Investigation into the death of a man who was a prisoner at HMP Swaleside in October 2005

Report by the Prisons and Probation Ombudsman for England and Wales

July 2006

This is the report of an investigation into the death of a man who died from apparent natural causes on 2 October 2005 in outside hospital. He was 68 years old.

I would like to express my personal condolences to the man's family and friends. I know that my Family Liaison Officer has already expressed condolences on behalf of this office as a whole.

This investigation has been undertaken by one of my investigators. I would like to thank the Governor of HMP Swaleside and his staff for their participation in the investigation.

A doctor was commissioned by Swale Primary Care Trust to undertake a review of The man's clinical care, and I appreciate his assistance and endorse his recommendations. His review raises a number of concerns. I draw special attention to the absence of a referral to a cardiologist, in spite of the severity of the man's problems.

I have made a single recommendation in respect of family liaison, but my report also includes other advice to the Governor on this most sensitive of issues. Unfortunately, the man's family and the prison have different memories of what passed between them, and every effort should be made to try to prevent a recurrence of such problems in the future.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2006**

Summary

1. The man was born in 1937 and was 68 years old when he died on 2 October 2005. The man arrived at HMP Swaleside on 27 October 2004. He was received into custody after being sentenced to 23 years imprisonment.

2. At his first reception health screen, it was noted that the man suffered from angina and was on a waiting list for a triple heart by-pass operation. As a result of the problems with his heart, the man was prescribed a range of medication which he was allowed to keep in his possession.

3. At 6:45am on 2 October 2005, while counting prisoners for the roll check, an Officer Support Grade (OSG) looked into the man's cell and saw that he was lying in an unusual position. When the man did not respond, the OSG requested assistance from staff in the Operations Room.

4. Around 06:50am, the two Night Patrol Officers arrived at the man's cell. The officers entered the man's cell and, as they could not rouse him, one of the officers contacted the Operations Room to request medical assistance.

5. A Senior Officer and the Healthcare Senior Officer responded to the request for assistance and arrived at the man's cell around 6:54am. The Healthcare Senior Officer noted that, although the man was not breathing, he was warm. The Healthcare Senior Officer then requested that an ambulance be called while she commenced cardio-pulmonary resuscitation (CPR).

6. At 7:24am, the ambulance technicians arrived at the man's cell. The technicians continued with CPR and, after making a further assessment of the man's clinical needs, decided that he should be taken to hospital. The ambulance left the prison at 7:54am. The paramedic continued to try and resuscitate the man. Sadly, the man was pronounced dead on his arrival at outside hospital at 8:20am.

7. The clinical review notes that, although the man suffered from ischaemic heart disease, he could not find evidence of his care being efficiently managed. The reviewer says that this was despite the man, his family, his solicitor and prison officers raising concern about the man's health. The review makes five recommendations which I endorse.

8. One of my Family Liaison Officers contacted the man's family. Their concerns centred on the cause of the man's death and the clinical care provided by Swaleside prison.

9. The report lists the concerns of the man's family and other matters raised by prisoners. It details the response to these issues from the prison.

The investigation process

10. My investigator studied all relevant prison records relating to the man. These included his main prison record, his medical records and statements from prison staff.

11. My investigator issued notices to staff and prisoners and considered a number of issues raised by prisoners as a result.

12. A clinical review was commissioned by Swale Primary Care Trust (PCT). I am grateful to the reviewer for undertaking this review in a most timely manner.

13. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

14. One of my Family Liaison Officers met with the man's family in the company of my investigator. The family told them of their concerns which are considered later in the report.

15. My investigator discussed aspects of the man's treatment and the issues raised by his family with both staff at Swaleside and with the clinical reviewer. The clinical review finds that the care provided to the man fell short of what was acceptable, and makes recommendations for improvements.

HMP Swaleside

16. Swaleside opened in 1988 as a category B training prison. It accepts category B prisoners who are serving four years or more or who have at least 18 months left to serve. It has a total of 460 places for life-sentenced prisoners, being a main centre for prisoners in the first stage of a life sentence and accepting prisoners in the second stage of a life sentence. Swaleside has a high minority ethnic population of between 30 and 40 per cent. It also has a high proportion of foreign national prisoners.

17. Swaleside has an active regime with a focus on resettlement. The prison provides a range of accredited offending behaviour courses and other non-accredited courses, including victim awareness and anger management.

