Investigation into the circumstances surrounding the death of a prisoner at HMP Swaleside, who died at the Medway Maritime Hospital in September 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is a report into the circumstances of the death of a man in September 2007 at the Medway Maritime Hospital. He was a prisoner at HMP Swaleside and was 38 years old. On the morning of his death, staff had discovered him unconscious on the floor of his cell. Following attempts to revive him, he was taken to the Medway Maritime Hospital by ambulance and located on the critical care ward. Unfortunately, the man's condition deteriorated and, on the advice of medical staff, his family took the difficult decision to remove all life support.

A post mortem examination carried out by a Home Office Pathologist concluded that he died of an intracerebral haemorrhage. I would like to offer my sincere condolences to the man's family and friends for their sad loss.

One of my colleagues, conducted the investigation. I would like to thank the Governor of Swaleside for facilitating the investigation and Eastern and Coastal Kent Primary Care Trust, who conducted a review of the man's medical care while in custody. However, it is unfortunate that, in spite of several requests, the prison did not make available documents that were significant to the investigation until some weeks after the death. This was despite numerous requests from the investigator. I apologise for the consequent delay in issuing this report.

The man had complained of severe headaches for some time before his death. The healthcare team had seen him on several occasions for these symptoms, but investigations had not identified the cause and were continuing.

I make four recommendations, which have been accepted by the Prison Service and commend two Governors for the way in which they assisted the man's family.

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

CONTENTS

Summary	4
The investigation process	5
HMP Swaleside	6
Key findings	7
Issues	11
Recommendations	14

SUMMARY

The man was remanded to HMP Winchester in April 2003, and was sentenced to 30 months imprisonment in August 2003. In October of that year he was charged with murder and, on conviction in July 2004, sentenced to life imprisonment.

In March 2005, he transferred to HMP Swaleside. Most of his contact with healthcare staff was for joint pain. He also reported migraines in February and August 2006 for which he was given painkillers. In June 2007, staff asked a nurse to see him on the wing, as he was feeling unwell with symptoms of dizziness, headaches and a stiff neck. The nurse sent him to see a doctor in the healthcare centre. Over the next few months the headaches continued, along with nausea and vomiting. He spent time in the healthcare centre and was referred to a urologist.

At 6.10am the morning before the man's death, an Operational Support Grade (OSG) saw him lying on the floor of his cell. Although the OSG was initially concerned, he took no further action as he could hear the man breathing. On completion of his roll check, the OSG reported to the Assistant Night Orderly Officer, that the man was lying on the floor of his cell. The Assistant Night Orderly Officer advised that it was sufficient that the OSG was satisfied that the man was breathing.

At about 6.40am, during a handover with the day officer, the OSG told him about the man. Both officers went to the cell. The man was lying in the same position and the OSG attempted to gain a response by banging the door. The OSG noted a slight movement and was satisfied that the man was in a deep sleep. He then finished his duty and the day officer continued his roll check. The day officer checked the man again at 7.25am and became concerned that he was in the same position. He therefore contacted the operations room and spoke to a Senior Officer (SO) who attended C wing with a Principal Officer (PO) and two other staff. The PO entered the cell and called to the man but there was no response. On closer observation, it became clear that he was in some distress and medical assistance was requested. The man was taken to Medway Hospital by ambulance where medical staff diagnosed a brain haemorrhage and confirmed his condition was critical.

In spite of some initial difficulty, the prison contacted his mother to inform her of his condition and the family travelled from their home in Scotland to see him. The prison arranged for him to be released on compassionate licence on the afternoon of 10 September. Sadly, he was confirmed dead at 11.20pm. Prison staff maintained close contact with the family, providing extensive support and meeting the costs of the funeral, and I commend them for their assistance.

Although the clinical reviewer concluded that nothing could have been done to save the man's life, I am concerned that the discipline staff who first saw him lying on the floor took no action to rouse him, leading to a delay in him receiving medical treatment. In addition, the nurse on duty could not access the wing and had to wait for an escort. I have made recommendations relating to these issues.

