Investigation into the circumstances surrounding the death of a man, who was a prisoner at HMP Swaleside, on 17 December 2005

Report by the Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the death of a man who died from apparent natural causes on 17 December 2005 in outside hospital. He was 59 years old.

I would like to add my personal condolences to those already expressed to the man's family by my Family Liaison Officer.

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 and willing assistance.

Swale Primary Care Trust was asked to conduct a clinical review of the man's care in line with my terms of reference. I am disappointed that the review did not deal with the issues raised by the family and did not comment on the medical care provided to the man. I draw this to the attention of Prison Health. In addition, the Coroner may wish to consider calling someone from Swale Primary Care Trust to the inquest on the man to comment on the clinical care he received.

I make two recommendations in this report. One relates to the quality of the clinical review. Much more positively, the other reflects the good, kind and sensitive practice shown by Swaleside towards the man and his family.

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 **October 2006**

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Summary

1. The man was born in 1946. He was 59 years old when he died on 17 December 2005.

2. The man was received into custody after being sentenced to 18 years imprisonment. He was initially held at HMP Belmarsh before being transferred to HMP Swaleside on 21 September 2004.

3. At his first reception health screen, it was noted that the man suffered from diabetes and Crohn's disease (an inflammatory disease of the gastrointestinal tract). As a result of his health problems, the man was prescribed a range of medication which he was allowed to keep in his possession.

4. On 10 December 2005, the man was taken to outside hospital. Whilst he was an in patient at the hospital, a bedwatch was carried out by prison officers. The security risk assessment identified that a closeting (escort) chain was used. However, this was removed when the man's condition started to deteriorate, shortly before his death, on 17 December.

5. A doctor was identified by Swale Primary Care Trust, to carry out a clinical review of the care provided to the man.

6. On 10 January 2006, 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 the outside hospital.

The investigation process

7. 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.

8. My investigator contacted Swale Primary Care Trust who identified a doctor to carry out a clinical review of the care the man received while in prison. The review was completed but did not address issues raised by the family and did not comment on the quality of medical care the man received whilst in custody. I am disappointed that the review did not address these issues.

9. 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.

10. One of my Family Liaison Officers contacted the man's family. The family told her of their concerns, which are considered later in the report.

11. My investigator discussed aspects of the man's treatment and the issues raised by his family with both staff at Swaleside and the clinical reviewer.

HMP Swaleside

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

13. 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.

14. 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. Medication is administered on a weekly and/or monthly basis to those prisoners who have been assessed as suitable to manage their own administration. It 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.

15. 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.

16. There were three deaths from apparent natural causes at Swaleside during 2005.

Key Findings

17. The man arrived at Swaleside on 21 September 2004 and, after induction, was allocated a cell on F wing. During his health screen interviews, it was noted that the man had diabetes and Crohn's disease. Due to his health problems, the man was prescribed a range of medication which he kept in his possession.

18. On 25 September 2005, the man was taken to outside hospital to attend a consultation with a Consultant Physician and Gastroenterologist.

19. On 2 November, the man's son moved onto F wing. He had been moved from another prison to be closer to his father.

20. During the morning on 7 December, the man was found lying on the floor of his cell. His son and officers helped him back onto his bed. The man was asked if he wanted to go the Healthcare Centre, but he declined.

21. However, two days later on 9 December, the man was moved to the Healthcare Centre. He was accompanied by his son who stayed with him while he settled in.

22. At 3:40pm on 10 December, it was decided that the man needed to be transferred to hospital for further assessment. He arrived at the outside hospital at 4:30pm and was moved onto a ward at 10:20pm.

23. Once the man was settled on the ward, a closeting (escort) chain was used instead of handcuffs. This was entirely appropriate and enabled the nursing staff to have easier access when they carried out their duties. While the man was an in patient at the hospital, a bedwatch was carried out by prison officers.

24. On 14 December, doctors at the hospital stated that the man had a chest infection and pneumonia at the base of both of his lungs. The man was visited by his family on 16 December.

25. On 17 December, the man slept most of the morning and missed his lunch, but had some chocolates. He fell asleep again at 1:00pm. Officers noted at 2:30pm in the bedwatch log that the man had been talkative and fully co-operative whilst he had been awake. When a nurse checked on the man at 3:20pm, she noted that he had stopped breathing. The man's restraints were removed and attempts were made to try to resuscitate him. These were unsuccessful and he was pronounced dead at 3:40pm.

