Investigation into the circumstances surrounding the death of a man at hospital, whilst a prisoner at HMP Ranby, in October 2009

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of an investigation into the death of a man at HMP Ranby in October 2009. He was 58 years old and had been in custody since 1983. At 8.10am, an alarm bell alerted staff to a problem in billet 3, the living quarters where he was located. Officers found him sitting on the floor and he informed them that he was having chest pains. An emergency ambulance took him to hospital and, after initial treatment, he was moved to the Intensive Treatment Unit (ITU). However, at 12.40am, he had a further cardiac arrest and despite attempts by medical staff to revive him, he was pronounced dead at 12.55am. I would like to offer my condolences to the man's family and friends for their loss.

One of my investigators conducted the investigation. The local Primary Care Trust was asked to conduct a clinical review into the standard of healthcare the man received in custody. A Clinical Governance Lead and General Practitioner (GP), along with the Head of Quality at the PCT carried out this review and their report is attached in full as an annex.

I would like to thank the Governor of Ranby and her staff for their co-operation and assistance with the investigation.

The man had a family history of ischaemic heart disease and both his parents had died at a young age after heart attacks. He had spent over 20 years in prison. Throughout this time, he made it clear that he had no wish to have contact with healthcare services despite being encouraged to do so. He had been at Ranby since September 2008 and during this time the healthcare team had not treated him.

Overall, I consider the treatment afforded to the man to have been appropriate. However, the clinical review highlights the need for a chronic disease management clinic at Ranby, as well as concerns that medical information held in paper form is not lost when copied to new IT systems. Offender Health has commented on this issue in response to the draft report and their comments have been added to the relevant section of this report. The review also questioned documents being held inappropriately with medical records. The Prison Service accepted the recommendation made in the draft report and their response is highlighted in this report.

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.

Jane Webb
Deputy Prisons and Probation Ombudsman **March 2010**

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SUMMARY

The man was remanded into custody in April 1983. Later the same year, he was convicted of murder and sentenced to life imprisonment. When he entered custody, he highlighted no immediate medical concerns, but told medical staff that he had a family history of chest problems. Both his parents had died relatively young as a result of heart problems.

In the first couple of years, the man raised no medical concerns. In August 1986, while at HMP Gartree, he was admitted to the Infirmary, after complaining of chest pains. Following examination, he was diagnosed as having had a myocardial infarction (heart attack) and provided with medication. He was a smoker and, despite his chest problems, continued to smoke throughout his sentence.

Several years later, the man was diagnosed with angina and given medication to alleviate the symptoms. However, he had a long history of not complying with his medication regime. In addition to not taking his medication regularly, he chose to have little contact with the healthcare department throughout his time in prison. He reported a phobia of needles and, despite advice to the contrary, he told medical staff that he had no wish to have blood tests.

The man moved to a number of prisons during his time in custody. On each occasion, he was seen on his arrival and a record made of previous medical history. When he transferred to HMP Ranby in September 2008, he was again seen on his reception and it was noted that he was receiving no medication. He expressed no concerns and had no further contact with healthcare during his time there.

At 8.10am in October 2009, staff were alerted by an alarm on billet 3, the unit where the man lived. They found him sitting on the floor complaining of chest pains. Medical staff and an ambulance were called and attended immediately. A prison nurse gave him initial first aid before he was taken to hospital by emergency ambulance. He was admitted to the Intensive Treatment Unit (ITU), where at 12.40pm he had a further cardiac arrest. Despite the efforts of medical staff to revive him, he was pronounced dead at 12.55pm.

Two recommendations in relation to medical records were made in the draft report, both of which have been responded to by Offender Health and Prison Service. The actions of the appointed prison's Family Liaison Officer (FLO) in trying to trace a next of kin for the man should also be commended.

THE INVESTIGATION PROCESS

1. The investigator opened the investigation on 29 October, when he contacted the prison and spoke with the Governor. He discussed the documentation that he would require and arrangements were made for this to be forwarded. Notices were issued to staff and prisoners informing them of the investigation process and inviting anyone who had relevant information to come forward. No responses were received.