THE INVESTIGATION PROCESS

1. One of my investigators conducted the investigation. In early September 2007, he introduced himself to the Governor's Secretary who gave him the details of the prison liaison officer. Although the Governor and liaison officer produced some documents, including the man's medical record, others critical to the investigation were delayed and this in turn affected the progress the investigator could make. However, he issued notices to staff and prisoners to inform them of the investigation process, and to offer the opportunity to speak. He received responses from some prisoners and arranged to visit them.

2. In December, my investigator visited Swaleside. He interviewed five members of staff as well as the prisoners who had contacted him.

3. I commissioned East Kent and Coastal Primary Care Trust to carry out a clinical review of the man's medical care in custody. The Trust appointed a doctor to conduct the review.

4. One of my Family Liaison Officers contacted the man's family in September. The family were very appreciative of the help and assistance provided by the prison. They felt that the prison had answered most of their questions but expressed some additional concerns that I have attempted to address in my report. My FLO offered the family a home visit but they did not consider it necessary.

5. My investigator wrote to HM 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.

HMP SWALESIDE

6. HMP Swaleside, a category B training prison for male offenders, opened in 1988. Situated near Eastchurch on the Isle of Sheppey, it is one of the three prisons on the island that make up the 'Sheppey cluster'. The other two are Standford Hill and Elmley.

7. The healthcare centre at Swaleside provides 24 hour nursing as well as inpatient facilities. At the time of the investigation, the inpatient area was in the process of being modernised. One member of healthcare staff is on duty at night, and has responsibilities for attending to inpatients as well as responding to medical emergencies elsewhere in the prison during the night.

8. HM Chief Inspector of Prisons, Ms Anne Owers, conducted an unannounced follow up full inspection of Swaleside in January 2006. None of her recommendations is relevant to this investigation.

9. Since Swaleside opened, there have been 18 deaths prior to this one. Twelve were from natural causes and the remainder self-inflicted. There do not appear to be any similarities between these deaths and this current death.

KEY FINDINGS

Events leading up to the man's death

10. In April 2003 at Southampton Crown Court, the man was remanded into custody at HMP Winchester having been charged with Grievous Bodily Harm (GBH). During the initial health screen at Winchester, healthcare staff identified that he was suffering from depression as well as alcohol detoxification. In view of these factors, healthcare staff opened a suicide and self-harm document, then known as F2052SH, to monitor and support him. There were no other significant medical concerns.

11. During the next few weeks, the man self-harmed on a number of occasions and consequently spent time in the healthcare centre. He returned to the wing in May 2003 and settled into the regime, although he kept to himself and mixed very little. The F2052SH remained open during this time. Later in May, police informed him that he was to be charged with murder and his mood deteriorated. Healthcare staff raised concerns about his wellbeing, which resulted in him moving to the healthcare wing. He spent several weeks in the healthcare centre where his mood fluctuated. Psychiatrists assessed him and he expressed feelings of hopelessness about his situation.

12. The Community Psychiatric Nurse (CPN) who saw the man when he returned to the residential wing in July said that he was coping well. This positive outlook continued and he asked for the F2052SH to be closed as he no longer felt the need for it. The F2052SH monitoring was closed following a review. During his time on remand, the majority of the man's contact with medical staff was in relation to self-harm.

13. He was sentenced to 30 months imprisonment in August 2003. On his return from court he raised no concerns and told medical staff that he was coping well.

14. In October 2003, police charged him and his partner with murder and he again began to deteriorate. Medical staff assessed him and opened a F2052SH on his return from court. This time the man only remained subject to monitoring for a week and the F2052SH form was closed on review.

15. In July 2004, he was convicted of murder. On his return to Winchester, healthcare staff offered him the opportunity to go into the healthcare unit but he declined. The CPN continued to see him regularly to assess his moods, but he had no contact with healthcare for any other matter.

16. He transferred to HMP Swaleside in March 2005. No significant medical concerns were raised on his arrival but, over a period, he was treated for several minor ailments. In February 2006, the man reported what he described as migraine headaches and the doctor prescribed medication. Over the next few months, he regularly reported sick for increased joint pain particularly in his knees. He made no further mention of headaches until August 2006 when he again complained to a doctor of right-sided headaches.

The doctor placed him on the waiting list to see the optician. Despite other contact with the healthcare team, there was no further mention of headaches for almost 12 months.

