Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vincent Harvey, a prisoner at HMP Elmley, on 15 December 2020

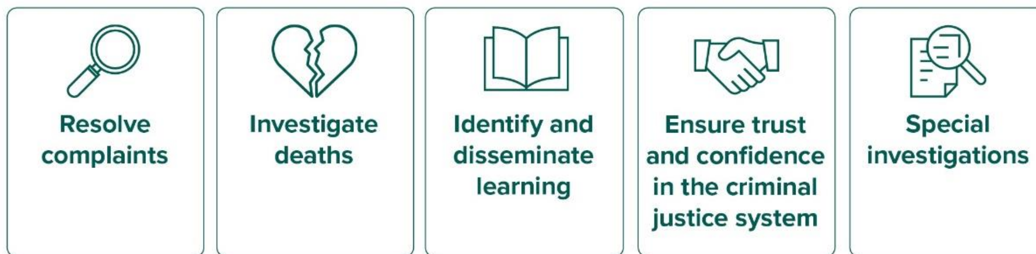
A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

© Crown copyright, 2024

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.

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 Vincent Harvey died on 15 December 2020 of a pulmonary embolism (a blood clot), caused by deep vein thrombosis while a prisoner at HMP Elmley. He also had COVID-19 which did not cause but contributed to his death. Mr Harvey was 62 years old. I offer my condolences to his family and friends.

The clinical reviewer found that overall, the clinical care that Mr Harvey received at Elmley was not equivalent to that which he could have expected to receive in the community.

I am concerned that healthcare staff at Elmley failed to follow up Mr Harvey's high blood pressure, risk of cardiovascular disease and blood test results which potentially indicated prostate cancer. I am also concerned that a nurse failed to examine him and call a medical emergency code blue on the morning he died when he presented with breathing difficulties and chest pain.

There was also a delay in calling an ambulance which the prison will need to address.

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 **February 2024**

Contents

Summary 1

The Investigation Process...3

Background Information..4

Key Events..6

Findings 10

Summary

Events

1. On 13 May 2020, Mr Vincent Harvey was remanded to HMP Elmley, charged with the possession of an offensive weapon. When he arrived, healthcare staff noted that he had asthma and gout, for which he was prescribed medication.

2. On 14 May, 8 and 12 June and 1 July, Mr Harvey's blood pressure was recorded as high, but no subsequent action was taken.

3. On 1 July, Mr Harvey's risk of cardiovascular disease was assessed as high, and his prostate-specific antigen (PSA) levels (which indicate prostate cancer) were also high. Neither of these results was followed up and Mr Harvey was not referred to a prison GP as he should have been.

4. At around 8.00am on 15 December, officers noted that Mr Harvey was breathing heavily and asked a nurse to assess him. A nurse observed him from the cell door. She said that Mr Harvey did not respond to her questions and that she did not complete clinical observations (blood pressure, temperature and oxygen levels) as she did not have an observation kit with her. She said that she told the officers that she would ask the duty nurse who would have an observation kit to assess Mr Harvey and that she would come back to assess him within the hour. She also asked officers to keep an eye on him. The nurse recorded that she thought that Mr Harvey was having a panic attack and that he was breathing quickly but was not in distress.

5. At around 10.55am, an officer noticed that Mr Harvey had been sitting on the toilet for some time. He went to Mr Harvey's cell with another officer, and they tried to get a verbal response from him. Mr Harvey did not respond and so they went into the cell and checked for signs of life.

6. At 11.05am, an officer radioed a medical emergency code and started cardiopulmonary resuscitation (CPR). Another officer arrived and checked for a pulse but found none. The officers continued CPR. Healthcare staff arrived, checked for signs of life and used a defibrillator.

7. At 11.10am, an ambulance was requested and arrived at 11.34am. Paramedics were unable to resuscitate Mr Harvey and at 11.56am, pronounced that he had died.

Findings

8. The clinical reviewer found that, overall, the care that Mr Harvey received at Elmley was not equivalent to that which he could have expected to receive in the community.

9. We are concerned that Mr Harvey's high blood pressure and abnormal blood test results which indicated that he was at high risk of cardiovascular disease and prostate cancer were not followed up.

