

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into the
death of Mr Abul Kashem Miah,
a prisoner at HMP Stoke Heath,
on 21 April 2022**

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

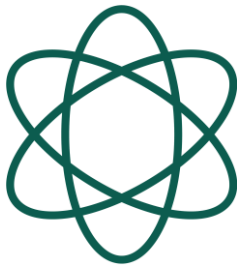
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100



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

OGL

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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 Abul Miah died of a heart attack, caused by heart disease on 21 April at HMP Stoke Heath. He was 44 years old. I offer my condolences to Mr Miah's family and friends.

The clinical reviewer concluded that the care Mr Miah received at Stoke Heath up until 18 April 2022 was equivalent to that which he could have expected to receive in the community. However, the clinical care provided to Mr Miah on 18 April, the day that he was found collapsed, was not equivalent. The clinical review identified issues regarding emergency bag equipment maintenance. Specifically, the availability of oxygen, which healthcare staff struggled to locate when Mr Miah collapsed. It also identified a lack of oversight by senior healthcare staff in the co-ordination of the emergency response. We are pleased that the Head of Healthcare has already taken steps to address some of the matters we raise in this report. It is important that this work continues, to ensure change improvements become embedded.

We found that prison staff worked well together to deliver the emergency response but are concerned that the officers we spoke to had not received refresher first aid training over a number of years. We also found that when prisoners found Mr Miah unresponsive, they did not use the designated panic alarm to alert staff to the emergency. This was due to a culture of not using panic alarms, through fears of being adjudicated for incorrect use, or due to perceptions around assisting staff.

It is not possible to measure the impact of the issues we identified in this report on the outcome for Mr Miah, but they might impact on future outcomes and should be addressed collaboratively by operational and healthcare senior management.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

March 2023

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Summary

Events

1. Mr Miah arrived at HMP Stoke Heath on 14 March 2022. Staff did not identify any significant physical or mental health needs at his initial healthcare screening.
2. On 18 April, at around 2.45pm, Mr Miah collapsed unexpectedly in the prison exercise yard. Other prisoners assisted by putting him into the recovery position and running to the internal staff office for support.
3. Officers attended the yard immediately and identified that Mr Miah was unresponsive. They radioed for healthcare attendance and called a code blue (a medical emergency code, indicating that a prisoner is having difficulty breathing) within seconds. Officers started cardiopulmonary resuscitation (CPR) and healthcare arrived a few minutes later, at around 3.00pm.
4. The prison control room called an ambulance at 2.57pm and it arrived at the prison at 3.30pm.
5. On 21 April at 2.50pm, Mr Miah stopped responding to hospital treatment and died in Royal Stoke hospital. His family had the opportunity to visit him before he died.

Findings

6. We found that there was no staff supervision or CCTV on I-Wing and its adjoining exercise yard because it was an area for enhanced prisoners. There was a panic alarm located in the exercise yard, a few metres from where Mr Miah collapsed, but this was not used. The prisoner who found Mr Miah travelled to the staff office for support, which created a short delay in the emergency response.
7. When healthcare arrived to support Mr Miah, they found that there was no oxygen in the emergency bag. This contributed to Mr Miah not receiving oxygen for around 18 minutes.
8. Prison staff worked together effectively to deliver timely CPR whilst waiting for healthcare assistance. However, some officers reported that they were not up to date with First Aid training.
9. When healthcare staff arrived to support Mr Miah, the senior member of healthcare staff did not take a lead in co-ordinating the emergency process, as would be expected.

Recommendations

- The Head of Healthcare and the Governor should complete a review of the emergency response provided for Mr Miah on 18 April 2022, to ensure that learning can be addressed.
- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.

- The Governor should ensure that operational staff have up-to-date training on basic first aid, and that systems are implemented to ensure training is appropriately refreshed
- The Governor and Head of Healthcare should ensure that all emergency 'grab' bags are checked daily to ensure that they contain the correct equipment, and that any missing items are recorded and replaced.
- The Governor should remind and encourage all prisoners to use panic alarms to alert staff of emergency situations, when safe to do so.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Stoke Heath informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
11. The investigator visited Stoke Heath on Monday 13 June. She obtained copies of relevant extracts from Mr Miah's prison and medical records and was shown around Mr Miah's wing.
12. NHS England commissioned an independent clinical reviewer to review Mr Miah's clinical care at the prison.
13. The investigator jointly interviewed eight members of staff with the clinical reviewer, some on teams and some at the prison between June and July 2021. The investigator also spoke with two prisoners during her visit to Stoke Heath.
14. We informed HM Coroner for Shropshire of the investigation. The Coroner gave us the confirmed cause of death. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Miah's family to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but requested a copy of the report.
16. Mr Miah's family received a copy of the draft report. They did not make any comments.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Stoke Heath

