

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Michael Freeman, a prisoner at HMP Elmley, on 14 June 2021

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



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Michael Freeman died on 14 June 2021 of Haemopericardium (a condition where blood gets into the pericardial sac of the heart and stops it from pumping), caused by a heart attack, while a prisoner at HMP Elmley. Mr Freeman was 82 years old. I offer my condolences to Mr Freeman's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Freeman received at Elmley was not equivalent to that he could have expected to receive in the community. She said that nursing care plans were clear and updated regularly. However, there was not enough knowledge of Mr Freeman's medical history to fully inform his care plans. We understand that Mr Freeman had not lived in England for 14 years, but he was likely to have had documented medical history in his previous name, prior to 2007. Mr Freeman had not been treated for any of the conditions that were noted in the post-mortem report.
5. The clinical reviewer also concluded that healthcare staff missed opportunities to act on Mr Freeman's irregular pulse recordings (atrial fibrillation). She made two recommendations accordingly. The clinical reviewer also made three further recommendations not directly linked to Mr Freeman's death, but which the Head of Healthcare will need to address.
6. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that healthcare staff obtain community medical records for newly arrived prisoners, in line with PSO 3050.
- The Head of Healthcare should review the basic processes around checking pulses to ensure that staff are able to detect signs of asymptomatic atrial fibrillation (irregular heartbeats) and escalate care accordingly.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Freeman's clinical care at HMP Elmley.
8. The PPO investigator has investigated non-clinical issues, including Mr Freeman's location, the security arrangements for liaison with his family and whether compassionate release was considered.
9. The investigator and clinical reviewer interviewed two members of healthcare staff in January 2022. The interviews were conducted by video and telephone.
10. The PPO family liaison officer wrote to Mr Freeman's next of kin, his wife, to explain the investigation. She did not respond to our letter.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Elmley

12. There were eleven deaths at Elmley in the two years before Mr Freeman died. Of these deaths, eight were from natural causes and two were self-inflicted and one was unascertained.

We have previously made a recommendation about accessing community medical records, following an investigation in June 2019. The Head of Healthcare accepted an action to ensure processes were in place for staff to consistently access community medical records.

Key Events

13. On 17 December 1969, Mr Freeman was sentenced to life imprisonment for murder. At the time he was convicted, he was known as Mr Michael Muldoon. He was released from prison on licence under the supervision of the Probation Service but absconded in 2007 and moved to Italy. He returned to England on 15 April 2021 and was arrested when entering the country. He was taken to HMP Elmley and his licence was revoked.
14. The Prisoner Escort Record (PER) noted that Mr Freeman had mobility issues, used a wheelchair and might need help with his personal care. Healthcare staff appropriately completed his initial health screenings. However, they did not request his previous medical records as they should have done.
15. Mr Freeman was located in the inpatient healthcare unit due to his general frailty and his need for support with his personal care. His door was left unlocked so that staff could assist him. A nurse noted that he had difficulty in hearing.
16. On 16 April, a prison GP examined Mr Freeman. He recorded that Mr Freeman had a tremor and difficulty with his memory and concentration. He diagnosed that he had advanced dementia. Mr Freeman was appropriately referred for an urgent social care assessment and a range of blood tests. Mr Freeman later refused to have these blood tests.
17. Mr Freeman had no recent medical records in England and healthcare staff had no information about any long-term illnesses or allergies that he may have had or any medication that he was prescribed. We found no evidence that the prison GP asked Mr Freeman for his medical history.
18. On 17 April, Mr Freeman was heard calling staff for help as he had fallen on the floor. The prison was in patrol state and there was a delay in supporting him as his door was closed. The clinical reviewer said that there was no record of a decision to reverse the earlier decision of keeping his door open. Mr Freeman was not injured following the fall and a falls assessment was completed.
19. On 19 April, a nurse completed a Waterlow assessment (a tool used to assess the risk of pressure ulcers). The score was 12, indicating that Mr Freeman was 'at risk'. Another nurse completed a clinical frailty score (CFS) and Mr Freeman scored 7 (The score runs from 1-9, 1 being very fit and 9 being terminally ill.) The clinical reviewer said that these assessment tools include questions that require knowledge of Mr Freeman's previous medical history and medication records. She assumed that some areas would have to have been left blank without this knowledge.
20. At 3.30pm on 19 April, a nurse took Mr Freeman's observations. His blood pressure was high at 160/98 mm/Hg (high blood pressure is considered to be 140/90 mmHg or higher) and his pulse was 92 beats per minute (bpm - normal rate is between 51-90 bpm), but the rhythm was noted as regular. His blood oxygen saturation was recorded as normal at 98% (normal is anything above 96%) and his respiratory rate was high at 23 breaths per minute (bpm - normal range is 12-20 bpm). Mr Freeman's temperature was recorded as low at 35.5° Celsius (normal temperature ranges between 36.1-38.0 Celsius). The nurse did not make any comment or escalate his care following these observations.