10. Although officers and prisoners reported that Mr Harvey was unwell, the nurse who attended failed to examine him or call a code blue, despite his breathing difficulties. She also failed to identify that he had symptoms of a pulmonary embolism – chest pains and breathing difficulties. This would likely have identified Mr Harvey's clinical deterioration and prompted earlier clinical intervention.

11. After the emergency medical code was called, there was a delay of five minutes before control room staff called an ambulance. Although this did not affect the outcome in Mr Harvey's case, it could be critical in future cases.

Recommendations

- The Head of Healthcare should ensure that healthcare staff follow the referral process for identified risks and abnormal test results so that prisoners receive prompt assessment and treatment where necessary.
- The Head of Healthcare should:
  - ensure that all healthcare staff carry observation kits when on duty so that they are able to undertake clinical observations when a prisoner shows signs of shortness of breath and that they call a medical emergency code blue when a prisoner has difficulty breathing; and
  - ensure that healthcare staff receive training on recognising and responding appropriately to the symptoms of a pulmonary embolism.
- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.

13. The investigator obtained copies of relevant extracts from Mr Harvey's prison and medical records, including CCTV footage covering events on 15 December.

14. NHS England commissioned a clinical reviewer to review Mr Harvey's clinical care at the prison. The clinical reviewer and investigator jointly interviewed five members of staff and three prisoners at Elmley on 21 January 2021, 26 May, 18 June and 2 September. All the interviews were conducted by telephone because of the COVID-19 restrictions in place.

15. We informed HM Coroner for Mid Kent and Medway of our investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

16. Our family liaison officer contacted Mr Harvey's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She raised her concerns about Mr Harvey's medication and the healthcare he received. She asked:

    - what medication he was given;
    - when he was given antibiotics;
    - why he was not taken to hospital and checked before he was given antibiotics;
    - how many days of antibiotics he was given and when he was due to be reviewed;
    - what time an ambulance was called; and
    - whether a prison GP was monitoring him.

    These concerns have been addressed in this report and the clinical review.

17. We shared the initial report with the prison service. There were no factual inaccuracies.

18. We shared the initial report with Mr Harvey's wife. She did not respond.

Background Information

HMP Elmley

19. HMP Elmley holds around 1,100 prisoners, remanded or sentenced, in six houseblocks, with a mixture of single and double cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Elmley was in April 2019. Inspectors reported that health provision was reasonably good although they considered the wait for nurse triage appointments was too long.

21. Inspectors also carried out a short scrutiny visit at Elmley in April 2020 during the COVID-19 pandemic. They reported that there had been a good leadership and management response to a fast-changing situation and management oversight of healthcare was effective. Most routine health provision such as external hospital appointments had stopped temporarily due to the risks of COVID-19 but there had been an increased focus on oversight and supporting those most at risk. Elmley had a daily COVID-19 meeting in addition to the regular morning meeting to ensure focus and coordination.

Independent Monitoring Board

22. 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 October 2020, the IMB reported that the treatment of prisoners was as fair as possible in the context of the COVID-19 pandemic but interactions between prisoners had to be limited because of the large number of staff affected by the pandemic.

Previous deaths at HMP Elmley

23. Mr Harvey was the eighth prisoner to die at Elmley since December 2018. Five of the previous deaths were from natural causes, one was self-inflicted, and one was drug-related. There have been 11 further deaths: seven from natural causes, three self-inflicted and one drug-related. There are no similarities between our findings in this investigation and our previous investigations.

COVID-19 (coronavirus)

24. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. HM Prison and Probation Service (HMPPS)

introduced several measures to try and contain the outbreak. These were implemented at local level, depending on the needs of individual prisons.

Key Events

25. On 13 May 2020, Mr Vincent Harvey was remanded to HMP Elmley, charged with the possession of an offensive weapon. During his reception health screen, it was noted that he had asthma and gout, for which he was prescribed medication. At his secondary health screen the next day, it was noted that his blood pressure was raised. On 8 and 12 June and 1 July, Mr Harvey's blood pressure was again recorded as high, but no action was taken.

26. On 19 June, Mr Harvey's asthma was reviewed and assessed as well controlled.

27. On 1 July, Mr Harvey's cardiovascular disease risk was assessed as high. No action was taken. Mr Harvey also had a blood test to measure PSA, the result for which was also high. Healthcare staff did not follow this up.

