

**Investigation into the death of a man in hospital whilst in
the custody of HMP Swaleside, in January 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

July 2009

This is the report of an investigation into the death of a man, a prisoner at HMP Swaleside. He died in January 2009 in hospital from natural causes. He had been admitted to the hospital three days earlier. He was serving a life sentence for murder.

I would like to add my personal condolences to those already expressed to his family on behalf of this office by my former Senior Family Liaison Officer.

This investigation was undertaken by one of my investigators. In addition, a General Practitioner was asked by the local Primary Care Trust to undertake a review of his clinical care. I am grateful for the assistance they both received from staff at HMP Swaleside and would ask the Governor to pass on those sentiments.

The man's family has expressed concerns about his care and treatment which I have considered carefully. However, the clinical reviewer concludes that the man's care was of an equivalent standard to that he would have received in the wider community. I hope that his family are reassured by the conclusions of my report.

I judge that the man was well looked after by staff at Swaleside. I make no recommendations.

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.

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Prisons and Probation Ombudsman

July 2009

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SUMMARY

The man was born in 1934. He was 74 years old when he died in hospital in January 2009. His death was from natural causes as a consequence of bronchopneumonia, cerebral infarction and ischaemic heart disease.

The man was first received into custody (on remand) at HMP Gloucester in late March 2002 and transferred to HMP Bristol in early April 2002. He was sentenced at court in June 2002 to life imprisonment for the murder of his wife. He transferred to HMP Swaleside in November that year. At his first health screening interview it was noted that he had high blood pressure (hypertension), and blocked arteries in his legs, and that he had suffered a heart attack in 1986.

Before he was arrested the man had tried to commit suicide. Accordingly, a self-harm observation and support regime was started when he was received into custody. This involved regular checks being carried out and recorded. The regime was stopped when staff decided that the risk of self-harm had abated.

The man was admitted to the healthcare centre at Swaleside in January 2009, after concerns were raised about his mobility and general health. After he experienced a suspected stroke during the morning in January, he was taken to the Accident & Emergency (A&E) Department of the local hospital. The initial security risk assessment concluded that handcuffs were not to be used but two officers were to be present at his bedside.

He was pronounced dead at 7.30am two days later.

After he died, the prison activated its death in custody contingency plan. The police were informed and visited the hospital. They found no suspicious circumstances and his body was released to the undertakers who removed him to the mortuary for post mortem examination. The Coroner's officer informed the Head of Safer Custody who was managing the prison's response following the death that the man had died from natural causes.

The review carried out by a General Practitioner concludes that the man's clinical care was good and comparable to that available in the community. I have made no recommendations.

THE INVESTIGATION PROCESS

1. The investigation was opened in January 2009 by my investigator. He issued notices announcing the investigation both to staff and to prisoners. The notices included an invitation to anyone who wished to submit information relating to the man's death to make themselves known. In the event, no one came forward. My investigator also studied all relevant prison records, which included the man's main prison record and his medical records.
2. The local Primary Care Trust commissioned a General Practitioner to carry out an independent review of the man's clinical care. I am grateful to her for undertaking the review most expeditiously.
3. My Investigator visited Swaleside in March and April 2009 and discussed aspects of the man's treatment with staff. He interviewed two officers. My Investigator also carried out joint interviews with the clinical reviewer.
4. My Investigator contacted HM 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.
5. My former senior family liaison officer contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. The family told my former senior family liaison officer they were concerned about why it had taken so long for the man to be admitted to hospital and why he had been in the healthcare centre for nearly a week before his admission. My Investigator has attempted to address the issues raised by the family. I hope that my report provides them with a better understanding of the events leading up to the man's death.

HMP SWALESIDE

6. HMP Swaleside is a category B training prison built in the late 1980s and holding prisoners who are serving four years or more or who have at least 18 months left to serve. It is a main centre prison for prisoners in the first stage of their life sentence. Swaleside also accepts prisoners in the second stage of their life sentence. It is part of the three prison Sheppey cluster, which also includes HMP Elmley and HMP Stanford Hill, and has a number of shared services. Swaleside has an operational capacity of 954 of whom half are life sentence prisoners in the first and second stages of their sentence.
7. Healthcare at Swaleside is provided by the local Primary Care Trust. Daily medical services are provided by the Senior Medical Officer and three nursing staff. At night there is one qualified nurse on duty with access to a doctor through the local Medoc service. Sudden illnesses and treatments are managed by appropriately qualified clinical staff.
8. Since the beginning of 2008, there has been one other death through natural causes at Swaleside. My Investigator has found no common factors between the circumstances surrounding this investigation and that for the previous death.

