Investigation into the circumstances surrounding the death of a prisoner at HMP Lewes, in April 2005

Report by the Prisons and Probation Ombudsman for England and Wales

October 2005

This is the report of an investigation into the circumstances of the death a prisoner at HMP Lewes who died from apparently natural causes in hospital in April 2005. He was 81 years of age.

I would like to extend my sincere condolences to those touched by the man's death.

I am grateful to the Governor of Lewes prison and his staff for their assistance in this investigation. All documentation relating to the man's death was meticulously completed, and readily available. Particular thanks go to the liaison officer. I must also express my appreciation to the Sussex Downs and Weald Primary Care Trust for undertaking a comprehensive clinical review into the man's healthcare needs whilst he was in custody.

I was pleased to find that Lewes had acted on a recommendation from a previous Ombudsman's investigation as to their handling of a death in custody that occurs at an outside hospital. Furthermore, Lewes has put in place arrangements to ensure considered and compassionate assessments in relation to escorting prisoners to hospital. I have highlighted these as examples of good practice.

The man who died was an elderly and frail man with chronic health problems. In the main, he was cared for well in Lewes although there are some improvements to be made in managing prisoners with chronic illness.

There appears to have been a delay in admitting the man to hospital due to the refusal of the ambulance crew to transport him. This causes me concern. I welcome the fact that the Sussex Ambulance Service are undertaking their own review into this matter, and trust the outcome will be an improved service to acutely ill prisoners.

I make eight recommendations, and highlight two examples of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2005**

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Summary

The man who died was sentenced to imprisonment in February 2004, and died aged 81 in April 2005 in hospital.

He was an elderly and frail man who had a long history of heart problems and unstable diabetes. In the main, the man was treated appropriately for his conditions. However, this investigation has revealed some problems regarding the consistent management of chronic illnesses when a prisoner is located on a wing rather than in healthcare.

On late in April, the man began to feel unwell. He was suffering nausea, and could not face food. The following day he either fell from his bed, or collapsed. Staff attended him but he gradually deteriorated. A few days later, the prison doctor felt it was necessary for the man to be admitted to outside hospital, and an ambulance was called.

The ambulance crew felt it was inappropriate that they were called as an emergency, and left without the man. It is unclear whether they examined him. This delayed his admission to hospital. Whilst his condition did not appear further to deteriorate in this time, he was acutely ill. He was transported in the prison van some hours later. The van was not appropriate for transporting such an ill man. However, risk assessments regarding restraints, and escort arrangements at Lewes enabled the man to be treated as compassionately as possible in the final hours of his life

The man arrived at hospital at 4pm and died at 6.20pm. The post mortem report records the cause of death as:
1. Cardiac arrest
2. Cardio-genic shock
3. Acute myocardial infarction
There was also evidence of ischaemia, myocardial fibrosis, congestive/chronic cardiac failure and coronary arteriosclerosis.

I conclude that the man's condition on the day of his death was well identified by healthcare staff, and attempts were made to ensure he received the best care possible. However, protocols need to be established with Sussex Ambulance Service to ensure the smooth transfer of acutely ill prisoners to hospital in appropriate transport.

Investigation process

I appointed one of my investigators to conduct the investigation. Notices were issued to prisoners and staff inviting comment.
My investigator spoke with prisoners and staff and examined all of the man's prison records, including his medical records.

A clinical review was carried out by a representative from Sussex Downs and Weald Primary Care Trust.

One of my family liaison officers contacted the man's son. He said he had no questions about the care his father had received at present but would like to receive my report.

Background

The man who died was born in November 1923 in Surrey. He was part of a large family. He spent some time in the navy where he qualified in electrical engineering which later became his trade.

On 6 February 2004, he was sentenced to 7 years imprisonment and started his sentence at HMP Highdown. The man was transferred to HMP Lewes on 12 November 2004, where he remained until his death at the age of 81.

