

**Investigation into the circumstances surrounding a  
prisoner at HMP Highpoint, who died at  
West Suffolk Hospital in May 2007**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**October 2007**

This is the report into the death of a life sentenced prisoner at HMP Highpoint, who died in May 2007 at the West Suffolk Hospital from natural causes. He was aged 54

I would like to offer my sincere condolences to the man's family and friends for their sad loss.

One of my investigators conducted the investigation on my behalf. In addition, Suffolk Primary Care Trust was commissioned to conduct a clinical review into the man's medical care in custody. I would like to thank the Governor of HMP Highpoint and her staff for their assistance during my enquiries.

The man had been receiving treatment for a chest infection in May 2007. On the day he died there was a sudden deterioration in his condition. The prison, in consultation with the hospital, notified the man's next of kin. They had to travel some distance, but were able to be at his bedside at the time of his death. The man's passing was a shock to all who knew him.

My report highlights two areas of good practice and includes one recommendation.

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## SUMMARY

The man was remanded into custody at HMP Exeter in July 1993. On reception, it was noted that he had been refusing food and healthcare staff asked him about this. He said that this was not an act of self-harm, but that he would starve himself to death. For this reason, he was initially located into the healthcare centre and placed on 'close' observations. After four days, the man began taking food. He remained in the healthcare centre for a month before being re-located to a residential unit. He settled quickly into the regime and no further concerns were raised. Towards the end of 1993, he was sentenced to life imprisonment.

In early January, the man transferred to HMP Gartree. Following his health screen on reception at Gartree, the healthcare team saw him on a number of occasions due to concerns about his mental health. It is documented that during a conversation with a member of healthcare staff, the man acknowledged that he was 'a little depressed' but wanted no treatment. The staff continued to monitor his behaviour and he was admitted to the healthcare centre, where a psychiatrist assessed him. The view of the psychiatrist was that he did not have an underlying mental illness, but would benefit from some time away from the residential wing. When the man returned to the residential wing, he was considered to be more settled. However, he preferred to keep himself to himself, mixing very little with other prisoners. This continued throughout his time in custody.

He spent time at a number of other prisons including Dartmoor and Dovegate. While at Dovegate in July 2002, he was admitted to the local hospital after complaining of dizziness and shortness of breath. He was diagnosed with pernicious anaemia. Medical staff felt that his decision to live as a vegan had contributed to his condition and he was provided with dietary advice.

In January 2004, the man transferred to HMP Highpoint to enable him to continue with his sentence planning objectives. When he arrived at Highpoint, a member of the healthcare team assessed him. In view of his previous anaemia, the prison GP offered a haemoglobin check, which he declined. Thereafter, he seldom had contact with healthcare, although he regularly received medication for an ongoing skin complaint. The man's time at Highpoint was largely uneventful. He continued to prefer his own company and spent the majority of his time studying in his cell. During his time in custody, he was awarded numerous certificates for academic achievements. However, his attendance for work was poor and often resulted in warnings. On several occasions, this led to him being reviewed and downgraded on the Incentives and Earned Privileges scheme.

About 10 days before the man died, he reported to the healthcare centre with flu-like symptoms. He was seen by the nurse who prescribed paracetamol and advised him to rest. He was told to return if he felt his condition was getting any worse. He went back to healthcare two days later, and was told to 'rest in cell'. He did this, but the following day staff on his unit became concerned by his appearance and contacted healthcare. A nurse later saw the

man on his unit. She checked his pulse, which was normal, and referred him to see the GP the following morning. The GP diagnosed an upper respiratory tract infection and prescribed a course of medication. The GP also asked for a full blood count check to be arranged.

Two days before he died, the man had been unlocked to attend work. He returned shortly afterwards, explaining to staff that he felt unwell and would go back to his cell. Shortly afterwards, staff were alerted by his call bell being sounded and attended his cell. He asked them to call healthcare as he felt unwell. This was relayed via telephone by the unit staff. Initially, healthcare staff asked the unit staff to monitor him and let them know if he did not improve. However, when staff returned to tell him he was standing in his cell and was having difficulty breathing. They called healthcare nurses, who attended immediately. The nurses assessed him and requested the doctor, who also attended and advised that an ambulance should be called. In the meantime, he was given oxygen to try to alleviate his difficulties. This had little effect. The man's condition deteriorated by the time the paramedics arrived, resulting in him being shocked twice with the defibrillator. He was transferred to hospital.