Independent Monitoring Board

9. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The most recent annual report by the Swaleside IMB covers the period May 2007 to April 2008. The Board noted that:

“Swaleside is a well run prison and the Governor and Senior Management team need to be praised for this. Staff and prisoner relationships are excellent and the personal officer scheme is effective. The Board recognises this as our IMB applications are reducing year on year.”

Her Majesty's Chief Inspector of Prisons

10. The most recent inspection of Swaleside by Her Majesty's Chief Inspector of Prisons was an announced inspection from 31 March to 4 April 2008. The Chief Inspector highlighted in her report that the management of long-term illnesses was good and that health services were adequate. However, prisoners complained about the attitudes of healthcare staff. Additionally, the Chief Inspector noted reluctance amongst some healthcare staff to modernise and develop services.
11. The Chief Inspector also recorded that the health services: “offered prisoners access to a broad range of clinical specialisms in the prison and through external NHS sources.”

KEY EVENTS

12. In June 2002, the man was sentenced by court to life imprisonment for the murder of his wife. He had been in custody since his arrest, first at HMP Gloucester and then at HMP Bristol. He transferred to HMP Swaleside in November. This was his first experience of prison and he had no previous convictions.
13. During the man's first reception health screening interviews, it was recorded that he had hypertension (high blood pressure), claudication (this is the name given to pain in the leg caused by "furred up" or blocked arteries) in both legs, and that he had suffered a heart attack in 1986. He received medication for his blood pressure and circulatory problems (Clopidogrel and Atenolol) and to help lower his cholesterol (Simvastatin).
14. Before the man was arrested he had tried to commit suicide by attaching a hose to the exhaust of his Robin Reliant. The heat of the exhaust melted the hose and he was later discovered by police and arrested. Accordingly, a self-harm observation and support regime was started when he was received into custody. This involved regular checks being carried out and recorded. The regime was stopped on 16 May 2002 when staff judged that the risk of self-harm had abated.
15. In her letter dated 13 February 2004, the Consultant Neurologist at the local hospital recorded that the man had had a cerebral-vascular event (stroke) in 2003, a heart attack in 1986, and had hypertension and peripheral vascular disease in his right leg. The Consultant Neurologist also noted that the man's current medication included the drugs cited in para 13 above and laxatives. The Consultant Neurologist wrote:

"I reviewed this gentleman who had a left-sided weakness in May [2003], which lasted a few days and a further episode in June. He has had stable persistence of a mild left-sided weakness since then. He has not had any new episodes. Unfortunately he refused to come to his appointment to have an MRI scan of his brain or his carotid dopplers. He tells me this is because he is on laxatives and gets worried that he is going to be caught short and feels that he would rather not have the tests. We had a long discussion about the prevention of further strokes and getting as much information as possible. Once more he declined further investigation. I am therefore not making him any further appointments but suggest he should continue on his preventative medication."

16. In November 2004, the man started to refuse to take his medication. When interviewed as part of this investigation, the second nurse said that he was very specific about how he wanted to be treated and did not want active treatment to prolong his life. The nurse said:

"I can remember going down to see him and he actually spoke to me and said that he did not wish to continue taking any more medication, I

advised him against this because obviously with his previous history but he appeared quite, adamant is probably not too strong a word, but he was actually quite au fait with what he wanted, we found that later on when I had dealings with him he was quite specific in what he wanted, he had actually declined any active intervention from staff. I spoke to the MO [Medical Officer] regarding this and he actually came in and an appointment was made for him to sign a disclaimer and the MO would have spoken to him to actually state, it gave him the option so that we could make him formal consent on his treatment.”

