Investigation into the circumstances surrounding the death of a man at a hospital while in the custody of HMP Usk and Prescoed in May 2010

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

The man entered prison in 1999 with a history of significant medical problems. He moved to HMP Usk in 2003 and his health continued to decline until he was taken to hospital in April 2010 where he died of heart disease and a respiratory infection in May. He was 62 years old. I offer my sincere sympathy and condolences to those touched by his death.

The investigation was carried out on my behalf by my colleague. A clinical review of the man's healthcare was undertaken by Healthcare Inspectorate Wales. I am grateful for the review which I attach as an annex to this report. I would also like to thank the Governor of Usk and his staff for their co-operation and assistance. Particular thanks go to two members of staff for their help throughout the investigation.

The man suffered from significant medical problems both prior and during his time in custody. His health was poor at the time he entered prison and it became progressively worse. Staff worked hard to look after him, although he did not always take his medication appropriately. I include two recommendations in this report relating to care plans and chest pain.

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

Thea Walton
Acting Deputy Prisons and Probation Ombudsman July 2011

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SUMMARY

The man was released from a life sentence in 1979 and was in the community until he was recalled in 1999 due to serious sexual offences. During his time in the community he suffered from several serious illnesses including a heart attack and stroke, made worse by his heavy smoking. Upon his return to prison, he continued to struggle physically despite the efforts of healthcare staff to treat his many ailments. Although he suffered from serious coronary and respiratory problems, he was not consistent in his approach to his medication. This was a particular problem as his blood pressure was very high, yet he sometimes declined to take his medication.

His health declined throughout his time in prison and he spent time in hospital following episodes of coughing up blood. It was also suspected that he had cancer, although the hospital tests showed that this was not so. During his last few months he continued to smoke despite the effect it was having on his health, and also decided to refuse to take his blood pressure medication.

He was taken to hospital in April 2010 having been found breathless and pale in his cell. He died in hospital in May 2010 due to ischemic heart disease, coronary artery atheroma and a lower respiratory tract infection. The prison engaged with the next of kin, his step-brother, and contributed to the cost of the funeral.

He was an ill man and he was not always an easy man to care for given that he sometimes would refuse to follow the advice of the healthcare staff. Despite these difficulties, his care was largely appropriate although two recommendations are included. These are drawn from the findings of the clinical review and relate to care plans and chest pain.

THE INVESTIGATION PROCESS

1. The investigation was opened on 10 May 2010 when the investigator issued notices announcing the investigation to staff and residents at HMP Usk. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. No prisoners came forward as a result.

2. The investigator visited Usk on 13 May 2010. During his visit he toured the establishment, including the wing on which the man lived. He met the Governor and was provided with copies of the man's prison records, including the medical record.

3. A review of the man's medical care in prison was commissioned by Healthcare Inspectorate Wales. However, Healthcare Inspectorate Wales wished to review and amend their report so I did not receive their final report until February 2011 which has significantly delayed this report. I can only apologise for this delay.

4. One of my family liaison officers contacted the man's step-brother to inform him of the investigation and to give him the opportunity to raise any questions or concerns he had about his death. The step-brother raised no issues that he wished the investigation to address.

HMP USK

5. HMP Usk opened in 1844 as a House of Correction and has a long and varied history. In 1870, after the addition of other buildings, it became the County Gaol for Monmouthshire. It remained in that role until 1922 when it closed, reopening in 1939 as a Closed Borstal and continuing in this role until 1964 when it became a Detention Centre. In 1983 Usk became a Youth Custody Centre and a Young Offender Institution between 1988 and May 1990.

6. Following this, it was designated as an Adult Category C establishment for Vulnerable Prisoners. It contains prisoners who cannot be trusted in open conditions but who are unlikely to try to escape. Presently, Usk is an amalgamated prison with HMP Prescoed. Usk provides the Core, Adapted and Extended Sex Offender Treatment Programmes, together with other Cognitive Skills Programmes such as Enhanced Thinking Skills. (Offending behaviour programmes are rehabilitation programmes designed to identify the reasons why prisoners offend and reduce and monitor these factors. The Sex Offender Treatment Programmes are specifically targeted for sexual offenders depending on the level of risk and need of the offender. Enhanced Thinking Skills is a relatively short programme which addresses thinking and behaviour associated with offending.)

7. The accommodation is made up of three wings in two storey blocks with the majority double cells. There is a small healthcare department staffed between 7.30am and 4.30pm from Monday to Friday. Outside of these hours a member of the healthcare staff is on call, but there is no full-time doctor, or inpatient facilities.