2. The local Primary Care Trust (PCT) was asked to conduct a review of the medical care afforded to the man in custody, particularly at Ranby. A Clinical Governance Lead and GP, along with the Head of Quality at the PCT, conducted the review and their report is attached as an annex.

3. The man had nominated no next of kin and none were identified by the prison despite attempts being made by the prison's nominated Family Liaison Officer. The Ombudsman's Assistant Family Liaison Officer was appointed to deal with any emerging family issues.

4. The investigator wrote to HM Coroner to inform him of the nature and scope of the investigation. A copy of the report will be provided to the Coroner to assist with his enquiries and the inquest process. The post mortem report indicated that the man died as a result of myocardial infarction as a result of coronary artery atherosclerosis.

HMP RANBY

5. HMP Ranby is an adult male training prison located on the outskirts of Ranby, Nottinghamshire. Holding sentenced category C prisoners it is a large site, incorporating both new and old accommodation as well as workshops. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Category C prisoners are those who cannot be trusted in open conditions, but who would not have the ability or resources to make a determined escape.) The prison also has a large plastics factory where prisoners are able to work various shifts making a variety of plastic items that are used across the wider prison estate. All prisons are given quarterly performance markings and Ranby is currently level 3, which indicates good performance.

6. Some of the older accommodation at Ranby was used in the prisons former guise as a military camp. The 'billet' style huts provide accommodation for those prisoners who work in the plastics factory and offer them more responsibility with fewer officers present.

7. There have been four previous deaths at Ranby since the Ombudsman was given responsibility for investigating all deaths in custody in 2004. Of these, two were self-inflicted and two were due to natural causes. Recommendations following these investigations highlighted concerns with medical record keeping, which are not repeated in this investigation report.

8. HM Chief Inspector of Prisons completed a full inspection of Ranby in March 2007. She said of healthcare provision at the prison:

> "… Healthcare provision at Ranby had developed well, and prisoners had good access to a wide range of clinical services. Highly qualified staff delivered a good standard of care and were committed to progressing the service, but many felt frustrated at the lack of support at a strategic level for health services. The department was extremely busy and nurses were employed on non-clinical duties. Wing-based treatments were in place, but the volume of prisoners who attended treatment rooms was, in some areas, overwhelming and prisoners were very demanding. The Primary Care Trust directly commissioned GP and mental health services, and the prison had an overarching clinical governance framework with relevant policies. There was good access to GP clinics. The mental health service was slowly developing, although there was a lack of structured primary mental health systems and staff could only deliver primary mental health care when other pressures permitted. Pharmacy provision had improved since our last inspection, and there were excellent dental services, despite major faults in equipment. A large number of prisoners failed to attend dental appointments …"

9. The Prisons Act 1952 requires all prisons to be monitored by an independent board appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The Independent Monitoring Board (IMB) at Ranby published their last annual report in March 2009. In relation to healthcare, the IMB acknowledged that some progress had been made in this area, with the refurbishment of the healthcare centre providing additional space. However, the Board also expressed concerns about the lack of 24-hour healthcare services at the prison. The IMB felt that this was unacceptable in a prison the size of Ranby, which is one of the largest Category C prisons in the country.

KEY FINDINGS

10. The man was received into prison custody at HMP Brixton in April 1983 as a remand prisoner and sentenced to life imprisonment in October of that year. This was not his first time in custody. He was 58 years old when he died.

11. When he went into prison, the man reported no significant medical problems although he spoke about a family history of chest problems, having lost both parents to heart attacks. After he was sentenced, he moved to HMP Gartree, a designated prison for life sentenced prisoners. At Gartree, he underwent assessments to address his offending behaviour with a view to release on parole.