17. At the end of June 2007, medical staff examined the man at the request of wing staff as he had complained of dizziness, headaches and a stiff neck. He was sent to the healthcare unit where he was given a check up. Over the next few months the headaches continued, along with nausea and vomiting. He spent time in the healthcare unit and was referred to a urologist.

18. While at Swaleside, the man was employed on the 'bins party'. This involved working outdoors gathering rubbish from all areas of the prison for collection by the refuse lorry. He was described as a hard worker who was always willing to do a bit extra. However, in the last few months leading up to his death, the man was unable to continue working due to his headaches. Around the wing, he mixed with a few prisoners and staff considered him a quiet individual.

19. The man was pursuing a cross-border transfer to move to a prison in Scotland to be closer to his family. This caused him some frustration as the process was very slow and at times he felt he was getting nowhere. Despite these setbacks and, with the help of his wing staff, he remained positive and continued with the process.

20. The morning prior to the man's death, an Operational Support Grade (OSG) was on night duty on C wing. At approximately 6.00am, the OSG began his morning roll check starting on the first landing. At 6.10am, he arrived at the man's cell, which was cell 6 on the third landing. The OSG looked into the cell and saw him lying on the floor without a mattress, on his front, dressed only in a pair of boxer shorts. During an interview with my investigator, the OSG said that he initially thought it was strange, as he had not seen the man sleeping on the floor before. He also said he automatically feared the worst and thought he was dead. He took a closer look and could hear him breathing in a manner which he described as 'heavy'. When the OSG returned to the office at around 6.20am, he contacted the Assistant Night Orderly Officer, and told him about the man. The OSG told the Assistant Night Orderly Officer he was not concerned, as he had heard the man breathing.

21. At around 6.40am, an officer began duty on C wing. Before carrying out his roll check, he and the OSG had a handover. When interviewed, the officer said that the OSG explained that the man was lying on the floor of his cell, but he was breathing. Both the officer and OSG went back to the man's cell to check on him again. The officer looked in and saw the man lying on his front on the floor but did not attempt to get a response. The OSG banged on the door and told the officer that he had noted a response. The OSG told my investigator that, having seen a slight movement, he was satisfied that the man was in a deep sleep. Neither member of staff considered the possibility of entering the cell at this time.

22. The officer then continued the roll check and, on completion at around 7.10am, returned to the wing office to report his numbers. The OSG went off duty.

23. At 7.25am, the officer returned to the man's cell to check him again. My investigator asked him why he felt the need to return if he had been satisfied the first time. The officer replied that he was just trying to reassure himself that everything was all right. The officer became concerned as the man was in the same position on the floor. He therefore returned to the wing office and spoke to a Senior Officer (SO) in the operations room. He expressed his concerns and asked if she could come to C wing. The SO told the officer that she would speak to the orderly officer and get someone to attend.

24. The SO attended with a Principal Officer (PO), and two other members of staff. The PO looked through the observation panel and saw the man lying on his front beside his bed. The man had now been in this position for over an hour. The PO entered the cell and called out to the man but got no response. He said that he could see that he was breathing heavily and there appeared to be blood around his mouth and nose. The PO tried again to get a response, without success, and it became clear to him that the man was in distress.

25. My investigator asked the SO and PO if they were able to recall whether the man had been covered in a way that would suggest that he had chosen to sleep on the floor. Both replied that they had not seen any covers. This contradicted the comments made to my investigator by the OSG that he believed the man had been covered by a blanket. There was clearly some confusion surrounding this but my investigator established that it was likely that the man had not been covered when discovered.

26. The SO used her radio to request medical assistance and an ambulance. The nurse had difficulty leaving the healthcare wing as she was on night duty and therefore had no keys. The control room notified the SO of this and she immediately left C wing to collect her.

27. While waiting for medical assistance, the PO and the other staff continued to talk to the man to reassure him and they placed him in the recovery position. There was no response and no movement of the limbs.

28. A nurse attended after being collected by the SO and began to check the man's vital signs. The paramedics arrived shortly afterwards and administered treatment, including an injection to relax his muscles. With the help of prison staff, they then lifted him into a wheelchair to take him to the ambulance. The paramedics spent around an hour at the prison and departed for the hospital after stabilising him at 8.45am. By then, over two and a half hours had passed since the OSG had first seen the man lying on the floor.