17. The man was admitted to the healthcare centre on December 2007 for observation due to mild dehydration. He declined to take any medication for hypertension. He discharged himself from healthcare against medical advice. The man was advised to greatly increase his fluid intake.
18. On 3 January 2008, the man was advised about the dangers of hypertension. He declined to see the doctor with regard to his medication. He did not want treatment for his hypertension and signed a medical disclaimer to that effect.
19. The High Court sitting at the Royal Courts of Justice in February 2008 set the minimum period for how long the man would have to remain in custody. The tariff was set as 12 years and he would have been eligible for parole in 2014.
20. In his letter dated 3 September 2008, the Deputy Head of Offender Management informed the man that his risk of re-offending had not sufficiently reduced for him to be a category C prisoner.
21. Around 3.20pm on 22 November 2008, Healthcare staff were called to C wing to see the man. It was recorded that his calf was swollen and hard. He said that his leg had been like this for some time. He was not in any distress and was not willing to come and see the doctor. He agreed to be seen by the Senior Medical Officer at Swaleside, in November. When interviewed as part of this investigation, the Senior Medical Officer said:

“When he came to me he said what about my leg, I said the person that first saw it was an officer said the colour was different and his left leg was not right and he made a joke of that and said this is what I said the left is not right, of course left is not right and we had a laugh about that and I said you are quite right and mean not right in the sense that the colour wasn’t what you would be expecting. So okay I examined him, vaguely I could not remember seeing anything unusual.”

22. When interviewed as part of this investigation the man’s personal officer, said:

“He was unlocked at the same time as all the cleaners to be allowed to associate rather than leave him locked up purely because of his age, it would have been unfair to him. He used to potter around, mixed with a few of his peers, didn’t associate greatly, certainly not with the younger prisoners. Kept himself pretty much himself to himself, he was never a problem to staff ... He was happy to talk, the impression with him was

he accepted what he was, and he had made up his own mind that he would probably die in prison. He wasn't looking to the future, he wouldn't do anything to end his life but he wasn't overly concerned with doing anything to prolong it."

23. The man was seen by the second nurse in the blood pressure clinic on 8 December. It was noted that his blood pressure was very high and he agreed to be seen by the Senior Medical Officer with a view to starting to take his medication.

24. In his note dated 17 December 2008, a fellow prisoner and the wing representative for the Healthcare Patient Consultation Group, wrote:

"He has a history of strokes, and is quite frail ... I don't know what you could do for him, as he is quite grumpy and nearly always refuses help from inmates. It has been suggested that a wheelchair could be provided so that he is taken to see the doctor every three months and his meds [medication] sent to the wing. I would be interested to hear your comments on a solution for this problem. Please note: he is unaware of my intervention."

25. When interviewed for this investigation, the Head of Healthcare at Swaleside said:

"He [the man] continually declined and his quote was 'when my time comes' which was he was an old man who wanted to, he wasn't about to die but he accepted that when the time was up he would like to go, this wasn't seen as a living will or anything but you do have to respect somebody, it is in effect a living will ... If he needs to have the medication he was an old man and if he wasn't going to collect it then we would take it to him as opposed to well it is there you are willing to take it come and get it and if you don't then we would accept that. There was two ways of doing it, which was he could come into healthcare which would be the ideal."

26. The Head of Healthcare also said that the man:

"... was supported by the lads, this note from the fellow prisoner he was cared for by the community whether he liked it or not in a sense quite well, people did respect him, did respect his decisions rather than just accepting ok he has made his decision, we did continue to try and get his co-operation so I was happy with the efforts that were made and achieved."

27. On 12 January 2009, he was admitted to the healthcare centre after concerns were raised about his mobility and general health. A third nurse recorded the following entry in his medical record on 18 January: "The man tends to isolate himself. Happy with own company." Two days later on 20 January, he was seen by another prison doctor as he was experiencing pain in both legs after walking a short distance. He was diagnosed with claudication and an urgent referral was made to a vascular surgeon.

28. Around 7.00am on 21 January, the second nurse did a roll check of the prisoners in the healthcare centre. When interviewed the second nurse said:

“I get a response from everybody, you don’t always get the best response in the morning when you have woken somebody up but I can remember him moving and sort of hissing he was ok to me, I didn’t have any cause for concern”.

29. When a fourth nurse unlocked the cells in the healthcare centre at around 8.10am and he told his colleague, the first nurse, that the man was asleep. Around 8.20am, the first nurse went into the man’s cell to give him his medication. When the first nurse was unable to rouse him he summoned assistance from the fourth nurse. The first nurse then went to the upper floor of the healthcare centre to ask the prison doctor to come and see him.
30. Interviewed as part of this investigation, the first nurse said:

“I came in and I brought the medication for him he was breathing but he wasn’t responding so I shook him, normal shakes, [the man] and he went urrrrr, but he was kind of panting and I moved his arm, I think the left arm I can’t remember and there was not much movement and the leg as well so I called to [the fourth nurse] that this is the position he is in you take over here, get the obs machine take his obs and then if you need the cylinder I will get the oxygen cylinder in case you need it I am going now to get the doctor and I went upstairs to get the doctor”.