12. On 17 August 1986, the man was admitted to the Infirmary after complaining of chest pains. It was recorded that he smoked around 30 cigarettes a day and had a family history of ischaemic heart disease (ischaemic refers to a reduced blood supply.) He was recorded as having suffered a myocardial infarction (heart attack) and following treatment, he made a good recovery. He was given glyceryl trinitrate (GTN) spray, which is used to alleviate the symptoms of angina.

13. Over the next 14 years, the man moved to various prisons. During this time, he had little contact with prison healthcare departments. His progress with his sentence was not without problems. In March 1993, he absconded from custody at HMP Erlestoke, which resulted in any possible parole release being delayed. Each time he moved to another prison, medical staff assessed him as part of the reception process and his recorded history. It was also noted that he continued to smoke. On some occasions, he declined to be seen by a doctor saying that he did not feel it necessary. Apart from initial health screenings, his interaction with medical staff was minimal.

14. On 13 May 2000, at HMP Featherstone, the man again complained of chest pains. He told medical staff that he had not used his GTN spray as it gave him headaches. He was given a new spray and, after being assessed by the prison doctor, he was admitted to hospital. Following an examination, he was diagnosed as having unstable angina and prescribed further medication to relieve the symptoms before being discharged. He continued to transfer to various prisons in order to complete offending behaviour work.

15. While at HMP Dovegate in April 2002, a doctor who assessed the man recorded that since being admitted to hospital in 2000, he had not had any further chest problems. He told the doctor that he had been taking medication for angina but had stopped taking it of his own accord. He provided no clear reason for not wishing to take the medication and the doctor explained to him the consequences of not doing so. Following the assessment, further appointments were arranged for him to attend the healthcare department at various times in order for his cholesterol to be checked, but he declined to attend on each occasion.

16. The man transferred to HMP Risley in October 2003, and again was seen on his reception by medical staff. Due to his history of heart problems, staff arranged for him to have regular blood tests and the importance of them was explained to him. However, he told nursing staff that he had a phobia of needles and had no wish to attend in the future. He also said that he would not take any medication other than his GTN spray and signed a disclaimer to this effect. There was little contact with healthcare services at Risley after this.

17. In March 2005, the man reported sick at Risley and was spoken to by a nurse. He explained that he had been experiencing chest pain and pains down his arm for around eight days but this had eased off. He told the nurse that he had not taken any medication for "months" and had a fear of needles. It was recorded that he continued to smoke and his diet was good. At the time, he was working in the prison kitchens. He agreed to begin taking aspirin again, his GTN spray, and a follow up appointment was made with the GP. No further problems were recorded at Risley.

18. A transfer to HMP Sudbury took place in September 2006. Again, all past medical history was recorded as well as the fact that the man had not previously taken his medication. It was recorded that he had very little contact with the healthcare department at Sudbury, but would occasionally attend to collect medication. In June 2007, he escaped from Sudbury and after returning to custody the same month, was taken to HMP Birmingham. As in other prisons, at Birmingham he had minimal interaction with healthcare staff and reported no chest problems. He remained at Birmingham until 12 September 2008 when he transferred to HMP Ranby.

19. At Ranby, the man's medical screening recorded his past history and that he was not taking any prescribed medication. He was not considered high risk of serious illness and highlighted no medical concerns. He had no further contact with healthcare staff. He worked on the night shift in the plastics factory located within the prison and his general behaviour was considered good.

October 2009

20. On a morning in October at 8.10am, two officers responded to an emergency alarm call in 'billet 3'. When the officers went into the billet, they found the man sitting on the floor. He told them that he had pains in his chest and arm and thought that he was having a heart attack. The second officer immediately radioed for medical assistance informing the control room that a prisoner was having a suspected heart attack.