18. The Kainos Community Programme is also based within Swaleside. This is a rehabilitation programme where prisoners are allocated to a specific landing on B wing and where they live as part of a supportive community. The aim of the programme is to create a learning atmosphere that will help prisoners lead lives that are socially acceptable and positive. Course and group work as well as meetings are a part of the programme. The basic ethos of the Kainos Community is for individual prisoners to earn respect, both for themselves and others, and to regain a sense of self-esteem which they may have lost. All prisoners on the wing are located in single cells.

19. From 1 April 2004, the provision of healthcare within the prison became the responsibility of Swale Primary Care Trust. A medical officer provides primary health care and prescribes weekly or monthly administration of medication to prisoners who have been assessed as capable of holding it in their own possession. Medication is administered on a daily basis to other prisoners, when either they are considered to be at risk or the medication is unsuitable to be held in their cell.

20. The system for seeing the prison doctor changed during the summer of 2005. Prisoners now need to book an appointment in advance to see the doctor, and specific days are allocated for each wing of the prison.

Key Findings

21. The man arrived at Swaleside on 27 October 2004 and, after induction, was allocated a cell on B wing which includes the Kainos Community landing. During his health screen interviews, it was noted that the man had acute angina and was on a waiting list for a triple heart by-pass operation. Due to his heart problem, the man was prescribed a range of medication which he kept in his possession.

22. On 19 March 2005, it was noted that the man had a good visit with his daughters. Afterwards, while rushing to get his dinner, the man felt tightness in his chest and then gave himself a time out to relax. A Senior Officer organised a couple of volunteers to collect the man's dinner.

23. On 21 May, his peers elected the man as president of the Kainos Community. He was re-elected to this position on 20 July.

24. The man's personal officer made a number of entries on the man's prison history record which highlighted his concerns about the medical care provided to the man.

25. On 18 April, the personal officer wrote, "Is now due for medication mayhap he can pick up the tablets without mishap, we shall see on the morrow". On 1 May, the personal officer wrote, "yet again prescription renewal disappeared". When interviewed, the personal officer explained that there had been an ongoing issue over the man being able to collect his medication. The personal officer said that on a number of occasions the man's medication was not available, as healthcare had apparently not received his prescription renewal paperwork.

26. On 24 July, the personal officer wrote, "Tried in vain to get … to Healthcare ... Healthcare being pedantic when a more hands on approach may be more suited. The man is struggling for breath ...". The personal officer told my investigator that, at this time, the man had a chest infection and difficulty in moving around. The personal officer said that he and colleagues had unsuccessfully tried to get healthcare staff to come over to the wing to see the man. The personal officer felt that healthcare were creating barriers to the man getting medical support.

27. On 6 August, the personal officer wrote, “I feel that our [the prison’s] duty of care has been undermined by healthcare”. When interviewed, he stated that the man’s chest infection had got worse and staff on the wing were trying to arrange for healthcare to see him. When this issue was probed further, the personal officer admitted that he felt frustrated with the inaction of colleagues in healthcare. He also said that the man’s condition did improve after he saw the prison doctor later the same week.

28. During his interview, the personal officer was asked about what was done on the wing on a daily basis to make life easier for the man. He explained that the Kainos Community was a closed unit based on the ground floor and that the severy was on the next floor. He stated that the ethos of the Kainos community was to support each other and prisoners were happy to volunteer to collect the man’s meals for him. When asked whether a wheelchair had been considered to assist the man with his mobility problems, the personal officer replied that it had not although another prisoner who had been unable to walk had been assisted in this way.

29. On 11 August, healthcare staff at Swaleside contacted a hospital in London. They wanted to find out about how long the man would be on the waiting list for his triple heart by-pass operation as the man was unable to get hold of his medical paperwork. The hospital informed the prison that, as the man failed to attend an appointment with them in December 2003, he had been taken off the waiting list and would need to be referred back to the waiting list. On 19 August, the prison doctor wrote to the Cardio Thoracic Surgeon at the hospital in London, to request that the man’s name be put back on the waiting list for a triple heart by-pass operation.

30. My investigator asked the Healthcare Senior Officer why the man was not admitted to healthcare. She said that he refused, as he did want to move away from the Kainos Community.