On arrival at the West Suffolk Hospital, the man was immediately admitted to the Intensive Treatment Unit. The doctor treating him advised staff that, due to the seriousness of his condition, it would be advisable for his next of kin to be informed. This was relayed to the prison and efforts to trace the man's family began. As he had not had regular visits, there were no up to date address details at the prison and outside agencies had to be contacted. Finally, prison staff had a breakthrough. They were able to notify his sister, who in turn informed the other members of his family. They then travelled to the hospital. Because of the distance, most of them arrived late at night, but were accommodated by the hospital. The family remained at his bedside throughout, taking it in turns as only two were allowed in the room at one time. The prison reduced the escort to one officer who remained outside the ward.

The man's condition continued to deteriorate and he failed to respond to treatment. Sadly, he was pronounced dead by a Doctor at 3.30pm. His family were with him.

## **THE INVESTIGATION PROCESS**

On 6 June, my investigator visited Highpoint and met with the Deputy Governor. The man's prison records, including his medical record, were produced for examination.

Notices were displayed to staff and prisoners, informing them of the investigation process and to give them the opportunity to speak with my investigator. No responses were received.

I commissioned Suffolk Primary Care Trust to conduct a clinical review into the medical care the man had received.

One of my Family Liaison Officers contacted the man's sister. The family declined the offer of a meeting. They had no concerns regarding his treatment either at Highpoint or at the hospital. Indeed, they were very grateful to the prison and hospital for all that had been done.

My investigator wrote to Her Majesty's Coroner to inform him of the nature and scope of the investigation. A copy of the report will be sent to the Coroner to assist with his enquiries. The post mortem concluded that the cause of death was acute myocardial infarction, coronary thrombosis and coronary artery atherosclerosis.

## **HMP HIGHPOINT**

HMP Highpoint is located at Stradishall, about thirteen miles from Bury St Edmunds in the Suffolk countryside.

Originally split into north and south sites, the north site was re-rolled in 1997 to a female establishment and re-named St Edmunds Hill. (Due to population pressures, this has recently reverted to the male estate.)

The accommodation at Highpoint has varying styles, reflecting its change of function over the decades. Currently, it holds sentenced male prisoners with a security category of C or below, with terms of imprisonment up to and including life sentences. Prisoners are employed in a variety of areas and there are good opportunities to undertake offending behaviour courses and full time education classes. Highpoint has sufficient capacity to ensure that all prisoners are gainfully employed.

An unannounced inspection by Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, in 2004 found that a majority of previous recommendations had been implemented:

“Despite a very large expansion in prison numbers, staff at Highpoint have risen to the challenges that they faced and have delivered a significantly improved prison.”

The IMB (Independent Monitoring Board) at Highpoint told my investigator that the Board's annual report had been critical of staff shortages. The IMB said they were concerned that staff were being taken from specialist duties to carry out wing duties. However, they pointed out that they had never doubted the level of care provided to prisoners despite the shortages.

The IMB said that healthcare at Highpoint had greatly improved over the last two to three years. However, there still appeared to be a problem with recruitment of nursing staff. The IMB also felt that there was a need for a regular GP at the prison as they currently rely on locum cover. In the IMB's opinion, this means there is no continuity of care.

## **KEY FINDINGS**

### **Events leading up to the man's death**

Following his remand at HMP Exeter in July 1993, he was sentenced to life imprisonment in December and given a tariff of 16 years (minimum time to serve) at a Crown Court. During his initial health checks on his arrival into custody, concerns were raised about him not eating. At the time, he denied any suicidal intent, but said he intended to starve himself to death. Due to the concerns regarding his refusal to eat, the man was located into the healthcare centre and placed on close observations. His food refusal lasted for four days, during which time he was closely monitored by healthcare staff. He remained in the healthcare centre for one month before being moved to ordinary location, where he settled into the regime very quickly.

On 18 January 1994, the man transferred to HMP Gartree. It was here that he spent the majority of his sentence, with brief spells at Dovegate, Garth and Dartmoor. On reception at Gartree, a health screening was completed. The man was then seen by healthcare staff a number of times in the first few months as his behaviour had raised concerns about his mental state. It was noted that he was neglecting himself, possibly as a result of depression. When asked, he acknowledged that he was depressed, but was adamant he wanted no treatment. His problems persisted and culminated in his being admitted to the healthcare centre to be seen by the psychiatrist. The psychiatrist's view was that he did not have a mental health problem, but would benefit from time away from the wing as his demeanour had led to verbal abuse from other prisoners. When he returned to the wing he became more settled, although he mixed very little and preferred his own company. The man often failed to attend work, for which he received repeated warnings. Despite these warnings, his reluctance to attend work or report to places on time, featured very prominently throughout his sentence.

The man also spent a short time at both Dartmoor and Dovegate prisons. While at Dovegate, he complained of feeling 'dizzy' and 'light headed' and was admitted to the local hospital for tests. These concluded that he was suffering from pernicious anaemia. He followed a strict vegan diet. When this was not provided, he would refuse meals and this was felt to be a contributing factor. As a result, he was seen by a dietician who gave him advice which was passed to the healthcare centre at Dovegate. The man also had further haemoglobin checks to monitor his condition.

