INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF A MAN IN HOSPITAL IN JULY 2007 WHILST A

PRISONER AT HMP STANDFORD HILL

Report by the Prisons and Probation Ombudsman for England and Wales

January 2008

This is the report of an investigation into the death of a man in hospital in July 2007. He was a prisoner at HMP Standford Hill and died of natural causes. He was aged 69.

The man had a history of ill-health related to various chest problems. He had diagnoses for asthma, emphysema and, latterly, cardio obstructive pulmonary disorder (COPD). These conditions were thought to be related in part to his longstanding cigarette habit.

During the morning of his death, the man complained to prison staff that he was feeling unwell. He was assessed in his room by a doctor and a nurse who decided he needed to be admitted to hospital. An ambulance was requested to arrange for him to be taken to hospital. This was done by way of a direct call to the ambulance service rather than via the emergency services. The deputy governor was asked to authorise the man's absence from the prison and queried whether an ambulance needed to be called more urgently. She was told that the man had been assessed by a doctor. She went to see him anyway and asked a member of wing staff to "keep an eye on him". At 11.40am, a prison officer found the man unconscious. Emergency resuscitation was started and 999 called. An ambulance arrived and took him to hospital where he died later that evening.

The investigation was undertaken on my behalf by one of my colleagues. I would like to express my thanks to the governor of Standford Hill for the help my investigator received. Particular thanks go to the prison liaison officer for making the arrangements to facilitate my investigator's visits. A medical practitioner conducted a review of the clinical care received by the man on behalf of Eastern and Coastal Kent Teaching Primary Care Trust. I thank him for his contribution and invaluable input.

I make four recommendations. In making these I have been guided by the findings of the clinical reviewer who found the long term management of the man's chronic health problems fell below expected standards. Whilst the man was at times a difficult patient to treat, there was no evidence that this was challenged in a structured way. The way he was managed on the day of his death is also a cause for concern. I am pleased to say that the Prison Service have accepted the three recommendations which apply to them.

On a more positive note, I was pleased to learn that the prison arranged for six prisoners to attend the man's funeral to pay their respects. In addition, the prison properly recognised the actions of two prisoners who helped staff in attempting to revive the man after he was found unconscious.

Fatal incident investigations conducted by my office attempt, as far as possible, to address the concerns of family members and anyone to whom the person who died was close. Sadly, the man had lost contact with his family over the course his lengthy prison sentence and it has not been possible to trace any next of kin.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2008**

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SUMMARY

The man was sentenced to life imprisonment in October 1985. He progressed through the prison system before being released on life licence in February 2000. He was recalled to prison in June 2001 after breaking the terms of his licence. Upon his return to custody it was noted that he was in poor health, and that he suffered with asthma and chronic emphysema.

In November 2003, the man secured a progressive move to HMP Standford Hill. When he arrived it was once again recorded that he suffered from a chest complaint related to his asthma and emphysema. In February 2004, the man saw a specialist at outside hospital and was diagnosed with chronic obstructive pulmonary disease (COPD) and prescribed recognised medication to treat it. His chest problems and other ill health were treated as an ongoing concern by the healthcare team throughout his time at Standford Hill. However, the man failed to attend numerous appointments.

During the morning of his death, the man complained to prison staff that he was feeling ill. Staff called their colleagues in the healthcare department and a nurse and a doctor attended. They assessed him and found that he had lost weight and was struggling to breathe. A fungal growth was also observed on his tongue. The doctor concluded that the man was too poorly to be treated at the prison and therefore contacted the hospital to arrange for him to be admitted. He also organised an ambulance to transport the man to hospital, although he did not say it was an emergency.

The nurse who assessed the man asked the deputy governor to authorise his temporary release from the prison. The deputy governor enquired how long it would take for the ambulance to arrive. She was told “anything up to four hours”. She questioned whether the man would be alright for this long, and was told that he would. However, she went to see the man anyway and asked a member of wing staff to “keep an eye on him”. Whilst waiting for the ambulance to arrive, the man was allowed to return to his room.