Independent Monitoring Board

8. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report available from the Usk IMB is that of April 2007 – April 2008. The report noted that it got few applications about healthcare at Usk, and prisoners have access to a doctor and dentist.

Her Majesty's Chief Inspector of Prisons

9. Her Majesty's Chief Inspector of Prisons conducted an unannounced follow-up inspection of Usk & Prescoed from 3 - 5 March 2008. The report noted that the healthcare facilities had not been upgraded since the last inspection, and urged for further work in this area.

Previous deaths at Usk

10. The man's death was the sixth death at Usk due to natural causes since 2005. The two most recent were in 2009, one of which was caused by

cancer, and the other due to a heart attack. In the latter case, the report also made a recommendation regarding the accurate recording of hospital visits.

KEY FINDINGS

11. The man had been convicted of murder in 1968. He was released in 1979 on life licence. He had been a smoker since the age of six and, during his time in the community, he suffered from a number of illnesses including heart and circulatory disease and a stroke. In 1999 his licence was revoked and he was recalled to prison. It was noted that he had suffered heart problems in the past. He received a seven year sentence for sexual offences. He suffered from coughing up blood and experienced further strokes. This necessitated a number of visits to hospital. It was also confirmed that he suffered from chronic inflammatory disease in his lungs and tuberculosis. On 23 December 2003, he was transferred from HMP Bristol to HMP Usk. During his time at Usk he saw healthcare staff repeatedly. The report does not list every interaction he had with healthcare staff, but does highlight the relevant moments during his time in prison.

12. Upon his arrival at Usk, the man was noted to have suffered strokes, high blood pressure and neck stiffness. However, he was also advised that he could participate in light gym sessions. In June 2004 he began the Sex Offender Treatment Programme (SOTP). He had escorted absences to Cardiff and Newport in 2004, 2005 and 2006. (The purpose of escorted absences include enabling prisoners to familiarise themselves with community life, making resettlement arrangements and showing their ability to behave responsibly. Prisoners are escorted by prison staff who monitor their adherence to the expectations set out for them.)

13. During 2006 and 2007, he frequently felt unwell and may have suffered from a number of transient ischaemic attacks (known as mini-strokes, causing symptoms similar to a stroke but lasting less than 24 hours). He saw healthcare staff often and was strongly advised during 2006 and 2007 to stop smoking because of the impact it was having on his health.

14. In February 2008, he had another escorted absence in Cardiff. He began working in the laundry in June 2008. It was reported that in July 2008, his attitude to healthcare staff deteriorated, and he became verbally abusive to them. Throughout 2008, he was given paracetamol because of headaches. In June, the doctor told him that he was taking too many paracetamol and should reduce his intake. He was provided with amitryptiline for further pain relief. In August, he was transferred briefly to hospital after coughing up blood.

15. In November 2008, the prison received a letter from the NHS Trust. It said that although an earlier scan showed some evidence that the man had lung cancer, further tests had revealed the mass to have been caused by an infection so he was discharged from the lung cancer pathway.

16. His application for open conditions was rejected in December 2008. In January 2009, he stopped working due to ill health. His parole application was turned down in June 2009 as his risk of re-offending was deemed to be still too high. A note was made in his medical record on 10 June that he

seemed to have experienced another mini-stroke a few weeks earlier, but had since made a full recovery.

17. A note was made in his medical file in August 2009 that his health appeared to be deteriorating. In September, healthcare staff advised him about the importance of taking his blood pressure medication as prescribed. In October, he complained of coughing up blood. Staff offered smoking cessation services in November because of the very poor circulation to his left leg, but he declined the services. (Smoking cessation services offer help to people who wish to give up smoking.)

18. On 15 February 2010, the man signed a form to say that he wished to stop taking Persantin medication (reduces high blood pressure and acts to prevent clots). Later in the month it was noted that he declined to take his blood pressure medication. On 27 February, he complained of chest pain which was queried as indigestion. On 31 March, he returned to healthcare, and complained of feeling ill with a cough.

19. On 8 April, he was found breathless and pale in his cell, and was taken to hospital. A note in the medical record shows that it was expected that he would return to the prison. The following day, he was transferred to another hospital for an urgent coronary angiogram. He urgently needed of a quadruple by-pass and was told that he would die within weeks without the operation. However, on further assessment he was considered to be too ill to undergo the surgery and so palliative care was commenced. (Palliative care focuses on reducing the suffering and symptoms of the patient due to the severity of the problem, rather than providing a cure.)

20. The man was transferred back to the first hospital on 23 April where he continued to be provided with palliative care. On 4 May, a note was made in the records that said that the doctor wished him to be transferred to a prison with 24 hour healthcare facilities but HMP Parc and HMP Cardiff did not have any beds available at that time.