On 5 January 2004, the man transferred to HMP Highpoint with a view to continuing the progress made on his sentence plan. The prison doctor saw him during reception. Apart from an ongoing problem of psoriasis and heavy smoking, no other health difficulties were recorded. The doctor offered the man a haemoglobin check due to his previous anaemia, but he refused. After his reception, his contact with the healthcare team at Highpoint was mostly to obtain further treatment for his skin condition and minor ailments.

The man's poor attendance at work continued. This resulted in him being reviewed under the Incentives and Earned Privileges (IEP) scheme. (IEP is a system to encourage prisoners to sustain good behaviour. The scheme has three levels, enhanced, standard and basic. Monthly reviews are held to determine a prisoner's level.) Following his review, he was reduced from the 'enhanced' to the 'standard' regime. This meant that he was entitled to less spending money and fewer visits. This administrative action had little effect on him, and staff were of the opinion that a further reduction in his privilege status would likewise have little effect. Staff commented, that despite his reluctance to work or attend for work at the required times, he enjoyed a polite and respectful relationship with staff.

During 2005, there was some change, when he attended regularly for work. Consequently, he moved back to the 'enhanced' wing, but a recurrence of bad time-keeping found him once again removed from the 'enhanced' regime in July 2006.

By his own admission, the man preferred his own company. He spent little time with fellow prisoners, opting instead to spend the majority of his time in his cell reading and studying. His studies led to several academic qualifications, including English, mathematics, O level science, Open University courses and various IT courses. The man put his studies to good use by becoming involved in the Highpoint prison magazine, LOCDOWN. His involvement with the magazine went from strength to strength and he eventually became the editor, a position in which he took great pride. The hard work that he put into the magazine was recognised by wing staff who rewarded him with an upgrade to the 'enhanced' regime in January 2007. However, he chose to remain on the standard wing, as he felt settled.

In May 2007, the man reported sick and was initially assessed by a registered nurse. He complained of having flu-like symptoms and was advised to increase his fluid intake and rest. He was also given paracetamol and ibuprofen and advised to return to see the GP if he felt his symptoms got worse. His symptoms did not improve, so two days later he reported to healthcare where he saw another registered nurse. He was advised to 'rest in cell' for one day (rest in cell is the term used to indicate that a prisoner is permitted to refrain from work for medical reasons). However, the following day an officer on his residential unit was concerned by his appearance and contacted the healthcare centre. A registered nurse attended the wing and saw him in his cell. The man was in bed and told the nurse that he still had flu-like symptoms and generally felt unwell. He also mentioned that he had not eaten much for the past week as a result. His blood pressure and pulse were recorded and it was documented that his chest was 'rattly'. The nurse documented that he was conversing well and appeared hydrated. A referral was made for him to see the GP the following morning.

The locum GP saw the man and recorded his weight, pulse and temperature. He explained to the doctor that he had been feeling unwell for about a week and had had a fever for the previous two days. He was pale and had some swelling to his throat. The doctor concluded that the man had an upper

respiratory tract infection that needed further investigation, and so a full blood count was arranged. A seven day course of penicillin was prescribed. In view of the man's lack of appetite, some 'Ensure Plus', a nutritional supplement in the form of milkshakes, was also provided.

Two days before he died, the man was unlocked as normal to attend work. He returned to the wing a short time later, explaining to the officer on duty that he felt unwell and would not be going to work. He went back to his cell. The man pressed his cell bell about ten minutes after he had returned. He asked the officer who responded to contact healthcare as he was having difficulty breathing. The officer telephoned the healthcare centre and spoke to a nurse who advised him to tell the man to lie down and try to relax. She asked the officer to monitor the man and report to her if there was no improvement within 15 minutes. However, when the officers went to relay that advice, they found him standing in front of his open cell window, appearing to struggle for breath and becoming more agitated as a result. Despite his condition, he was still able to converse with the officers. One remained with him, attempting to calm him while the other went to request that healthcare attend.

Two nurses attended very quickly. When they arrived, the man was sitting on his bed wearing just a pair of boxer shorts although it was cold outside. The nurse recorded that his breathing was 'laboured' and he sounded very 'chesty' and 'crackly'. The nurse asked him if he had any chest pain to which he replied that he did not. The doctor attended shortly after the nurses had arrived. On his instructions, 15 litres of oxygen was administered to the man. He also instructed the nurses to give three puffs on a 'Ventalin' inhaler. The nurse recorded that these interventions seemed to make no difference to the man's breathing. The doctor's provisional diagnosis at this stage was 'acute left ventricular failure secondary to possible myocardial infarction'. (A myocardial infarction is a heart attack.) The doctor instructed that an ambulance be called immediately.