At 11.40am, the wing officer was carrying out a roll check on C Wing. She found the man unresponsive on his bed and summoned assistance using the prison radio. With the help of a prisoner she moved the man onto the floor and started cardio pulmonary resuscitation (CPR). Nursing and discipline staff soon arrived en masse and 999 was called.

The ambulance arrived at 11.55am and paramedics continued CPR before taking the man to hospital. Sadly, he never regained consciousness and died later that evening.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation into the man's death on 1 August 2007. He met a governor appointed as the prison liaison officer, who outlined the circumstances surrounding the man's death and provided the investigator with his prison records.

2. Prior to my investigator arriving at Standford Hill, notices had been issued to staff and residents announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigator. No one came forward. However, my investigator returned to the establishment on 25 September to interview a governor who had contact with the man on the morning he died. He also spoke to the chair of the prison's Independent Monitoring Board (IMB). He returned again on 11 October to interview a doctor who assessed the man in the hour before he was found collapsed in his room. Another member of staff to whom my investigator wanted to speak has retired and emigrated since the man's death. As a consequence, she has not been interviewed.

3. My investigator also contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Another colleague has completed the report as the lead investigator has now left my office. Upon completion, this report will be sent to the Coroner to assist him in his enquiries.

4. A medical practitioner undertook a review of the clinical care received by the man who died on the instructions of Eastern and Coastal Kent Teaching Primary Care Trust.

HMP STANDFORD HILL

5. HMP Standford Hill is an open (category D) prison, part of the cluster of three adjacent prisons (Elmley and Swaleside are the others) on the Isle of Sheppey in Kent. It was originally opened in 1950 and became a category D prison in 1985. It can hold up to 464 prisoners. Like all category D prisons, the ethos at Standford Hill is one of preparing prisoners to lead independent, crime-free lives in the community after release.

6. Eastern and Coastal Kent Primary Care Trust is responsible for the delivery of primary health services in the prison. There are no inpatient facilities and prisoners requiring 24-hour healthcare are transferred to HMP Elmley. Elmley is a category B prison, and therefore any Standford Hill prisoner who is transferred experiences some reduction in their freedom of movement. Some prisoners who need a transfer for medical reasons are reluctant to go for this reason.

7. A daily ‘sick parade’ is held in the healthcare unit at Standford Hill for prisoners wishing to access primary care services. A general practitioner from a practice in Sheerness holds a clinic every weekday morning, from 8.00am until 10.30am. Out of hours medical cover is provided by MEDOC, a local on-call service based at Sheppey Hospital. Healthcare also provides dental, optical, psychiatric and chiropody services. As the ethos governing healthcare services is one of ‘comparative care’, Standford Hill does not have special resources allocated to elderly prisoners.

8. Standford Hill was last inspected by Her Majesty’s Chief Inspector of Prisons in December 2006. Her report was critical of the physical state of the prison and the healthcare centre was described as suffering from a lack of investment. However, she commented positively on prisoners’ access to health services, and noted that all prisoners received their medication in possession as they would in the community. Overall, Standford Hill was assessed as being a safe, respectful and purposeful place for prisoners.

KEY FINDINGS

9. As noted above, the man arrived at Standford Hill in November 2003. Upon reception he was interviewed by a Healthcare Officer (HCO) and disclosed that he suffered from two serious illnesses, asthma and emphysema. A comprehensive list of his current medication was recorded in his medical notes. The HCO also wrote that the man described himself as a social drinker when it came to alcohol consumption. After being processed through reception, he was transferred to one of the residential units.

10. Two weeks after his arrival, he was seen by a doctor after suffering from acute shortness of breath. After carrying out an examination, the doctor referred him to a chest specialist in the local hospital. The doctor thought that he might be suffering from chronic obstructive pulmonary disease (COPD), a disorder characterised by an impaired ability to expel air from the lungs which makes breathing extremely painful and difficult.