29. He was taken to the Medway Maritime Hospital where medical staff assessed him as critical. No handcuffs were used as the prison considered it unnecessary and medical staff were better able to administer treatment.

30. Due to the severity of his condition, the prison decided to inform his next of kin. This proved to be somewhat difficult but, through perseverance, a governor obtained a contact number. The governor then phoned the man's mother, at 5.10pm, and told her what had happened.

31. The family travelled from their home in Scotland at 9.00pm that evening and arrived at Medway Hospital at about 7.00am on the following day. The governor who had contacted them met the family at the hospital and explained what had happened and the reasons for the presence of prison staff. The family asked a number of questions that prison staff were able to answer. My investigator was told that the family appreciated this.

32. At 11.30am that day, the prison submitted an application for the man to be released on compassionate licence, and at 1.30pm, the bed watch staff were withdrawn. This gave the man a degree of dignity and offered his family privacy at a very distressing time.

33. The prison remained in contact with the Medway Hospital to check on his condition. At 11.20pm that evening, the hospital revealed that a brain stem function test had confirmed the man was dead. His family donated his organs.

Events following the man's death

34. The following day, the prison appointed a governor as the Family Liaison Officer. He contacted the man's parents and offered condolences on behalf of staff at the prison. He also explained the support available and assured them that he would assist with any problems.

35. The governor kept in regular contact with the family. He also contacted the funeral director and the Coroner. The prison offered to pay the funeral costs in full and sent a wreath on behalf of staff and prisoners.

36. The man was well known within the prison, having been there for some time, and Swaleside's chaplain held a memorial service for him. The family described the help and assistance offered by the prison before and after their son's death as 'fantastic' and said they were very appreciative.

ISSUES

Clinical Care

37. As noted earlier in this report, the man had previously only seen the healthcare staff for minor ailments when he first complained of headaches. The doctor who conducted the review of the man's medical care concludes that:

> "The man died suddenly of a serious and probably untreatable intracerebral lesion. His symptoms prior to his death were fairly non specific and there was little to indicate that a man of his age was at risk of major intracerebral bleed. It is unlikely in my opinion that his fatal cerebral haemorrhage could have been prevented by an earlier investigation or intervention."

38. The clinical reviewer found the quality of medical record keeping to be poor. Handwriting was frequently illegible and the status of those staff writing in the medical notes was frequently unclear. I endorse these views and make the following recommendation,

The Head of Healthcare should ensure that the medical records are clear, concise, and continuous, in accordance with the Nursing and Midwifery Council's guidelines.

39. The man's family also found not only the medical records difficult to decipher but also other prison documentation provided to them as part of the investigation. The family felt that there was little point in writing in documentation if it was not able to be read by other people and this had caused them some frustration. I endorse their views and make the following recommendation,

The Governor should issue a Notice to Staff reminding everyone of the importance of writing clearly and concisely in documentation and signing and printing a name after all entries.

40. It was evident from the documents reviewed that the man had been expected to ask for further appointments from the doctor, rather than being treated proactively. It was also evident that there had been little if any discussion between the doctor and the nursing staff or any other health professionals in relation to his treatment. The clinical reviewer comments:

> "Where there is no diagnosis of a patient's symptoms, the doctor should normally initiate arrangements for follow-up review appointments and investigations until such a time as a specific diagnosis has been reached. It should not in my opinion be left to the patient to decide whether to follow up arrangements need to be made. A patient may mistake a symptom e.g. headache with a diagnosis e.g.

migraine and therefore not fully appreciate the need to make a definitive medical diagnosis for any particular symptom."

The doctor also makes the following recommendation, which I endorse:

Where follow-up consultations are with healthcare staff members other than the doctor, there must exist lines of communication such as regular clinical meetings where specific diagnostic problems or management issues are discussed, ideas shared, and agreed plans of action drawn up. There should be a designated clinical lead eg the patient's registered doctor or prison medical officer who is ultimately responsible for the overall management of the patient.