21. A nurse was on duty in the healthcare centre when he heard the call for medical assistance. He immediately went to billet 3, taking with him a defibrillator and other emergency equipment. A defibrillator is a machine that can restart the heart by giving an electric shock in some cases of cardiac arrest. An ambulance had been called which the nurse was aware of. He said that when he arrived the man was conscious and in obvious pain. The man described having central chest pain, which also went down his left arm. He told the nurse that he had felt the pain for about five hours but had not asked for

any help. The nurse gave him oxygen and checked his pulse. He said that at this point the man vomited and, almost at the same time, the ambulance staff arrived. It was now 8.20am. The nurse helped ambulance staff to get the man into a chair so that he could be moved to the ambulance. Once in the ambulance, paramedics continued to treat him. Two members of staff were instructed to go in the ambulance with him, no restraints were used and the ambulance left the prison at 8.30am.

22. The man arrived at hospital at 9.00am. He was given treatment to stabilise his condition before being moved to the Intensive Treatment Unit (ITU). His condition remained serious and at 12.40pm, he suffered a further cardiac arrest. Despite the best efforts of the medical staff he was pronounced dead at 12.55pm.

23. Following notification of the man's death, Ranby appointed a Family Liaison Officer. She liaised with the police, Public Protection Casework Team and the man's solicitor and offender supervisor in trying to trace his next of kin. Over the following few weeks it became evident, that his contact with the outside community had been severed some years earlier.

24. In addition to her attempts to trace a next of kin, the Family Liaison Officer liaised with the Coroner's office, and spoke with other prisoners that had known the man. A celebration of the man's life was held at the prison on 29 October also organised by the Family Liaison Officer, and a book of condolence was opened.

25. When it became apparent that no next of kin were likely to be identified or traced, the Family Liaison Officer made all the necessary arrangements for the man's funeral, organising a wreath to be sent on behalf of the prison. The funeral took place on 19 November, attended by a number of staff from Ranby, of all grades.

26. While sorting the man's property, the Family Liaison Officer discovered correspondence to him from other prisoner's that were located at other prisons around the country. Although not a task that she was expected to carryout, she wrote to the prisoners and notified them of his death.

ISSUES

Medical records

27. Due to the length of time that the man had been in custody his medical record was quite extensive, in spite of the limited contact with healthcare staff. There were various notes from all of the prisons in which he had served. These were difficult to read as they had become mixed up and there appeared to be little chronology. In addition to his medical notes, his record contained a large number of psychological reports. Given they appear to have no medical significance and describe the details of an individual's offence in graphic detail, I question the propriety of them being stored within the medical record. The clinical review team also makes reference to this in their report:

> "… The medical records reviewed were a combination of previous handwritten medical notes, computer generated notes and the notes made on the day of death by both hospitals. There were also many psychological reports prepared, for parole boards. It is questionable on confidentiality grounds as to whether these should have been held with his medical record …"

28. The clinical review team made the following recommendation, which I have slightly recast.

    The Head of Healthcare should review the policy on inclusion of psychological assessments in medical records.

29. Nationally, prison healthcare services are in the process of removing paper medical records in favour of a computerised system used in community health practices. This requires information held in paper records to be input into the new system. This is a time consuming task and the investigator was told that this cannot be given priority at Ranby. It is possible that prisons that do not yet operate the new systems could receive a prisoner with a long medical history, but miss some of this information as they still rely on paper records. The clinical review team refer to this in their report:

> "… Ranby reported that some prisons are now removing paper records from use entirely, and not forwarding them on when a prisoner is transferred. If the prisoner's computerised records are inadequate, it then may be a self-reported history that becomes the entire medical history. In the man's case there were no medical records regarding him at all from October 2007 until his arrival at Ranby in September 2008 …"

    Although the clinical review team found that prisons within the region had set up a process for sharing information, I am unaware of a similar national initiative. Availability of clinical records is particularly important as the prisoner population is ageing as is the number on life or indeterminate sentences. The clinical review team have recommended that "prisons [and healthcare] work collaboratively to transfer key information held in paper records on to the new

computer systems to ensure that information is not lost when prisoners are transferred". I appreciate that this would require a huge investment in resources. I draw the matter to the attention of the National Offender Management Service and to Offender Health.