11. On 18 February 2004, the man attended an outpatient appointment with the specialist. His main problem was assessed as breathlessness on exertion. It was noted that central heating made his breathing worse and that he could walk 400-500 yards on flat ground before having to stop. A history of hypertension and high cholesterol was identified, as was the fact that the man had been a smoker since the age of 14. The specialist's diagnosis was that the man suffered from a moderate to severe form of COPD, but considered that it could be controlled by medication. The specialist made out a prescription for Serevent and Atrovent, two widely used treatments for COPD, and set a review date for three months.

12. As arranged, the man attended a further outpatient appointment with the chest specialist on 2 June 2004. It was recorded that he had been stable on his medication and his tolerance to exercise was unchanged. It was further noted that he continued to smoke, although he told the consultant that he had reduced his intake to three to four cigarettes a day from a previous level of ten. The specialist advised him to stop smoking as this would be likely to make the most difference to his ability to breathe. He also issued him with an inhaler. As the man's condition was assessed as stable, no follow-up appointment was made.

13. On 20 July, the man attended an appointment with an optician who noted that his eyesight was getting worse. From late 2004 and throughout 2005, the man attended numerous outpatient appointments at the local hospital in order to correct the problem.

14. In January 2006, the man was due to be released from prison on temporary licence in order to stay at an Approved Premises (probation hostel) for four nights. Unfortunately, this was cancelled at the last minute when he came down with flu.

15. Six months later, on 16 June 2006, the man was seen by a member of the healthcare team after complaining of feeling unwell. His blood pressure was raised so he was referred to the prison's General Practitioner (GP). The prison doctor assessed him and noted that his symptoms were related to his COPD. No further action was deemed necessary.

16. In July 2006, the man was seen again in healthcare and it was recorded in his notes that he was suffering from "severe COPD". A random blood sugar test was carried out and revealed that his blood sugars were at a borderline diabetic level. A fasting blood sugar test was suggested, although there is no evidence that this was followed up.

17. In order to prepare for their eventual release, many category D prisoners are released for short periods on temporary licence order to stay at an Approved Premises or another suitable address. As the man was one of the longest serving lifers at Standford Hill, staff knew he felt settled in the prison environment. He was described as a quiet, insular man, and as a consequence preparations for his release had to be carefully managed. Between 4 December and 8 December 2006, he was released on temporary licence (ROTL) to a probation partnership hostel. His stay was successful and he returned to the prison, as required, on 8 December.

18. On 30 January 2007, the man was seen again by the prison. It was noted that he continued to smoke heavily, against the advice of the chest specialist he had seen at the local hospital.

19. Between 5 February and 9 February, and again between 10 April and 13 April, the man was released on temporary licence to hostel. Both stays apparently passed without incident and, on 1 May 2007, the hostel offered him a permanent place if he was released from prison. (A Parole Board Oral Hearing, which could have resulted in him being released, was due to take place on 3 October 2007.)

20. Around 10.00am on 23 July, the man complained to staff that he was feeling ill. A call was made to the healthcare department and the duty HCO and the prison doctor attended. Unfortunately, the HCO has now retired and it has not been possible to speak to her about what happened. However, the prison doctor told my investigator that, when he and the duty HCO arrived at the door to the man's room, they knocked and initially received no response. The doctor considered breaking the door down just as the man was heard making his way across the room. He opened the door and the doctor immediately noticed that he looked "grey" and ill. The HCO and the doctor helped him back to bed before he carried out an examination.

21. The prison doctor found that the man had lost a lot of weight and was struggling to breathe. He examined his tongue and saw that it was covered in a fungal growth. He concluded that the man was too ill to be

treated at the prison and phoned the hospital to arrange an admission. The doctor described the man's symptoms to the specialist at the Medical Assessment Unit and the specialist told him to "send him in straightaway".

