, as the request for nurses had started as a general assessment, but had become an emergency.

76. We are concerned that prison staff did not comply with key aspects of national and local emergency response guidance or follow the SEND protocol and that this led to an excessive delay in passing information to the Ambulance Service. We make the following recommendations:

The Governor should ensure that all staff know how to request medical assistance at night when the prisoner's condition is not considered to be life-threatening.

The Governor should ensure that staff understand the policy on opening cells at night, notably that subject to a personal risk assessment, they are permitted to enter a cell in an emergency when there is potentially a risk to life.

The Governor and Head of Healthcare should ensure that all prison staff understand PSI 03/2013, as well as local instructions and their responsibilities during medical emergencies, including:

- **using the appropriate emergency code to effectively communicate the nature of a medical emergency and enable staff to take the relevant equipment to an emergency;**
- **calling an ambulance immediately in an emergency; and**
- **promptly providing the information expected in the Secondary Emergency Notification of Dispatch (SEND) protocol, when requesting an ambulance.**

Emergency bags

77. The healthcare protocol requires the contents of each wing emergency bag to be checked weekly and tagged. The tags should then be checked daily, but there is no evidence that this was completed on 10 or 11 September. Several items were missing and a nurse left the cell twice to get additional resuscitation equipment, including a mask, airway and oxygen cylinder, which took around 5-7 minutes. We agree with the clinical reviewer that although the delay did not affect the outcome for Mr Penny, it could be critical in future emergencies. We make the following recommendation:

The Head of Healthcare should ensure that emergency bags are fully equipped and checked in line with the healthcare policy and that checks are documented.

First aid training for operational support staff

78. The OSG was fairly new to her role and it was the second night of her first night shift. She had completed the standard OSG course, which did not include training in first aid, or basic life support.

79. We acknowledge that, generally, OSGs have minimal contact with prisoners. However, as evidenced by this incident, there are occasions when such interaction is possible. We agree with the clinical reviewer that it would be beneficial for staff responsible for prisoner welfare to receive first aid training.

80. During the investigation, the prison informed us that although there is no mandatory national requirement for operational staff to be first aid trained, Bristol has made it mandatory for all OSGs to have Emergency First Aid at Work (EFAW) training. At present, 45% of OSGs have been trained. Due to the COVID-19 pandemic, there has been a delay in training the remainder. As this training is already underway, we do not make a recommendation on this issue.

Record keeping

81. An officer said that she had requested medical help for Mr Penny after he was found in the staff toilet and she believed that healthcare staff had checked him afterwards. Although the CM later made a note of the incident on the briefing and handover sheet, there was no reference to a request for Mr Penny to be seen by healthcare that afternoon, nor any record of him being examined. Therefore, we cannot be certain of the facts around the request, such as the level of detail given to healthcare about his symptoms.

82. Operational staff were aware that Mr Penny was in considerable pain and vomiting blood, which can be a sign of a serious medical condition. We consider that due to the gravity of his symptoms, they should have recorded and monitored the request for healthcare to see him, to ensure that he was examined. In addition, healthcare staff should have recorded the decision and reason for not seeing Mr Penny immediately. We make the following recommendation.

The Governor and Head of Healthcare should ensure that staff fully document requests, significant interactions and decisions relating to prisoners.

Good practice

83. We consider that the prison's family liaison officer provided an exceptional standard of support to Mr Penny's mother, over an extended period. We commend her professionalism, responsiveness and compassion. We make the following recommendation:

The Governor should ensure that this report is shared with the prison liaison officer, so that she is aware of the Ombudsman's comments.

84. We also commend the Governor's personal involvement with staff, prisoners and Mr Penny's family; his explicit commitment to learning any lessons arising from Mr Penny's death; and his open communication with the investigator.

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