December 2020

28. Prisoner A in the cell next to Mr Harvey's told the investigator at interview that on the night of 14 December, Mr Harvey was making strange noises which sounded like grunting or coughing. He said that he asked Mr Harvey if he was okay, and that Mr Harvey mumbled something in reply. He said that he pressed his emergency cell bell, and he told the officer who attended about the noise. He said that the officer checked on Mr Harvey through his cell door observation panel and that Mr Harvey gave him a "thumbs up". Prisoner B in the cell above Mr Harvey's told the investigator that at dinner time on 14 December, Mr Harvey had looked unwell and that his skin appeared ashen. He also said that Mr Harvey told him that his knees were hurting him and that he had been coughing. He said that he asked an officer to keep an eye on him.

15 December 2020

29. Prisoner B said that between 8.00am and 8.30am on 15 December, he heard officers attend Mr Harvey's cell and that one of them said that they would go back to check on him. He said that at around 9.15am, he heard staff ask Mr Harvey why he was sitting on the toilet and that Mr Harvey replied that he could not breathe. He said that Mr Harvey told them that something was wrong and that he did not feel himself. He said that staff told Mr Harvey that he was anxious about his COVID-19 test which was due that morning.

30. At approximately 8.00am, Officer A was unlocking prisoners' cells for COVID-19 testing. He told the investigator that he saw Mr Harvey in his cell, sitting on his bed. He asked him if he was okay because he looked as though he was breathing heavily. He said that he tried to speak to him again but he did not respond and so he asked Officer B, who was on the landing nearby, to speak to him. Officer A said that Mr Harvey started moving around on his bed and that his breathing was slightly faster. He said that Officer C came over to the cell and that Officer B suggested that they seek help from a nurse on the houseblock. Officer C returned with a nurse approximately two minutes later.

31. CCTV footage (of the prison landing area/entrance area to Mr Harvey's cell) shows that at approximately 10.13am, Officer A arrived with a nurse and, together, they

appeared to enter the entrance area to Mr Harvey's cell. Officer A said that the nurse tried to speak to Mr Harvey and advised him to slow down his breathing. CCTV footage shows that the nurse spent approximately eight minutes in Mr Harvey's cell. Officer A said he opened the cell window and turned on the fan. The nurse said that she did not recall Officer A going into Mr Harvey's cell while she was in there, and that CCTV supports this. She told the investigator that she observed Mr Harvey from his cell door, that she asked him if he was okay or if he was in pain. She said at interview, that after several attempts to gain a response from Mr Harvey on whether or not he was okay, he replied yes. The nurse said that she was unable to complete clinical observations (blood pressure, temperature and oxygen levels) as she did not have an observation kit with her as part of her role on the houseblock that day. She said that she told Officer A that she would tell the duty nurse to assess him, that she would come back to assess him within the hour and that they should keep an eye on him.

32. Prisoner C at Elmley told the investigator that at approximately 10.15am, Mr Harvey spoke to his next of kin by telephone and complained of chest pain and breathing difficulties. His next of kin telephoned the prison and asked staff to check on Mr Harvey but this did not happen. (However, prison records show that at approximately 11.15am, an officer noted that Mr Harvey's next of kin had telephoned the prison because she was concerned that she had not heard from him. The officer recorded that he spoke to Officer D, who said that he would arrange for someone to check on Mr Harvey and then contact her.) The officer confirmed that a nurse attended Mr Harvey's cell, that he told her that Mr Harvey had chest pains and that the nurse told him that he was anxious about testing for COVID-19. (Prisoners on Mr Harvey's houseblock were due to be tested routinely for COVID-19 that day.) The nurse refuted that she was told that Mr Harvey had chest pains or difficulty breathing.

33. At approximately 10.55am, while checking cell bells, Officer C noticed that Mr Harvey had been sitting on the toilet for some time. He told Officer B, who in turn told Officer A. At 10.59am, Officers A and B arrived at Mr Harvey's cell and spoke to him through the cell door observation panel. Mr Harvey did not respond and so they entered the cell and checked for signs of life.