31. In interview, the prison doctor said:

“They asked me if I could just come and have a look at him downstairs. When I got there it was obvious that he had had a stroke, he was stuporose [unresponsive], semi comatosed in actual fact and he just moved the one side, the arm and the leg was going, I did make a note ... The right was the one that was no movement at all and I checked for reaction, his pupils were reacting but he was not responding to verbal command at all, bp (blood pressure) was virtually normal and his pulse was 107. The Senior Medical Officer then walked in and relieved me and said I can go he knows him better than I do and he will continue with it and he was then transferred off to hospital.”

32. An ambulance was called, and when the paramedics arrived around 8.45am they took over the man’s care. At 9.17am, the ambulance left the prison. Two officers escorted the man in the ambulance to the hospital. He was admitted to the hospital while tests were carried out. One of the escorting officers noted in the bedwatch log at 11.45am: “Update on prisoner unconscious, bleeding on brain and is critical, having lots of tests done will contact us when they know more.”
33. Whilst the man was in hospital his health continued to deteriorate. The initial risk assessment was that restraints were not to be used but two officers should

remain on duty at his bedside ('bedwatch'). A log of activities was maintained by the officers on bedwatch duty and this was checked on a regular basis by a visiting duty governor.

34. At around 7.10pm on 23 January, two officers relieved their colleagues to take over bedwatch duty.
35. When interviewed, the first officer confirmed that the man was not conscious throughout his bedwatch duty. The first officer said that he noticed that during the early hours on 24 January that the man's breathing became more erratic. The first officer said :

"I noticed the difference in his breathing which I logged, I think I logged in to the bedwatch book, that his breathing was shallow one moment, and then his breathing was very, his breathing was shallow one minute and then it was normal the next, and it would be like you've got phlegm in your chest and you're trying to breathe through, do you know what I mean, it's not a nice sound, and towards the end of the bedwatch, say between two and four o'clock in the morning I noticed that there was more of that breathing going on, there was you know, where his breathing had been a little normal at the end of the bedwatch it was more shallow and sort of like a gurgling."

36. Around 6.20am the following morning, the man's daughter approached the bedwatch staff who were sitting nearby to say that her father had passed away. The officers informed the medical staff and a nurse confirmed that the man had died. A hospital doctor later pronounced death at 7.30am.

37. In her incident report form, a fifth officer wrote:

"I was carrying out my duties as an officer on the bedwatch of the above named prisoner [the man]. At approx 06.20 the man's daughter asked me to contact [a named] PO as her father had died. The nurse on duty confirmed that he had died. I informed the prison at approx 06.25. The doctor at the hospital confirmed the death at 07.30."

38. As mentioned above, the man's daughter was with him when he died. She was met by a Principal Officer (PO) who had arrived at the hospital shortly after the death. The PO had been appointed as the prison's Family Liaison Officer after the man had been admitted to the hospital. The PO offered his condolences and support. He subsequently maintained contact with the family and assisted with the funeral arrangements. Swaleside also offered financial assistance with the costs of the funeral. A memorial service was held at the prison on 29 January and the man's funeral took place on 9 February 2009.

39. In his log of events the PO wrote:

"I received a call from the prison Night Orderly Officer telling me that the man had died, I left home and attended the prison and then the hospital arriving at the hospital at around 8.00am. I spoke with the

nursing staff who informed me that the man's daughter was still at his bedside. I went to support her and she was unsure of what would happen next, I talked to the nurses and they said that the man would remain where he was until she had said her goodbyes, they would then wash him and arrange for the porters to take him to the mortuary. This I told the man's daughter, she sat for a short time and then said she was ready to leave. She asked if she could visit the prison to see where he had lived, I telephoned the duty governor to inform him that we were on our way to the prison and that we would be visiting the Healthcare Department and Delta Wing so that the man's daughter's wishes could be met. On arrival at the prison we went to the Governor's office where we were met by the duty governor and he passed on his condolences, I then took her to both areas and we returned to the Governor's office for a hot drink before I escorted her to the gate, at this time I gave her all of the man's property to take with her."