The ambulance arrived at the prison about 15 minutes after being requested and the paramedics took over his care. Whilst arrangements were being made for him to be escorted to the local hospital, his condition deteriorated. Officers were advised not to use restraints so that treatment could be administered quickly. Once placed in the ambulance, he 'arrested' twice and, prior to leaving the prison the defibrillator (a device that delivers a measured electrical shock to the heart) was applied. On arrival at the hospital, the man was taken immediately to the Intensive Treatment Unit (ITU), escorted by two prison officers. The doctor who attended him advised the staff that, due to the severity of his condition, his next of kin should be informed as a matter of urgency. This was relayed back to the prison by the escort staff.

The man was sedated and remained on a ventilator. At regular intervals, hospital staff briefed the escort officers as to his condition. Early indications from medical staff were that his condition was critical but stable. The prison attempted to trace his next of kin but had no up to date addresses for them. The prison searched the records and contacted probation services in the Plymouth area to request their assistance. However, an address was then

discovered for the man's sister who had visited him in 2004. The information was passed to police in that area with a request for them to verify the details and pass on the information about the man. The police made contact and his sister contacted the ITU on 30 May.

The man's condition showed no signs of improvement. The Consultant Anaesthetist, gave his prognosis as 'very poor' as the man was not responding to treatment. The hospital asked for further information on his medical history and the prison faxed through his medical record immediately.

On the afternoon of 30 May, the escort staff were told that members of the man's family would be visiting later that day, but might be quite late as they were travelling from Plymouth. At 6.00pm, the escort staff were informed that the man had taken 'a turn for the worse' and that they were struggling to maintain his stability. This was reported to the prison. At 11.25pm, two of his brothers, and his brother's fiancée arrived from Southampton, and were spoken to by the hospital staff. At 12.25pm, his sister, brother-in-law and niece arrived from Plymouth. The hospital provided the man's family with rooms to enable them to rest and freshen up after their long journey. The family took it in turns to sit with him as the hospital allowed only two visitors at a time in his room. After speaking with the hospital staff, his family asked for enquiries to be made at the prison as to whether there was any evidence that the man wished to allow his organs to be donated.

There was no change in his condition and he remained 'serious but stable'. Three more relatives arrived and joined the others in taking turns at his bedside. The escort staff regularly checked on the well-being of the man's family during their routine checks. Family members were interested in knowing about his time in Highpoint, so officers spoke to them about this. The family also expressed their thanks to all the staff that had been involved with the man's care. At 10.10am, the escort was reduced to one officer.

The Deputy Governor, was notified at around 11.30am that the man was not likely to survive the day. At this time, the hospital had withdrawn all other treatment with just the ventilator remaining. As a result of the information shared with the Deputy Governor, a senior manager from Highpoint visited the hospital and spoke with the man's family.

At 3.30pm, a doctor pronounced the man dead. His family were by his side.

The prison offered his family assistance with the funeral costs. This was gratefully accepted. The prison's chaplain attended the funeral.

## **ISSUES**

The initial decision not to use restraints on the man gave him both a level of dignity and enabled medical staff to administer immediate medical care.

**The Governor and staff at Highpoint should be commended for the actions taken to ensure medical care could be administered quickly, and the level of dignity this afforded the man.**

The Governor and her staff worked energetically to trace the man's next of kin to ensure they were able to be with him at the time of his death. Their actions were both appropriate and compassionate.

**The Governor and her staff should be commended for the efforts they made in tracing the next of kin, as well as the sensitive way in which they dealt with the family both before and after his death.**

## **CLINICAL REVIEW**

Suffolk Primary Care Trust, conducted the clinical review into the man's care. In the review, it concludes:

“I can find no evidence that the man received a standard of healthcare that could not be expected from the wider community. There is no evidence to indicate that the care he received from the healthcare department had a direct link to his death.”

The reviewer makes one recommendation:

**It would be beneficial to be able to identify patients who have underlying medical conditions who do not wish to engage with routine checks. A monitoring process could be established that would:**

- **Let them enter the screening/monitoring process**
- **Monitor their general health should they wish not to engage with healthcare.**

## **RECOMMENDATIONS AND GOOD PRACTICE**

- 1. The Governor and staff at Highpoint should be commended for the actions taken to ensure medical care could be administered quickly, and the level of dignity this afforded the man.**
- 2. The Governor and her staff should be commended for the efforts they made in tracing the next of kin, as well as the sensitive way in which they dealt with the family both before and after his death.**
- 3. It would be beneficial to be able to identify patients who have underlying medical conditions who do not wish to engage with routine checks. A monitoring process could be established that would:**
  - Let them enter the screening/monitoring process**
  - Monitor their general health should they wish not to engage with healthcare.**