18. HMP Stoke Heath is a medium secure category C 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.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Stoke Heath was in November 2018. Inspectors reported that the prison remained an “overwhelmingly safe institution”. Staff had good relationships with prisoners and provided a good balance between care and control.
20. The inspectors did report some concerns in relation to healthcare resources. They found 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 be difficult to deploy swiftly. This concern was addressed during the inspection and more equipment was deployed around the prison. Emergency resuscitation equipment should be deployed around the site to enable a swift response in a medical emergency, and there should be no delay in summoning an ambulance when required. In June 2019 Shropshire Community NHS Trust and the Governor accepted the action.

Independent Monitoring Board

21. 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.
22. In its latest annual report, for the year to 30 April 2021, the IMB reported that the prison remained safe and decent and that healthcare services were well led. The Care Quality Commission (CQC) conducted an emergency support framework inspection during this period and considered that “no further regulatory activity is indicated at this time”. There is no mention of issues with emergency resuscitation equipment during this period.

Previous deaths at HMP Stoke Heath

23. There were four deaths at Stoke Heath in the two years before Mr Miah’s death. Three were from natural causes and one was self-inflicted. There are no similarities in our investigation findings across these investigations.

Key Events

Background

24. On 11 November 2015, Mr Miah was given a 14 year life sentence. He spent time at numerous prisons and was transferred from HMP Dovegate to HMP/YOI Stoke Heath on 14 March 2022.
25. Mr Miah had no significant long term health issues and reported no issues with his mental health.
26. On 24 March, the clinical nurse manager conducted a full health assessment of Mr Miah. She found no health concerns that required further monitoring. She noted that a QRISK assessment (a tool for predicting risk of heart disease) had been completed for Mr Miah at his previous prison and identified that he presented a low risk of developing cardiovascular disease within five years. No further action was taken, and Mr Miah received no further healthcare during his time at Stoke Heath.
27. Mr Miah was located on an enhanced wing with minimal staff supervision, and which included an outside gymnasium that residents were free to use. Mr Miah enjoyed regular exercise after his gym induction, which took place on 13 April.

Events of 18 April 2022

28. On the afternoon of 18 April, Mr Miah was in the I-Wing exercise yard with Prisoner A. Prisoner A saw Mr Miah running in the yard and later sitting down on the equipment. He noticed that Mr Miah was coughing and struggling to breathe. He then saw foam around Mr Miah's mouth as he fell backwards. Prisoner B placed Mr Miah in the recovery position while Prisoner A ran to the staff office on the wing, which took approximately two minutes. Prisoner A asked for immediate assistance when he arrived at the office. Two officers ran towards the exercise yard, followed by another officer.
29. As Officer A ran towards Mr Miah, he observed that he was lying on the floor unresponsive and made a radio call for immediate healthcare assistance and additional prison officers. Officer B arrived within approximately two minutes and saw her colleagues trying to get a response from Mr Miah. She heard over the radio that Officer A had requested healthcare attendance, but she radioed a code blue (a medical emergency code indicating that a prisoner is having difficulty breathing) to request an ambulance. The code blue was received in the control room at 2.57pm and the log confirms an ambulance was called immediately at 2.58pm.
30. Officer A said that Mr Miah's eyes were "sunken", and his skin was cold. A senior officer and Officer A could not get a response from him and lifted him onto the ground to administer cardiopulmonary resuscitation (CPR).
31. Nurse A was the first nurse to respond to the call at around 2.58pm. She started chest compressions with the officers and asked for someone to fetch an emergency grab bag. Nurse B arrived soon after, with the emergency equipment. Nurse A asked for the defibrillator to be put on Mr Miah straight away. The body worn camera footage, viewed by the investigator, was turned on at 3.01pm and confirmed that there was no oxygen in the emergency bag. A healthcare assistant

was asked to bring oxygen to the exercise yard and Nurse A administered oxygen to Mr Miah at approximately 3.10pm. The senior nurse arrived at about 3.01pm and observed the process, giving occasional prompts to healthcare staff.

32. The first ambulance arrived at Stoke Heath at 3.33pm and was escorted to the exercise yard. Healthcare staff and officers continued CPR until the paramedics arrived at 3.40pm. On arrival, the paramedics could find only a faint pulse.
33. At 4.10pm, Mr Miah was transferred to Royal Stoke University Hospital Major Trauma Centre by a blue light ambulance. The control log states that three more ambulances arrived and were also escorted to I-Wing between the times of 3.37pm and 3.52pm.
34. On 21 April, Mr Miah stopped responding to treatment and he died at 2.50pm following a visit from his family.