41. The doctor who completed the clinical review considers that in future the introduction of electronic medical record systems in the prison system will make the interpretation and review of medical histories easier. It should improve screening, continuous care, and medical record sharing. While the system is being rolled out across establishments, Swaleside is still using paper records. Moreover, a new IT system will not remedy inconsistent record keeping. Any IT system is heavily reliant on healthcare staff using it to record clear, concise and continuous data.

Intervention

42. I recognise that for varying reasons a small number of prisoners choose to sleep on the floor of their cells, but this is usually with a mattress and bedding. There is a clear difference between a prisoner who chooses to sleep on the floor and someone lying on the floor without a mattress or covers and wearing only their underwear.

43. In my opinion, the assumption made by the OSG and Officer that it is common for prisoners to sleep on the floor of their cells was misguided. This assumption led to a significant delay in the man getting medical attention.

44. The doctor judges that earlier intervention would have made no difference given the severity of the man's condition. Nevertheless, I believe that the staff who went to the cell at 6.10am and again at 6.40am should have erred on the side of caution by summoning assistance or entering the cell to be sure of the man's wellbeing.

The Governor should review the actions of the OSG and the Officer. He should also provide firm advice and guidance for all staff who carry out early morning checks. In particular, they should be advised that if there is any doubt about the wellbeing of a prisoner, they should seek a response.

Medical Response

45. A nurse located in Swaleside's hospital provides medical cover at night. The nurse does not have access to keys and relies on being collected by someone else when there is a medical need within the prison. On the morning the man was discovered when staff requested medical assistance for him, the nurse was locked in the hospital still awaiting her relief and was unable to respond. There was a delay of around ten minutes before she arrived at the cell. This highlighted a flawed system that could lead to further delays in responding to medical emergencies. Since the man's death, the Governor's request for additional medical support at night has been approved.

    The Governor should consider locating the staff who provide medical support at night in an area where they will have unrestricted access to the wings. This would provide a faster response and prevent delays in administering emergency treatment.

Family Liaison

46. The efforts made by the governor who traced the man's family and the compassionate way in which she and her colleague dealt with the family before and after the death should be commended.

    I commend both governors for the compassion and support they showed to the man's family.

RECOMMENDATIONS

1. **The Head of Healthcare should ensure that the medical records are clear, concise, and continuous, in accordance with the Nursing and Midwifery Council's guidelines.**

   The Prison Service accepted this recommendation and said:

   Hand written records received from other prisons continue to have entries that are difficult to read. The move towards electronic record keeping is addressing this issue.

   A copy of all staff names, their designation, signature and initials is now routinely entered in the clinical record.

2. **The Governor should issue a Notice to Staff reminding everyone of the importance of writing clearly and concisely in documentation and signing and printing a name after all entries.**

   The Prison Service have not had the opportunity to respond to this recommendation.

3. **Where follow-up consultations are with healthcare staff members other than the doctor, there must exist lines of communication such as regular clinical meetings where specific diagnostic problems or management issues are discussed, ideas shared, and agreed plans of action drawn up. There should be a designated clinical lead e.g. the patient's registered doctor or prison medical officer who is ultimately responsible for the overall management of the patient.**

   The Prison Service accepted this recommendation and said:

   The Senior Medical Officer has overall clinical responsibility for patients at Swaleside.

   A review of patients is conducted by the nurse lead in association with the doctor.

4. **The Governor should review the actions of the OSG and Officer. He should also provide firm advice and guidance for all staff who carry out early morning checks. In particular, they should be advised that if there is any doubt about the wellbeing of a prisoner, they should seek a response.**

   The Prison service accepted this recommendation and said:

   A formal investigation has now been commissioned in order to review the actions of both the OSG and Officer.

5. **The Governor should consider locating the staff who provide medical support at night in an area where they will have unrestricted access to the wings. This would provide a faster response and prevent delays in administering emergency treatment.**

   The Prison Service partially accepted this recommendation and said:

   It would be inconsistent with security standards to provide any member of staff with unrestricted access to wings at night and the current healthcare location is as central as any other location.

   Alternative ways of providing a faster response to prevent delays will be investigated along with the opening of G wing.

6. **I commend both governors for the compassion and support they showed to the man's family.**