21. On 20 April, Mr Freeman's observations were repeated. His temperature and respiratory rate remained outside the normal parameters. Healthcare staff asked a prison GP to review Mr Freeman. She observed some potential symptoms of Parkinson's disease and spoke with Mr Freeman about having a blood test, ECG and dementia screening. Mr Freeman declined all of these tests and she was satisfied that he had capacity to make this decision.
22. On 21st April, a prison GP saw Mr Freeman as he was having difficulty passing urine. The GP wanted to perform an examination to check his prostate gland. Mr Freeman declined this examination
23. On 23 April, a nurse reviewed Mr Freeman's probation assessments and made a note that she had gathered information about his health and wellbeing. She told us that she did not request his medical records as this was done when someone first arrives at the prison.
24. On the same day, the nurse requested that Mr Freeman's door was unlocked overnight to help staff support Mr Freeman. Mr Freeman moved to another cell the next day so that this request could be actioned safely.
25. Mr Freeman's pulse had been previously recorded as normal on four occasions (19 April, 20 April, 24 April and 26 April). On 28 April, a nurse noted that Mr Freeman's pulse had sometimes been irregular. Nursing staff continued to provide daily support to assist Mr Freeman with his care with regular evaluations of their plan. The clinical reviewer notes that Mr Freeman became increasingly frail, with increased incontinence but had a high level of support from nursing staff to assist with his personal care.
26. On 14 June at 3.09pm, a nurse noticed a significant change in Mr Freeman's behaviour. He was challenging towards staff and was incontinent of faeces and had smeared it around his cell.
27. At 5.09pm, a nurse saw Mr Freeman as he said he felt sick and had been vomiting. She took his observations and another nurse recorded them on the system as the first nurse was called away to another emergency. His oxygen saturation was recorded as dangerously low at 62%. The first nurse told us in interview that she believed that this was an error in the recording but was unable to evidence this. We are unsure if the second nurse's record of the oxygen level was written in error. The follow up 24-hour healthcare investigation report notes that his oxygen saturation level was 96%. Staff also tested Mr Freeman's urine and sent the results to a GP for them to assess. There was no response to this recorded.
28. At 7.00pm, an officer completed a routine hourly check on Mr Freeman and noted that he was in bed resting.
29. At 7.32pm, the officer and a nurse were completing general welfare checks and found Mr Freeman unresponsive in his cell. The officer radioed a code blue (an emergency code indicating that a prisoner is not breathing or is having difficulty breathing) and the nurse started CPR. Staff in the control room immediately called an ambulance.
30. At 7.35pm, a Physical Exercise Instructor (PEI) and a custodial manager responded to the radio code and arrived at Mr Freeman's cell. On arriving the PEI ran straight to the wing office to get the defibrillator as the nurse did not have an emergency

bag when she found Mr Freeman unresponsive. Another nurse was administering medication on another wing and arrived at the cell at approximately 7.40pm, taking the emergency equipment bag with her. She supported staff with CPR.

31. Paramedics arrived at 7.53pm and took over Mr Freeman's care. At 8.23pm, they confirmed that he had died.

Post-mortem report

32. The pathologist concluded that Mr Freeman had died of haemopericardium (when blood gets into the pericardial sac of the heart and stops it from pumping) caused by a ruptured myocardial infarction (heart attack). The pathologist noted that this heart attack had occurred five days before Mr Freeman had died. (The clinical reviewer was satisfied that there were no clear signs of this missed by healthcare staff.) The heart attack was due to coronary heart disease (when coronary arteries become narrow and blocked by fatty tissue). Mr Freeman also had Chronic Obstructive Pulmonary Disease (COPD) (a lung condition which causes breathlessness) which did not cause but contributed to his death.

Sarah Stolworthy
Assistant Ombudsman

July 2022

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100