Contact with Mr Miah's family

35. On 18 April, immediately after Mr Miah's collapse, two officers were appointed as the liaison officers. At 4.23pm, one of the officers called Mr Miah's family and informed them that he had suffered a heart attack and was being transferred to Stoke hospital. The family were given regular updates and supported to visit Mr Miah in hospital before he died. The officers offered their condolences and support.
36. Stoke Heath offered a contribution towards the cost of Mr Miah's funeral, in line with national guidance.

Support for prisoners and staff

37. After Mr Miah left the prison on 18 April, a custodial manager 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. On 21 September, when staff arrived for the morning shift, they were briefed that Mr Miah had died in hospital. Support was also offered through staff notices.
38. The wing staff spoke directly to prisoners who knew Mr Miah about his death and offered support. The prison posted notices informing other prisoners of Mr Miah'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 Miah's death.

Post-mortem report

39. A post-mortem examination was not conducted. The Coroner accepted the hospital doctor's cause of death as an out of hospital cardiac arrest (the heart stops pumping blood around the body), caused by acute myocardial infarction (a heart attack which blocks the supply of blood to the heart), and coronary artery disease.

Findings

Clinical Findings

Emergency Response

40. Prison Service Instruction (PSI) 29/2015 'First Aid' requires that there are suitably trained first aiders available to treat anyone who becomes ill in the prison. First aid certificates are valid for three years and the PSI requires that training is refreshed before certificates expire. It strongly recommends that training is refreshed on an annual basis, in line with Resuscitation Council Guidelines UK (2021). We are satisfied that prison staff responded appropriately when they were told that Mr Miah needed help. However, we found that officers involved in the response had not updated their training for a number of years and were not aware of the requirements.
41. PSI 03/2013 'Medical Emergency Response Codes' requires staff to bring all equipment relevant to the nature of the emergency. When healthcare staff arrived to support the emergency response, they did not bring oxygen. This was because it was missing from the emergency equipment bag. This resulted in a 12-minute delay in providing Mr Miah with oxygen, after the emergency code had been called. The Clinical Nurse Manager told us that emergency equipment used for life support was checked daily. However, on 28 July, the Head of Healthcare conducted an audit of the grab bags and identified that five out of seven bags had no oxygen in them.
42. Nurse A administered oxygen to Mr Miah, despite feeling nervous and uncertain about this process. The clinical reviewer was concerned that a senior nurse was present but did not lead the emergency response process.
43. The control room called an ambulance at 3.57pm, but paramedics did not arrive until 3.33pm. We are satisfied that prison staff followed up the request appropriately and provided emergency responders with updates on Mr Miah's condition. However, we are concerned about the delay in administering oxygen to him. While quicker access to oxygen and a follow-up-call to the ambulance service may not have changed the outcome for Mr Miah, they might impact on the outcomes for other prisoners in future. We make the following recommendations:

The Head of Healthcare and the Governor should complete a review of the emergency response provided for Mr Miah on 18 April 2022, to ensure that learning can be addressed

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.

The Governor should ensure that operational staff have up-to-date training on basic first aid, and that systems are implemented to ensure training is appropriately refreshed.

The Governor and Head of Healthcare should ensure that all emergency 'grab' bags are checked daily to ensure that they contain the correct equipment, and that any missing items are recorded and replaced.

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.

44. The clinical reviewer identified a number of specific issues in relation to clinical supervision and clinical roles when administering emergency processes, which the Head of Healthcare will need to address.

Use of Panic Alarms

45. We found that there was no staff supervision on I-Wing and its adjoining exercise yard because it was an area for enhanced prisoners trusted to move around freely. We also found that there was no CCTV on either the wing or the exercise yard. There was a panic alarm located in the exercise yard, a few metres from where Mr Miah collapsed, to ensure that communication could be made with the staff office inside the wing. Prisoners did not use the alarm to alert staff to the emergency, due to a culture of not wanting to be perceived as helping staff, and fears of being adjudicated for improper use. In practice, this meant that the prisoner who found Mr Miah had to travel to the staff office for support. This created a short delay of approximately two minutes in the emergency response to Mr Miah's collapse. It is not possible to determine whether this delay impacted on the outcome for Mr Miah, and we are satisfied that staff responded appropriately when they were notified of the emergency. However, it is important that prisoners understand and are encouraged to alert staff to emergencies using panic alarms, where there is no supervision in place. We therefore recommend:

The Governor should brief all prisoners to remind them that they are permitted to use panic alarms to alert staff of emergency situations when they consider it safe and necessary to do so.

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