22. The doctor then arranged for an ambulance to collect the man and take him to hospital. He called the ambulance service directly rather than by making a 999 call. He then wrote a memorandum to the specialist at the Medical Assessment Unit, briefly describing the man's medical history and his current presentation. The doctor wrote:

    > "[l]ongstanding COPD and asthmatic. Today he has lost a lot of weight. Tongue dry, coated & fungus. Unable to walk or breathe properly. Looks greyish. Cyanosed+."

    After faxing this off to the hospital, the doctor says he left the man in the care of the duty HCO.

23. Whilst waiting for the ambulance to arrive, the HCO completed the Release On Temporary Licence (ROTL) paperwork so that the man could leave the prison with proper authority. She went to the administration block at the prison and asked the deputy governor, to sign the documentation. The deputy governor asked the HCO why the man needed to go to hospital and says she was told that he had deteriorated quite badly. The deputy governor asked the duty HCO whether the man could go to hospital in a taxi with an accompanying member of staff. The duty HCO apparently replied that he was too poor for that. The deputy governor asked whether 999 needed to be called if the man was too ill to go by taxi. She says the HCO told her that the doctor had assessed him and had arranged for an ambulance. The deputy governor asked how long it would be before the ambulance arrived, and the HCO apparently said "anything up to four hours". The deputy governor thought this was a long time and asked the HCO whether the man would be alright for four hours. She was assured that he "should be". Finally, she enquired whether the man was going to hospital willingly, as she knew from previous experience that he was a very reluctant patient. She told my investigator that the duty HCO told her that she hoped he would get in the ambulance when it arrived.

24. The deputy governor then made her way to the man's wing to speak to him. She observed that he sounded very chesty and asked him how he was doing. He said he was quite bad. She enquired whether he was going to go to hospital. He replied that he did not want to before conceding that he would have no alternative. The deputy governor then left his room, leaving the door open so that wing staff could keep an eye on him. She also spoke to the officer on duty and said, "The man is quite poorly, the ambulance is en route, can you keep an eye on him?"

25. Around 11.30am, the wing officer started carrying out the roll check on C Wing. At 11.40am, she arrived at the man's room, C1-16. She looked into the room and observed that he appeared to be asleep on his bed. Aware that he was unwell, and mindful of the deputy governor's'

instruction to keep an eye on him, she spoke to him but got no reply. She then approached the bed, continuing to speak. Arriving at the man's bedside, the officer touched his arm in order to rouse him. The man was unresponsive and the officer immediately realised that there was a problem. She sent a message over the prison's radio network urging all available staff to come to C Wing immediately.

26. At this point, prisoner A, came into the man's room, followed shortly afterwards by another prisoner, prisoner B. The latter quickly left to find first aid trained staff whilst prisoner A helped the officer lift the man onto the floor. The wing officer checked the man's vital signs, could find no pulse and started cardio pulmonary resuscitation (CPR).

27. A prison officer then arrived at room C1-16. He removed a face mask and pair of surgical gloves from the first aid pouch issued to all frontline staff, and then took over from the wing officer who is not CPR trained. He also instructed the wing officer to send out a 'code blue' message over the radio, which prompted the communications department to call 999 and request an emergency ambulance. The prison officer continued to administer CPR for a number of minutes before being relieved by the senior officer (SO). a second prison officer, a healthcare worker (HCW), the duty HCO and the deputy governor subsequently arrived at C1-16, and collectively they worked on the man until an ambulance arrived at 11.55am.

28. The paramedics assumed responsibility for administering CPR whilst prison staff helped as best they could. The man was taken by ambulance to hospital, situated 17 miles away. He was admitted as an inpatient and received emergency treatment. However, he failed to regain consciousness and died later that early evening. He was aged 69.