He had serious heart problems and had suffered myocardial infarctions (heart attacks) in 2002 and 2003. He often suffered with bronchitis, and was an insulin dependent diabetic. His diabetes was frequently unstable. The man was also incontinent of urine. In July 2004, he was diagnosed with pleural effusion to his right lung, bi-ventricular impairment, aortic valve disease, pulmonary hypertension and mild mitral valve regurgitation.

On his admission to Lewes on 12 November, he underwent an initial healthcare screening. He was referred to pharmacy in light of his medication requirements, and to the chiropodist.

Between November 2004 and April 2005, there are few medical notes regarding the man, other than episodes to haematuria (blood in the urine) and urinary tract infections. During this period, he was due to attend several appointments at hospitals outside of prison for various ailments, but only in fact attended one. Although it appears that the man himself chose not to attend most of these, the reasons behind his refusals are unclear, and there were several cancellations for unknown reasons.

One of his friends at Lewes reported that he used to help the man with day to day tasks that he found difficult, such as fetching meals and helping make his bed. The man's friend reported that the man received a high level of care from healthcare staff, and that he often praised them for their help.

Events leading up to his death

On Monday 25 April 2005, the man's friend fetched his lunch at 11.30am, and went back to see him at 2pm. The man has not eaten his meal as he said he had an upset stomach. His friend collected his evening meal and took it to him at 4.30pm, and went back at 6pm. He reported that the man looked unwell, with a white face and had not eaten his evening meal. When the man's friend suggested he ask to see someone from healthcare, he said he would be okay.

The following day, after checking on him in the morning and at lunch, the man's friend went back with his evening meal and talked to him for some time. He reported being so worried about the man that he went and asked the Principal Officer on the wing to call healthcare, which he did straight away.

A nurse attended. The man told her that he had been exercising and not eating and his blood sugars had been high. The nurse arranged for the man to see the doctor the following day, and returned to check on him at 7.30pm. On this visit, his blood sugar was very high at 23.2mmols (the normal levels are between 4 and 8 for an insulin dependent diabetic). The man reported that he had eaten five biscuits instead of eating his dinner. The nurse documented this visit on her return to the healthcare centre at 8.45pm, and requested that the man be reviewed by night staff in approximately 30 minutes time. It is not clear if this occurred.

At approximately 11pm, another nurse went to see the man following a call from wing officers after he had either fallen out of his bed or possibly collapsed. The nurse reported that the man was alert. He felt as if his blood sugars were low but in fact they were still high at 21.2mmols. He administered insulin to himself and appeared calm and stable after five minutes. The nurse found no other physical injuries, but did notice that the mattress was overhanging from the bed and was not a good fit. The nurse felt this could have contributed to the man's fall. The nurse said that the man was to report to the nurse in the morning and be monitored by wing staff.

The day he died

The Senior Healthcare Officer (SHCO) called the wing at approximately 9.30am to request that the man be brought to the healthcare centre to see the doctor. A little later, an officer contacted healthcare to say the man was unwell and could only be transported by wheelchair. The SHCO discussed the situation with a doctor and decided the man should be admitted to healthcare so his eating and glucose levels could be monitored. Unfortunately, a bed was not immediately available.

At approximately 11am, the SCHO visited the man on the wing. his blood sugar was recorded as 15.2mmol. He said that he had been vomiting and not eaten since the day before. He was not drinking because he felt nauseous and was concerned fluid might be gathering in his lungs as he had experienced this before. The SCHO found the man to be dehydrated, with a dry and furred tongue, cracked lips and dry skin, and found his blood pressure to be barely recordable. After a thorough examination, the SCHO felt that the man should be admitted to outside hospital, and called the doctor. The doctor attended with a nurse and agreed that the man should be admitted to the hospital.

The SHCO returned to the healthcare centre at approximately 12.10pm and was advised that the Sussex Ambulance Service had arrived and been escorted to the wing. However, the crew had been unhappy with the emergency 999 call, as they did not consider the man's transfer to hospital to be an emergency. They also queried whether it was more appropriate for the man to go to a different hospital. The reason for this is unclear. It also appears that the ambulance crew may have made this assessment without having examined the man as he was locked in his cell at this time.