34. At 11.05am, Officer B radioed a medical emergency code blue (used when a prisoner is unconscious or has breathing difficulties). The officers moved Mr Harvey from the toilet onto the floor and started CPR. An officer arrived and checked for a pulse but found none. The officers moved Mr Harvey from his cell to the landing area just outside and continued CPR. Healthcare staff arrived, they checked for signs of life and used a defibrillator. Prison and healthcare staff tried to resuscitate Mr Harvey for approximately 45 minutes.

35. At 11.10am, an ambulance was requested while resuscitation efforts continued. Paramedics arrived at Elmley at 11.34am and were with Mr Harvey nine minutes later. Prisoner B said there was a 45-minute delay in the ambulance arriving.

36. At 11.56am, paramedics and healthcare staff stopped resuscitation efforts and pronounced that Mr Harvey had died.

37. At 12.39pm, a nurse recorded retrospectively in Mr Harvey's medical record, that while conducting healthcare checks, an officer asked her to see him. She recorded that she thought he was having a panic attack, that he was breathing quickly but

that he was not in distress. She told the investigator that she went to Mr Harvey's cell and observed him from his cell door. She said that he was sitting upright on his bed, that he was alert and that there were no signs of cyanosis. She said that she asked him several times what was happening and if he was struggling to breathe but that he did not reply. She said that when she asked if he could hear and understand her, he said that he could. She said that although he appeared to be hyperventilating, his respiration rate was 21 to 22 breaths per minute, and he did not appear to be in any respiratory distress. She said that she advised Mr Harvey to slow down his breathing, which he did. She asked the duty nurse to review Mr Harvey and told Officer A and Officer C to check on him and report any changes to healthcare staff.

38. A trainee prison officer who had previously worked in the Ambulance Service and was shadowing another officer that day, said that the nurse stood at the cell door and asked Mr Harvey what was wrong. When he did not answer, she said to him that she could not help him if he was not willing to talk to her. The nurse said that she said this to try and elicit a response and further information from Mr Harvey. An officer said that the nurse also said to the officers that she could see that he was not in distress as he was breathing from his abdomen and not from his chest which meant it was some kind of panic attack or even being put on. The nurse said that she did not recall seeing Mr Harvey breathe from his abdomen and did not recall commenting that he did so. She said that she did not say that he was putting it on, and that to do so, would have been inappropriate and not something she would say. The officer said that Mr Harvey appeared very unwell and that she thought that Mr Harvey was probably unable to answer the nurse. The nurse refuted that Mr Harvey appeared very unwell. We were unable to interview the officer as she has since resigned from the Prison Service.

Contact with Mr Harvey's family

39. On 15 December, the prison chaplain was appointed as the prison's family liaison officer. At midday, he telephoned Mr Harvey's wife and broke the news of Mr Harvey's death. They spoke again later that afternoon.

40. Mr Harvey's funeral took place on 23 April 2021. The prison offered to contribute to funeral costs, in line with national policy.

Support for prisoners and staff

41. After Mr Harvey's death, the duty 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.

42. The prison posted notices informing other prisoners of Mr Harvey'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 Harvey's death.

Post-mortem report

43. The post-mortem said that that Mr Harvey died from a pulmonary embolism, caused by deep vein thrombosis. He also had COVID-19, which did not cause but contributed to his death.

Inquest

44. At an inquest held on 16 August 2023, the Coroner concluded that Mr Harvey died of natural causes.

Findings

Clinical findings

45. Mr Harvey had not been diagnosed with COVID-19 before his death, and there is no record of him having any symptoms. The clinical reviewer noted that he and the other prisoners in his houseblock were due to be routinely tested in prison on the day he died.

46. The clinical reviewer found that while the care that Mr Harvey received in prison for his acute conditions was equivalent to that which he could have expected to receive in the community, the overall care that he received was not equivalent.

47. The clinical reviewer found that although it was noted several times that Mr Harvey had high blood pressure, healthcare staff failed to follow this up as they should have. He also found that when Mr Harvey's PSA levels and cardiovascular disease risk were assessed as high, healthcare staff took no action to address these issues. We recommend that:

    The Head of Healthcare should ensure that healthcare staff follow the referral process for identified risks and abnormal test results so that prisoners receive prompt assessment and treatment where necessary.