Chronic disease management

30. The man had been diagnosed with chest problems for a number of years. It is clear that he chose not to have contact with the healthcare services in prison and seldom took his prescribed medication. During the investigation, it became apparent that HMP Ranby does not have a Well Man clinic. When asked about this, the Head of Healthcare said that a Well Man clinic is scheduled as part of the healthcare programme at Ranby. This would highlight prisoners with perceived chronic illness and they would be invited to attend. However, he told the investigator that the clinic had been suspended due to staff shortages and priorities elsewhere. He also said that while priority in this clinic would be given to those suffering from chronic illness, the man did not fall into this category. The clinical review team comment on this in their report:

> "… While the reviewers do recognise that there are strong competing priorities within the prison health services, chronic disease management clinics should be established, based on the commonly understood read codes. A basic framework for this is held within the GMS contract Quality and Outcome Framework. Given his history of non-compliance, it is possible that attempts to engage this particular individual would not have been successful in changing this outcome, but it should have been tried …"

31. I make no recommendations in relation to this, as it is clear that the services are scheduled to be delivered. However, I urge the prison and local PCT to work together to find a way for this important service to be delivered regularly.

Medical response in October 2009

32. The clinical review team concluded that as soon as staff at Ranby were aware the man was suffering from a suspected heart attack he was dealt with quickly and appropriately by all concerned. I agree with their conclusion.

Family Liaison

33. The man for reasons known only to himself and his family had severed all ties some years ago. This made it difficult for the prison and particularly the Family Liaison Officer to trace them after his death. It would have been easy for her to conclude early on that attempts to trace the family were unlikely to be successful and give up. However, it is clear that this was not the case and her actions in making tireless attempts to find a next of kin and ensuring that those friends that were identified were notified, should be commended. Her actions are I believe a demonstration of good practice and I urge the Governor to share my comments with her.

CONCLUSION

34. The man had been aware of his medical problems since suffering a suspected heart attack in 1986. Prior to this, he knew of his family history of chest problems and that this put him at greater risk. His medical history clearly shows that he took little responsibility in alleviating the potential risks. Even after subsequent chest problems he continued to smoke, and was reluctant to have health checks. At Ranby, he had no contact with healthcare apart from his initial health screen and reported no problems of any kind whilst there.

35. Given his previous refusal to attend clinics in other prisons, it is likely that even if offered at Ranby, he would have declined. I am satisfied that the care he received in prison was appropriate.

RECOMMENDATIONS

1. The Head of Healthcare should review the policy on inclusion of psychological assessments in medical records.

   In response to the draft report, the Prison Service accepted this recommendation and said:

   '… A policy has been implemented that all medical records of prisoners coming into Ranby will have any psychological assessments removed and guidance sought from the healthcare managers as to its appropriateness for inclusion in this medical file …'

2. The National Offender Management Service should develop a policy and process to ensure that prisons across the service work collaboratively to transfers key information held in prisoner's paper medical records to new computer systems. This is to ensure that information is not lost on any subsequent transfers.

   In response to the draft report, Offender health responded and said:

   '… Offender Health and the Prison Health IT programme have considered the important issue of summarising paper based primary care clinical records, which would include inmate medical records currently held in a prison and those received as part of a prisoner transfer. It would also include GP records received in paper format from the community. This issue is important to support continuity of care.

   There are established standards of summarising Primary Care records, which have applied in the community for many years as GP clinical records have become almost universally computerised. As such, the quality expected is firstly that paper based, clinical records should be transferred to the prison health care clinical IT system. The standard and approach should be decided and agreed by the local prison/PCT Partnership Board and there should be a clinical governance approach to assure the quality of the work. Who does the work, admin staff, nurses, medical students, doctors, will be determined by these discussions and relate to local capacity and resources …'

GOOD PRACTICE

1. The actions of the Prison Family Liaison Officer should be commended and highlighted as good practice.