29. A hot debrief subsequently took place and the staff who were involved in trying to resuscitate the man were informed of the support available to them. The governor and prison liaison officer wrote to prisoner A and prisoner B to commend them for helping the staff in their efforts to save the man's life.

30. The man had lost contact with his family many years previously, and he had named his solicitor as his next of kin. His funeral took place at a crematorium and was attended by six prisoners, one former prisoner, his solicitor, three prison officers and the governor appointed as the prison liaison officer. I commend Standford Hill for arranging for six prisoners to be released on ROTL to attend the funeral and to pay their respects.

CLINICAL ISSUES

Management of the man's chronic ill health

31. The clinical review prepared by the clinical reviewer details of the man's history of COPD, hypertension (high blood pressure) and hypercholesterolaemia (high cholesterol). From the man's 'in possession' prescription charts there is evidence that all these conditions were treated with prescribed medication. He received aspirin for his high blood pressure and Lipostat for his high cholesterol, recognised treatments for these conditions, right up until his death. However, there is no evidence in the man's medical records that his blood pressure or cholesterol levels were checked after he was discharged by the hospital on 2 June 2004. It is not therefore possible to say whether the medication was still having the desired effect. This is poor practice.

32. In interview, the prison doctor and medical lead ultimately responsible for the man's care, suggested that these levels would have been monitored as a matter of course. However, failing to document the results in the man's notes seriously diminishes the value of doing this. I therefore recommend:

    Healthcare staff should be reminded of the importance of record keeping. The results of examinations and tests should be routinely documented and all entries should be signed and dated.

33. The clinical reviewer's report is also critical of the fact that no coherent care plan was put in place for the man after he arrived at Standford Hill. The prison doctor said that the man would have been told when he arrived at the prison that he could access GP services every day. He also said that this is no different to how things are for ordinary members of the community. However, it was known that the man was not a particularly cooperative patient and that he seemed indifferent to his deteriorating health. (One example being the fact he continued to smoke against medical advice.) It was also known that he frequently failed to attend pre-arranged appointments, so it is doubtful that he would have referred himself to the GP. The clinical reviewer comments that there seems to have been no proactive attempt to improve the man's health and that he became a victim of his own indifference. A comprehensive care plan would have provided the healthcare team with a structured way of engaging with the man, and would have ensured that missed appointments were followed up more effectively.

    Prisoners with complex/chronic health problems should be managed by a care planning system. Care plans should be tailored to individual prisoner's needs and should adopt a multi-disciplinary approach.

    Failures to attend healthcare appointments should be recorded in the clinical records and audited regularly. If prisoners with chronic

diseases are regularly missing appointments, strategies should be developed to engage with them.

The man's care on 23 July

34. About an hour and a half before he was found collapsed in his cell, the man was jointly assessed by a healthcare officer (HCO) and by the prison doctor. It was immediately obvious to the doctor that the man was "in a bad state". A brief examination revealed he had lost a lot of weight and was struggling to breathe. His tongue was also covered in a fungal growth. The doctor concluded that the man was too ill to be treated at the prison and phoned the hospital to arrange an admission. After describing the man's symptoms to the specialist, the specialist apparently told the prison doctor to "send him in straightaway".

35. Given this, I was surprised to learn that instead of calling 999 the doctor contacted the ambulance service directly to arrange for the man to be transported to hospital. My investigator has learned that 'routine' ambulance transports of this type can take up to four hours. This was known by the HCO who spoke to the deputy governor who was asked to authorise the man's temporary release from the prison. When the deputy governor asked the HCO whether the man would be okay for four hours, she was told that the doctor had assessed him and he "should be" alright.

36. Whilst it is not possible to say whether the man's life would have been prolonged by an earlier hospital admission, it is manifestly the case that a hospital is a more suitable environment for treating an ill patient than a category D prison. To my mind, being asked to send a patient to hospital "straightaway" should prompt a more dynamic response than merely requesting an ambulance transport.