31. According to the man’s family, after he attended court on 6 September he collapsed on his return to the prison. My investigator could not find any evidence to substantiate this collapse in the man’s medical or prison history records.

32. On 24 September, the man’s daughters visited their father and noticed that his breathing was laboured and his body, especially his legs, were swollen. There is no record of the man seeing medical staff about this problem on this occasion or at any time before his death.

33. In his interview, the personal officer stated that 1 October was his last day on B wing as he was moving to a new wing the following day. He recalled two incidents that happened that day. One of the prisoners said to him, "I never had … down as being a religious man." When asked why he replied, "Well, in the last couple of days he's been locking himself up in his cell." The personal officer said that staff had not noted this change in behaviour. The second incident was that the man was the last prisoner to be locked in his cell on the evening on 1 October. The man went up to the personal officer, shook his hand and said, "Thanks for your help. It's been a pleasure being with you. I don't suppose I'll see you again." The officer did not attach any relevance to this at the time but felt that it should be recorded by the investigation. The man's family stated that their father respected the officer and appreciated his support. They felt that this was why the man shook his hand and thanked him.

34. During one interview, a prisoner who had previously been part of the Kainos community, stated that on 1 October the man had given away ten of his yoghurts. The prisoner stated that this was out of character for the man as he never took or gave away anything to other prisoners.

35. At 6:45am on 2 October, while counting prisoners for the roll check, the Officer Support Grade (OSG) looked into cell B1-41 and saw the man lying in an unusual position. As the man did not respond when called, the OSG requested assistance from staff in the Operations Room. A Senior Officer dispatched the two Night Patrol Officers to assist the OSG.

36. The Night Patrol Officers arrived at the cell around 6:50am. They released the OSG to continue with his roll count duties and they attempted to get a response from the man. They saw the man was lying across the bed with his head against the wall and his feet on the floor and, as he did not reply to them, they entered his cell. When he did not respond to being touched, one of the officers contacted the Operation Room. On receiving the call for assistance, a Senior Officer proceeded to healthcare and collected the Healthcare Senior Officer who was gathering the resuscitation equipment.

37. Around 6:54am, the Senior Officers arrived at the man's cell. While one of the Night Patrol Officers was allocated to assist the OSG with the roll count, the Healthcare Senior Officer assessed the man. She noted that, although the man was not breathing, he was warm. She requested that an ambulance be called and then commenced cardio-pulmonary resuscitation (CPR) using an ambubag and oxygen.

38. At 7:24am, the ambulance staff (a paramedic and a technician) arrived at the man's cell and continued with CPR. After making a further assessment of his needs, they decided that the man could be moved. The ambulance staff decided to take the man to hospital and they carried him from his cell to their ambulance. The ambulance left the prison at 7:54am. An officer accompanied the man to the hospital. He sat in the front of the ambulance, whilst the paramedic continued to try and resuscitate the man.

39. The man was pronounced dead on arrival at outside hospital at 8:20am on 2 October 2005.

40. As is standard practice at Swaleside, the prison asked the police to inform the man's family of his death. Unfortunately, the police failed to fulfil this request. When the police visited the man's family or next of kin they used the wrong name and then did not attempt to contact any other family member. As a result, the Duty Governor contacted the family by telephone to inform them of the man's death. He also offered his condolences and support.

41. On 3 October, the prison appointed a family liaison officer. He maintained contact with the family and offered to assist with arranging the funeral and providing financial help.

42. From comments made by staff and prisoners at Swaleside, The man was a respected and well liked prisoner. He had been an effective advocate for his fellow prisoners and had appeared to be well suited to his role as President of the Kainos Community, a position to which he was re-elected. His popularity was further demonstrated by the fact that prisoners on his wing collected £185 after his death.

43. The post mortem states that the cause of death was due to natural causes as a consequence of ischaemic heart disease (obstruction or inadequate flow to the arterial blood supply to the heart). After the family saw the draft report of this investigation, the family pointed out that in the weeks following the man's death they were advised that during the post mortem there was evidence of a recent heart attack.

Issues raised by the family

44. The concerns of the man's family were focussed on the clinical care provided during his time in custody. They listed their concerns as:

    I. The man's lack of access to doctors and medication;
    II. The man not receiving timely follow up care after being given medication;
    III. Lack of timely follow up following his removal from the operation waiting list;
    IV. Failure to assess the man after he collapsed on 6 September, as this may have been a heart attack which would have needed medical intervention.