According to the SCHO, the ambulance crew felt that normal prison transport could be used, but recognised this could take between two and three hours. They also suggested that the doctor telephone the other hospital to inform them of the transfer as this might speed up the process. The SCHO visited the man to inform him what was happening. At this point, he was able to stand, and pass urine.

Dr Mangat informed Dr Simon Jones at the Princess Royal Hospital of Peter's transfer to them. A thorough risk assessment was completed and it was decided that there was no need for Peter to wear handcuffs given his medical condition. Peter left the prison at 2.30pm in the prison van accompanied by a nurse and two officers.

At 6.05pm, Peter suffered a massive heart attack, and was pronounced dead at 6.20pm. The post mortem report records the cause of death as 1. Cardiac arrest, 2. Cardio-genic shock, 3. Acute myocardial infarction. There was also evidence of ischaemia, myocardial fibrosis, congestive/chronic cardiac failure and coronary arteriosclerosis.

Findings and Conclusions

Peter was held on the vulnerable prisoner unit in the prison. Staff appeared aware of Peter's needs, and were quick to contact healthcare with any concerns. However, there do not appear to be any comments to this effect in Peter's wing record. Where healthcare staff asked wing staff to keep an eye on Peter, I would have expected to see some comment as to the events leading to such a request, for example Peter's apparent fall or collapse.

My investigator was pleased to find that Peter's cell was on the same landing as the healthcare treatment room and servery. However, it was noted that the mattress on Peter's bed was too large for the bed and was considered by Nurse Hayden to have contributed to his fall on 26 April. In caring for an elderly or frail prisoner, continued attention needs to be paid to any specific needs as well as ensuring that their accommodation is appropriate for these needs.

Healthcare issues leading up to 26 April

Peter remained independent and appeared to have a good understanding of his chronic illnesses. He also appeared to be receiving medication appropriate for his conditions and this was, in the main, monitored well. However, it is noted in the clinical review that the drug spironolactone is known to have a side effect of hyperkalaemia (high levels of potassium in the blood). Peter's blood test on 12 January showed that potassium levels were at the top end of the normal range. The British National Formulary recommends spironolactone should be discontinued when hyperkalaemia occurs.

Furthermore, the clinical review notes that the blood test result from 12 January indicated a raised level of urea of 8.6mmol/l (the normal range is 2.7 to 7mmol/l), and a raised level of creatinine of 145mmol/l (the normal range is 55 to 110 mmol/l). Hyperkalaemia, raised levels of urea and creatinine could have been an indication of renal impairment and should have prompted further investigation. There also should have been regular monitoring of these levels.

I recommend that the head of healthcare reminds healthcare staff that on receipt of test results from the laboratories, they are to be examined and acted upon appropriately.

Peter often declined health appointments. However, it is not clear why he did so. There is no policy in place to follow this up and to establish the reasons behind such refusals although Lewes's consent policy number 45 makes some reference to this.

I recommend that, where a prisoner refuses to attend an appointment, a reason for refusal should be sought and documented in the medical records, signed by the patient and witnessed by staff. Refusals to attend should be brought to the attention of a Senior Nurse manager.

The medical records indicate that Peter was seen by healthcare staff on 28 occasions between his reception on 12 November 2004 and the end of March 2005. Most of these relate to an ulcer on his foot, and none note deterioration in his condition. There are no entries between 1 April and 26 April 2005. There appear to be no known problems reported to healthcare staff.

The clinical review also indicates that it is sometimes difficult to decipher who has made the entries in the medical records, as there are only signatures, names are not printed and there is no signature covering sheet.

I recommend that the healthcare manager reminds staff either to print their name next to their signature in medical records or provide a signature sheet at the front of the medical records.