37. The decision only to request an ambulance for transport purposes could be considered a defensible one in one set of circumstances. If the man had been given basic medical treatment (the clinical reviewer has suggested that oxygen, intravenous steroids and a nebulised bronchodilator may have been appropriate) whilst waiting for the ambulance to arrive, it is possible that his condition could have been stabilised. As it was, he was allowed to return to his room unaccompanied, his condition deteriorated and he lost consciousness. The only element of direct supervision was requested by the deputy governor who asked staff on the man's wing to "keep an eye on him". As she had already been told that the man should be alright until the ambulance arrived, I think she did all that could reasonably have been expected (indeed, she emerges well). Certainly, I cannot criticise her not asking the officer to watch the man constantly. Likewise, the officer concerned cannot be criticised. Nevertheless, there are self-evident concerns about the management of the man on the day of his death.

Eastern and Coastal Kent Teaching Primary Care Trust should conduct a critical incident review into the care received by the man on 23 July.

OTHER ISSUES

Preparing the man for release

38. Prisoners in category D establishments are expected to be proactive in planning for their own release. Usually this requires them to make efforts to obtain purposeful employment and suitable accommodation, and to show that they are capable of leading independent, law-abiding lives.

39. Due to his age, infirmity and the length of time he had spent in prison (over 20 years at the time of his death), the man was probably less proactive in planning for his release than most prisoners in category Ds. Indeed, according to the deputy governor, he seemed quite content to spend the rest of his life in prison. By almost anyone's measure, the man was 'institutionalised'.

40. For that reason, I was pleased to learn that, whilst taking on board the man's need to take things slowly, Standford Hill continued to engage with him in a way that ensured he did not stagnate in prison. At the time of his death he was three months away from a Parole Board hearing that would decide whether he would be released. Whilst there is no merit in speculating on what the outcome would have been, the man's successful stays at the hostel (facilitated by Standford Hill) would have helped his case.

Recognising the actions of prisoner A and prisoner B

41. I welcome the fact that the two prisoners who helped staff after the man was found unconscious were thanked in writing by the governor acting as the prison liaison officer. This was good practice.

RECOMMENDATIONS

1. Healthcare staff should be reminded of the importance of record keeping. The results of examinations and tests should be routinely documented and all entries should be signed and dated.

   The Prison Service have accepted this recommendation. Extra staff have been drafted into HMP Standford Hill since July 2007. This includes a full time Administrative Officer from January 2008. The extra staff will ensure a better standard of practice regarding documentation in the Healthcare Department. The use of the EMIS IT system is due to be in place by February/March 2008. This will further enhance the efficiency of documentation.

2. Prisoners with complex/chronic health problems should be managed by a care planning system. Care plans should be tailored to individual prisoner's needs and should adopt a multi-disciplinary approach.

   The Prison Service have accepted this recommendation. As noted above, extra staff have been brought in. Long Term Condition clinics have commenced in HMP Standford Hill and care planning is an inevitable part of this. Further clinical staff are required for HMP Standford Hill. This will be established as part of a re-profiling exercise.

3. Failures to attend healthcare appointments should be recorded in the clinical records and audited regularly. If prisoners with chronic diseases are regularly missing appointments, strategies should be developed to engage with them.

   The Prison Service have accepted this recommendation. Staff have been requested to follow up appointment failures for all prisoners who have made appointments or who have had appointments made for them. This will be part of Clinical Audit for the Department. Failure to attend will be entered in paper records and later on EMIS with the reason for failure to attend fully documented.

4. Eastern and Coastal Kent Teaching Primary Care Trust should conduct a critical incident review into the care received by the man on 23 July.

GOOD PRACTICE

1. Arranging for six prisoners to be released on temporary licence to attend the man's funeral is an example of good practice.
2. I welcome the fact that the two prisoners who helped staff after the man was found unconscious were thanked in writing by the governor acting as the prison liaison officer. This was good practice.