21. It was noted in the bedwatch records on 6 May that no restraints were being used. (The bedwatch records are the notes made by the officers who are required by the prison to monitor the prisoner in hospital.) I have made comments in some reports of the excessive use of restraints. I am glad to see that Usk removed the restraints once they deemed the level of risk to be appropriate. Next of kin details were given to hospital staff at 8.50am and at 12.25pm all medication was withdrawn. The man stopped breathing at 12.35pm. At 1.05pm his step-brother was contacted. He was pronounced dead at 1.15pm. The prison family liaison officer (FLO) spoke to the step-brother at 1.45pm and outlined the support the prison could offer.

22. The funeral was undertaken by a prison chaplain, and the FLO and a governor attended. The prison followed the guidance give in Prison Service Order (PSO) 2710 “Follow up to death in custody” by maintaining contact with his family and contributing to the cost of the funeral. The man’s property was returned to his step-brother.

ISSUES

Clinical care

23. The clinical review describes the man's declining health in prison. It notes his history of hypertension and arteriosclerosis, which led to the weakening of his heart muscle. The review says that the respiratory infection he suffered in February 2010 put additional strain on his heart and may have contributed to his collapse on 8 April. The review also makes clear that his decision to continue smoking was a key contributory factor in his advancing decline and death.

24. The clinical review describes the care provided to the man, as follows:

> "While he received appropriate health assessments upon his admission to the various prisons involved in his care and had access to various healthcare professionals including dentists, opticians and physiotherapists, there are a number of areas of care provided to him that raise questions."

Treatment of the man's heart disease

25. The clinical review explains that, although the man was supported in his attempts to stop smoking, no dietary advice was given to him and there is no record of him being advised to take more exercise. In January 2006, tests revealed that he was a borderline diabetic. The clinical review points out that there is no record of him being advised about a low sugar diet, or being spoken to about diabetes. The clinical review concludes this section by saying:

> "Our view is that he was referred promptly for all his medical conditions and was on the right medication for his hypertension and arteriosclerosis."

26. The clinical review makes three recommendations regarding the use of care plans for patients with ongoing serious health problems, and I draw the Head of Healthcare's attention to them. I include a summary recommendation below:

The Head of Healthcare should ensure that care plans are put in place for those prisoners with long term health problems in line with the Quality Outcomes Framework standards used by GP's across Wales.

Events of 27 February 2010

27. The man told healthcare staff that he had chest pain on 27 February, but "indigestion" is recorded in his medical record. The clinical review says:

> "In the community the advice UK wide is if an individual has chest pain call an ambulance NOW and get the patient to A&E [Accident and Emergency]. This guideline should also be followed by prisons."

28. The clinical review acknowledges that staff at Usk have since engaged with with the Primary Care Acute Chest Pain Awareness Project organised by South Wales Cardiac Network and made staff aware of chest pain training. However, it does also make the following recommendation:

The Head of Healthcare should ensure that all staff should be made aware of the UK wide protocol in relation to chest pain: "chest pain, call an ambulance NOW and get the patient to A&E".

Record keeping

29. The clinical review did not make a recommendation regarding record keeping, but it does mention that many of the records were often brief and illegible. I would encourage the Head of Healthcare to consider this further.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that care plans are put in place for those prisoners with long term health problems in line with the Quality Outcomes Framework standards used by GP's across Wales.

   The National Offender Management Service partially accepted this recommendation, writing:

   "A review is currently underway of chronic conditions management at HMP Usk/Prescoed. As a part of this CCD reviews are now held quarterly and care plans are agreed for prisoners with 3 or more chronic conditions, or prisoners with a chronic condition who are causing concern. However, it is argued that the care given to the man with regards to his conditions was appropriate and that it has been evidenced that the nursing staff and GP did all that they could considering he refused certain treatment/medication being offered."

2. The Head of Healthcare should ensure that all staff should be made aware of the UK wide protocol in relation to chest pain: "chest pain, call an ambulance NOW and get the patient to A&E".

   The National Offender Management Service accepted this recommendation, writing:

   "All healthcare staff have completed a training session delivered by Cardiac Care Wales advising them on the appropriate action to take in the event of someone presenting with chest pain. A protocol is in place that they will call the ambulance directly now, rather than asking that this be done by discipline staff, which may delay assistance in arriving. All healthcare staff have been instructed on how to do this.

   Information leaflets and posters have been requested from Cardiac Care Wales to ensure that guidance is made available to ALL staff. The feasibility of awareness training for all staff is being explored."