40. The prisoners on C wing were told the following morning about the man's death. Staff on the wing asked prisoners whether they required anything or wanted to speak to a Listener. (Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.) When the bedwatch officers returned to the prison they were offered support from the prison's care team.
41. The post mortem report records of the man's death as due to natural causes, as a consequence of bronchopneumonia caused by a cerebral infarction and ischaemic heart disease. The verdict of the Coroner's inquest into the man's death, which was held on 27 March 2009, was that he died from natural causes.

ISSUES CONSIDERED

Clinical care

42. As noted above, a review of the man's medical care was undertaken on behalf of the local Primary Care Trust by an appointed General Practitioner. My investigator informed the clinical reviewer of the concerns raised by his family.
43. In her review, the clinical reviewer records that staff at Swaleside carried out regular reviews and monitoring of the man's condition and medication.
44. The man's family were concerned that it took so long for him to be admitted to hospital and they queried why had been in the prison's healthcare centre for nearly a week before his admission.
45. When interviewed as part of this investigation, the second nurse confirmed that she had had a conversation with him on 12 January 2009 and he had agreed to be admitted to the healthcare centre. The second nurse said that he:

“... wasn't his normal self he just seemed a little bit down so we had quite a chat and I said to him how about coming in to in-patients for a little bit of extra help and much to my surprise he actually agreed ... I think I actually mentioned somewhere in his notes he didn't want active treatment to prolong his life, he was also very worried about that and it was an issue we discussed, whilst I said to him while we respected his wishes we still needed to look after him and I was actually quite surprised when he did say that he would come down in to in-patients so I thought perhaps he might be feeling a little bit low to what he normally was.”
46. The man's admission to the healthcare centre ensured that nursing staff had easy access to him and were able to provide him with additional support. He also began to comply with his medication regime.
47. When it was discovered that the man had suffered a stroke on 21 January he was immediately transferred to hospital. Unfortunately, he did not recover consciousness and passed away in hospital three days later. Neither my investigator nor the clinical reviewer could find any evidence of delays to the treatment received by the man.
48. The clinical reviewer notes that there was well documented evidence that attempts were made by healthcare staff to monitor his blood pressure and offer medication. The clinical reviewer judges that staff are to be commended for their monitoring of the situation which eventually resulted in him changing his mind and accepting treatment. She also notes that he had refused medical assistance on a number of occasions and healthcare staff had ensured that disclaimers were signed by him.

Use of restraints

49. According to the policy for performing hospital bedwatches adopted by Swaleside at the time that he was in hospital in January 2009, the following options were available to the Governor:
- i. Escort and bedwatch with two officers or more, with restraints.
 - ii. Escort and bedwatch with two officers or more, without restraints.
 - iii. Escort and bedwatch with one officer, without restraints.
 - iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
 - v. ... exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952).

The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

50. When he was taken to hospital on 21 January 2009, the risk assessment was that restraints were not to be used but two officers needed to be in attendance. I conclude that the use of restraints was appropriately revised in light of his condition.
51. I am pleased to report that my investigator found that the bedwatch notes were concise, legible and appropriate. After his family received the draft report, they said that he was well looked after by the prison and they appreciated everything that Swaleside had done for him. The family also said the prison officers who accompanied him at the hospital were very respectful.

CONCLUSIONS

52. The man arrived in HMP Swaleside in November 2002. He died in hospital in January 2009.
53. From the bedwatch log, it was clear to my investigator that the staff involved with his care behaved with compassion and sensitivity. The security arrangements at the hospital were in line with current policy and expectations.
54. In the clinical reviewer's opinion, the man's refusal to accept treatment or undergo investigation for his stroke undoubtedly hastened his death. She acknowledged that his wish was that his life should not be prolonged and ultimately that wish was respected. The clinical reviewer writes: "At the time of his death he was being well cared for in the hospital wing of the prison, and this enabled prompt referral to the hospital where he died."
55. The clinical reviewer judges that the quality of care he received was good and entirely equivalent to that he would have received outside prison. The clinical reviewer is not critical of any actions of healthcare staff and says that all appropriate clinical procedures were followed.
56. Given these findings, there are no recommendations that arise from my investigation.