The clinical review notes that the layout of the prison and the needs of security do not make it easy for prisoners on the wings to be monitored. The healthcare centre is usually full making it difficult to transfer prisoners from the wings to the healthcare centre when there is an immediate need.

Furthermore, the management of chronic disease within the healthcare centre and wings is unclear and insufficient.

I therefore endorse the following recommendation from the clinical review,

I recommend that as part of the National (Health) Service Framework for Long Term Conditions/Chronic disease management, all prisoners with a chronic disease should have a care plan which considers how their condition will be managed whilst in custody, wherever they are located in the prison.

Healthcare issues from 26 April

Although the incident was recorded in Peter's medical records, healthcare staff attending to Peter on 27 April appeared unaware of his fall or collapse the previous night. I therefore endorse the following recommendation from the clinical review,

I recommend that the healthcare manager reviews communication between shifts in the healthcare centre to ensure all untoward events, including those on the wings are communicated to the incoming staff.

On their arrival at Lewes, the Sussex Ambulance Service crew declined to transfer Peter to hospital following the 999 call that was made. It is alleged that the ambulance crew made this decision without examining Peter who was locked in his cell at the time. Several issues are unclear about this incident. The first issue is why the ambulance crew considered the call to be inappropriate and why the transfer to hospital could wait. I am concerned by this, and am pleased to learn that Sussex Ambulance Service is investigating this matter further.

The second matter is why Lewes healthcare staff did not override the decision and insist Peter be transferred. Finally, I am surprised that Lewes healthcare staff did not report this to a higher authority at the time. Peter's treatment for his severe dehydration and hypertension at a hospital was delayed by several hours as a result of the ambulance crew refusing to take him to hospital.

The prison van is used to transport prisoners to other prisons and to court, and can be out for a whole day. The van is a gated van and not appropriate for the transport of a very ill prisoner. There appeared to be no alternative transport until the prison van returned. Peter's condition did not appear to deteriorate further in this time. However, it should be noted that the healthcare staff had recognised that Peter required urgent hospital attention. The confusion surrounding the method of transport appeared to disempower them.

I therefore endorse the following recommendations from the clinical review:

I recommend that a protocol is developed between Lewes prison and Sussex Ambulance Service to ensure appropriate transport is requested and is available to ensure the needs of the patient are met in a timely and appropriate manner.

I recommend that the senior healthcare officer or senior nurse should have the authority to ensure prisoners are transferred to hospital urgently when they have been found to be in need of an acute hospital service.

I would further recommend that the Governor and head of healthcare carefully consider all the issues included in the clinical review.

Escorts and use of restraints

A thorough risk assessment was undertaken as to whether restraints were required to take Peter to hospital. The conclusion - that Peter did not require restraints - was both compassionate and appropriate. Furthermore, the form Lewes have created to assist the assessment is an example of good practice.

Peter was escorted by a nurse as well as two officers. The presence of the nurse demonstrated a good understanding of the seriousness of Peter's condition and was appropriate given the length of the journey. This is another example of good practice for which I commend Lewes.

List of recommendations

All recommendations are to be implemented locally and all relate to healthcare.

I recommend that the head of healthcare reminds healthcare staff that on receipt of test results from the laboratories, they are to be examined and acted upon appropriately.

I recommend that where a prisoner refuses to attend an appointment, a reason for refusal should be sought and documented in the medical records, signed by the patient and witnessed by staff. Refusals to attend should be brought to the attention of a Senior Nurse manager.

I recommend that the healthcare manager reminds staff either to print their name next to their signature in medical records or provide a signature sheet at the front of the medical records.

I recommend that as part of the National (Health) Service Framework for Long Term Conditions/Chronic disease management, all prisoners with a chronic disease should have a care plan which considers how their condition will be managed whilst in custody, wherever they are located in the prison.

I recommend that the healthcare manager reviews communication between shifts in the healthcare centre to ensure all untoward events, including those on the wings are communicated to the incoming staff.

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Examples of good practice

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