26. A Senior Nurse from the outside hospital immediately informed the man's family, by phone, of his death. The Principal Officer, who was on bedwatch duty, informed the prison control room. The duty Governor and Head of Residence, informed the wing where the man was located. The manager on the wing informed the man's son of the death and he was allowed to make a phone call to his mother.

27. The Principal Officer met the man's family when they arrived at the hospital and offered his condolences and support. The man's daughter informed the officer that her husband was also located in Swaleside. The officer notified the prison and the man's son-in-law was informed of the death. It was noted on the man's son-in-law's record that he was fine, as he had expected the news.

28. The prison's family liaison officer maintained contact with the family and offered to assist with arranging the funeral and providing financial help. The prison family liaison officer also invited the man's wife to the prison where she met with prisoners and staff and visited her husband's cell.

29. The post mortem states that the cause of death was due to natural causes as a consequence of bronchial pneumonia (inflammation of the lung), chronic pulmonary (lung) disease and chronic pancreatic (intestinal) disease.

Issues raised by the family

30. The man's family told my Family Liaison Officer that their concerns were mainly focussed on the clinical care provided during his time in the outside hospital. Their concerns were:

    I. The man's insulin being changed by the hospital the day before his death and the possible impact of this change of medication.
    II. The sister at the hospital not having any information about the shadow on the man's lungs. This was a concern because both the man and the doctor in the hospital were aware of this.
    III. The way in which the hospital notified the family of the man's death.
    IV. The fact that that the man's son informed his mother that her husband had been taken to hospital.

31. The prison was asked to comment about how the family was notified that the man had been taken to hospital. Swaleside was unable to explain why it was the man's son who informed his mother that her husband had been taken into hospital.

32. My Family Liaison Officer explained that the other issues concerning the man's treatment whilst in hospital were outside the remit of our investigation. However, she agreed that they would be forwarded onto the clinical reviewer.

33. The family also drew my Family Liaison Officer's attention to some of the positive practices employed by Swaleside. These included:

    I. Moving the man's son from another prison so that he could spend more time with his father.
    II. Giving permission for the man's son to attend his father's funeral and allowing him to sit next to his mother.
    III. Handing back the man's belongings in a timely manner.
    IV. The excellent support they received from the prison family liaison officer, where he kept in regular contact with the family.
    V. The sensitive way in which the man's wife's visit to the prison was handled including the prison flag being at half mast during their visit.

34. The family were also grateful that the officers who escorted the man's son to the funeral were sensitive and unobtrusive.

Clinical Review

35. The clinical review of the care provided to the man whilst in prison has now been completed. However, the reviewer did not look at the care given to the man whilst he was in outside hospital, which the family had raised as an area of concern. The review also did not give any opinion on the quality of care provided to the man whilst he was in custody. My investigator has therefore not been able to consider any of the clinical issues about the way the man was cared for by the prison and it has not been possible to provide the family with answers to the question they have raised.

    The Head of Prison Health should ask the Chief Executive of the Swale Primary Care Trust to arrange an urgent review into the clinical care received by the man. The review should specifically consider the issues raised by the man's family.

Conclusion

36. The man died from natural causes. It was not relevant that he was a prisoner at the time of his death.

37. From comments made by staff and prisoners at Swaleside it seems that the man was a respected and well liked man. His popularity was further demonstrated by the prisoners on his wing who spoke to the man's wife when she visited the prison after his death.

38. In reviewing the bedwatch log, it is clear that the staff involved with the man's care behaved with sensitivity. The security arrangements at the hospital seem to have been appropriate, and struck a good balance between public protection and sensitivity to the needs of someone in the last stages of life.

39. The comments from the family relating to Swaleside's treatment of the man (paras 33-34 above) reflect well upon individuals, their place of work, and the Service they represent. I draw attention to the good practice of allowing the man's son to be allowed to move to Swaleside so that he could be closer to his father and spend more time with him. I also commend the sensitivity employed by the prison in allowing the man's son to sit with his mother at his father's funeral, and the compassion shown to the family when they visited the prison after the man's death.

    The Governor should draw the attention of all staff to the findings of this report at paras 33, 34 and 39.

Recommendations

The Head of Prison Health should ask the Chief Executive of the Swale Primary Care Trust to arrange an urgent review into the clinical care received by the man. The review should specifically consider the issues raised by the man's family.

The Governor should draw the attention of all staff to the findings of this report at paras 33, 34 and 39.