45. The family consider that these problems continued despite several attempts to get the necessary help, and despite symptoms which were obvious and included swollen legs and shortness of breath. The family said that, when they made attempts to contact the prison, the response was inadequate. After the family were told that a visit by one of the man's friends had been cancelled as he was unwell, they phoned the prison. The family explained the situation to the switchboard and asked to speak to the Governor but instead they were put through to the Chaplain's extension. They were unable to speak to anyone from the chaplaincy, as there was only an answerphone service. The family then tried to contact the prison by fax and via the man's solicitor. They felt that no-one had listened or responded to their concerns.

46. The contact the family have had with the prison since the man's death has raised further concerns. These include:

    - The way in which they were informed of the man's death and the delays which occurred. (I understand the delays were because the police used the wrong name when they tried to contact the family, and this meant that they were not notified until much later than would otherwise have been the case.)
    - The family could not collect the man's possessions after the Coroner released them as the Governor was absent. This also involved them in having to put pressure of the prison to release the possessions.
    - The family were not given the option of the possessions being delivered. This meant they had to visit the prison which they would have preferred not to have done.
    - When they went to the prison they were taken to meet the Governor which they had said they did not wish to do.
    - When they met the Governor, he was unaware of the man's medical history in spite of all their previous attempts to inform him of the issues. In the opinion of the family, the Governor did not extend them the courtesy of preparing for their visit.

Response from HMP Swaleside to issues raised by family

47. The prison says that the man did have access to the doctor as per published procedures. Swaleside stated that the man was seen by the prison doctor on 28 October 2004, 5 April 2005, 28 July, 1 August, 19 August, 12 and 19 September, a locum Medical Officer, on 5 November 2004, the Senior Medical Officer, on 15 May 2005 and a locum Medical Officer on 11 August 2005. The prison confirmed that follow up care was reviewed by the prison's cardiac nurse, on 25 November 2004, and was reviewed three months later on 25 February 2005 and then again on 23 August.

48. In response to the concern about follow up of the removal of the man's name from the operation waiting list, the prison says that they relied upon information provided by the man when he came into custody. Like the clinical reviewer, I consider that a more pro-active approach should have been taken. This was particularly after the man advised the healthcare worker during his reception screening that he had cardiac problems. The prison have now revised their policy for when prisoners first arrive at the prison and now ensures that all external appointment are verified.

49. The prison confirmed that the man was taken to Bow Street Magistrates' Court from Swaleside in September 2005. The prison stressed that if the hearing was cancelled, and the man was not required, it was the responsibility of the court to inform the prison. The prison also says that it is mandatory that anyone whose presence is commanded by a court must be presented. The prison was not aware that the man collapsed after the court visit, and could not find any record in his medical or prison history records.

50. Swaleside says that they did respond to the concerns raised in correspondence from the family. My investigator found evidence to confirm this although, as the clinical reviewer concluded, it did not result in a review of the man's medical care. I feel this would have been a good opportunity to review and address the issues regarding the man's medical care raised both by the family and by wing staff.

51. The prison says that, when the police failed to inform the family of the man's death, the duty governor decided that it was appropriate for him to notify the family rather than them hear from another source.

52. The prison says they informed the family that the man's belongings could not be released until permission had been granted by the coroner's office. Subsequently, the family were informed that the man's possessions could be released, the post mortem having confirmed the cause of his death as natural causes. After the family received the draft report of this investigation they also confirmed that there had also been an issue about when the man's body could be released after his death. The prison stated that it was not possible to release the man's body before the 7 October whereas the Coroner's office advised differently.

53. In response to family's statement that they were not offered the opportunity of delivery of the possessions, Swaleside says this could have been arranged had the family made such a request. After the family received the draft report of this investigation, the family stated that they felt that the prison had acted insensitively in this matter. I have made a recommendation concerning this matter.

54. The prison states that, when the family visit took place, they were offered the opportunity to meet several people key to the man's life whilst he was at Swaleside. The family declined the offer and, according to the prison, did not say they did not wish to meet with the Governor. The prison said that, if this had been made clear, the meeting would not have taken place. After the family received the draft report of this investigation, the family added that they had also requested that the man's possession were moved to a private area so that they could spend some moments with them.