Responding to Mr Harvey's healthcare needs on 15 December

48. Officer A said he opened the window in Mr Harvey's cell and turned on the fan. The nurse said that she did not recall an officer opening Mr Harvey's window nor entering his cell while she was present, and that CCTV footage confirmed this. Mr Harvey's cell door is not visible on the CCTV footage that the investigator watched. It showed that the officer and nurse arrived together on the landing area outside Mr Harvey's cell, and they appeared to enter the entrance area of Mr Harvey's cell. We were therefore unable to resolve the difference in accounts.

49. The nurse said that she assessed Mr Harvey for eight minutes in his cell and asked him various questions. She said that she was unable to take Mr Harvey's clinical observations because she did not have an observation kit with her (because she was not the duty nurse). She recorded instead that she observed Mr Harvey from the cell door and concluded that he was "well perfused" (had a good blood supply), "not cyanosed" (did not have a shortage of oxygen), had a clear airway and was maybe having a panic attack.

50. The clinical reviewer noted that the nurse's conclusions were at odds with the accounts of officers and prisoners that Mr Harvey had difficulty breathing and chest pain. One officer said that Mr Harvey was probably unable to answer due to respiratory distress and that the nurse said to the officers that she could see that he was not in distress, and it was a panic attack or being put on.

51. The clinical reviewer concluded that the nurse's account was difficult to justify in the absence of closer examination and he was surprised that she had not summoned help immediately.

52. Although we understand why the nurse did not have an observation kit with her, a full set of clinical observations might have identified Mr Harvey's clinical deterioration sooner and led to earlier clinical intervention.

53. We are concerned that although a number of prison staff and prisoners were worried about Mr Harvey's health in the 24 hours before he died, the nurse concluded that he was having a panic attack and was not in distress, even without examining him. We would have expected her to have at least examined him closely when she was asked to review him. We note also that the clinical reviewer stated that chest pains, together with breathing difficulties, are well-recognised symptoms of a pulmonary embolism. We are concerned that she failed to examine him and seek urgent help, including radioing a medical emergency code blue (used for breathing difficulties). We considered recommending that the Head of Healthcare should commission a review into her actions when she attended Mr Harvey's cell on the morning of 15 December, including considering whether to refer her to the Nursing and Midwifery Council (NMC). However, since Mr Harvey's death, she has twice referred herself to the NMC about this incident, and the NMC declined to investigate. We have therefore not made such a recommendation but recommend that:

The Head of Healthcare should:

- **ensure that all healthcare staff carry observation kits when on duty so that they are able to undertake clinical observations when a prisoner shows signs of shortness of breath and that they call a medical emergency code blue when a prisoner has difficulty breathing; and**
- **ensure that healthcare staff receive training on recognising and responding appropriately to the symptoms of a pulmonary embolism.**

Emergency response

54. Prison Service Instruction (PSI) 03/2013 on medical response codes requires the control room to call an ambulance as soon as a medical emergency code is called, and for healthcare staff to attend with the appropriate emergency equipment.

55. Although Officers A and B responded promptly when they found Mr Harvey unresponsive and Officer B used an appropriate emergency medical code, control room records show that there was a five-minute delay in the control room calling for an ambulance. The prison was unable to provide us with a specific reason for the delay. While calling an ambulance immediately would not have changed the outcome for Mr Harvey, in other emergency situations, it could be crucial. We recommend that:

The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

Concerns about resuscitation and the use of multiple defibrillators

56. Prisoner C told the investigator that healthcare staff did not participate in Mr Harvey's resuscitation. From the CCTV footage that the investigator viewed, it was clear that healthcare and prison staff participated in Mr Harvey's resuscitation. At

times, there were members of staff standing at the side, but this is appropriate during resuscitation as not all staff need to participate at all times.

57. Prisoner C also said that that three defibrillators were used, the first of which did not work. Prisoner B told the investigator that two subsequent defibrillators were not charged and that there was a delay using them. A nurse told the investigator that the defibrillator was changed during resuscitation from an automated model to one that would give staff more information. There was no evidence from the audible instructions the defibrillators gave to indicate that they did not work, and we are satisfied that they worked and were used at the earliest opportunity.

58. Prisoner B alleged that officers observing CPR laughed. The investigator viewed the CCTV footage but found no evidence that this was the case.

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 I 020 7633 4100