55. The prison has not commented on the meeting between the family and the Governor.

56. What actually happened in respect of some of these matters cannot now be ascertained with any certainty. Nevertheless, I feel that there are lessons to be learned. In the event of future deaths, the prison should consider putting in writing the results of all discussions to ensure that there is a clear understanding of what has been agreed. This will avoid situations where either party may misinterpret what has been said.

57. I also suggest that families are offered the opportunity for their relative's belongings to be forwarded to them. This will avoid family members having to go to the prison to collect them if they do not wish to.

Issues raised by prisoners

58. Those prisoners who had asked to be seen by my investigator drew his attention to issues that they felt needed to be addressed. These included:

    I. the difficulties experienced with the application process for a healthcare appointment;
    II. cell bells allegedly not being responded to promptly;
    III. the alleged termination of the cardio health clinic;
    IV. prescribed medication not being available.

59. My investigator raised the above issues with the prison and discussed them with staff during interviews.

60. Since the man's death the prison has taken action to make the application process for a healthcare appointment clearer. Swaleside also pointed out that, where there was a need for an immediate appointment, this would be catered for.

61. My investigator was assured that staff responded promptly when the bell was rung. However, no cell bell records are kept by the prison as the electrical system indicates when a cell bell is pressed but this does not record any information. As a consequence, my investigator was unable to substantiate the allegation of a poor response by staff to cell bells. I can make no finding on this matter, but it is something the Governor and the prison's Independent Monitoring Board will wish to keep under review.

62. In contrast to what my investigator had been told by prisoners, the prison said that they still have a well managed cardiac clinic. The nurse sees those who are referred to her by whatever route: for example, those identified via reception screening, the well man clinic or from the GP surgery. The nurse also continues to offer advice on healthy living, and monitors and reviews prisoners' care and offers regular follow-up appointments. After the family received the draft report of this investigation, the family drew attention to the point that the nurse who dealt with the man nearly always turned down his requests for a screening with the prison doctor.

63. In relation to the suggestion that prescribed medication is not available, this point was discussed in detail with the man's personal officer and the Senior Health Officer during their interviews.

64. The personal officer pointed out that there had been occasions when the man's medication had not been ready for collection. He said he had raised his concerns with healthcare staff, sometimes on a daily basis. In her interview, the Senior Healthcare Officer acknowledged that there were difficulties with how the man administered his medication. She said that the man took more of his prescribed tablets than was recommended. She also said that this had been drawn to the man's attention but, as there had been no adverse effects, no other action had been taken.

Clinical review

65. The clinical review concluded that the man's care was not of an appropriate standard as it did not match the seriousness of his condition. The reviewer noted that it appeared that a doctor did not have responsibility for the man, and found it of concern that he remained on the wing rather than in the healthcare centre. The reviewer also found evidence of the man's medication being unavailable because prescriptions were missing.

66. The reviewer concluded that assessment by nursing staff should not bar access to medical treatment in such a way as to compromise health. The reviewer stated that it should not screen out those who need to be medically assessed and followed up.

67. The reviewer found the system whereby the doctor only sees patients he is informed of to be unacceptable. He considered that doctors should be pro-active in caring for patients with serious problems who may be unwilling or unable to go to them. The reviewer noted that nothing prevented the doctor from seeing the man on the wing and in his cell.

68. The reviewer also noted that, considering the concerns raised by the man's family and others, early medical responsibility should have been identified and a second opinion sought from outside hospital. This would have meant that the man's removal from the waiting list for a heart by-pass operation would have been noted earlier, and more likely to have been acted upon.

Recommendations

Policy

1 The role and responsibilities of the family liaison officer should be defined in accordance with the new Prison Service Order.

Health

2 A review of the nurse triage process should be undertaken and a system for clinical audit implemented to monitor its effectiveness and compliance with local triage policies.

3 Doctors need to be pro-active in caring for patients with serious problems who are either unwilling or unable to be in the hospital wing.

4 Early medical responsibility should be identified and a second opinion requested when necessary from local secondary care providers.

5 The clinical leadership at HMP Swaleside should be reviewed.

6 There is a need for a clinical governance committee, where untoward incidents can be investigated in a non judgmental atmosphere, and where key findings are translated to time-tabled action with post-incident reviews.