INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN IN SEPTEMBER 2005 AT HMP ELMLEY

Report by the Prisons and Probation Ombudsman for England and Wales

March 2006

This is the report of an investigation into the circumstances of the death of a man in September 2005 at HMP Elmley. He was 58 years of age when he died, apparently from a heart attack, in his shared cell.

My colleagues and I would like to extend our condolences to his family and friends for their loss. I would like to thank a Governor from Elmley who ensured that all relevant information was available to my investigator.

One of my investigating officers conducted the investigation. A medical officer carried out the clinical review on behalf of Swale Primary Care Trust. I am not convinced that the clinical review covers all the pertinent issues, and it may be that Prison Health will wish to commission a further investigation. It may also be that the Coroner will want to call a representative of the PCT at the inquest to answer questions about the healthcare the man received while in prison.

My report makes one recommendation relating to the clinical review. A further recommendation relates to the efforts made by both staff and prisoners in trying to resuscitate the man. My report also identifies one area of best practice.

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Prisons and Probation Ombudsman **March 2006**

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Summary

1. The man died at the age of 58 years, while in custody at Elmley. In June 2005, he had been sentenced to five years imprisonment for sexual offences. He was described by his cellmates and staff as a quiet and polite man who preferred to keep himself to himself.

2. Before arriving at Elmley, the man had been taking medication for hypertension. At his reception health screen, he stated that he had no concerns about his health but explained the medication he had been taking. This medication was not re-prescribed, but there is no evidence why this decision was taken. After the reception health screen, he was referred to see a doctor. There is no evidence that he actually met with the doctor.

3. On 3 September 2005, the man complained of chest pains and spent the night in the prison's Healthcare Centre. On the morning of 4 September, he was checked by the doctor before being allowed to return at his own request to his cell on house block 4. Before returning to his cell, he underwent a health review and a prescription for his medication to control hypertension was issued.

4. He shared a cell with two other men. On the evening of 7 September, he collapsed while cleaning his teeth. Despite the efforts of prisoners, staff and the paramedics, he was unable to be resuscitated. The post mortem suggests that he died as a result of a heart attack.

5. A clinical reviewer carried out a review of his healthcare needs on behalf of the Swale Primary Care Trust. I am critical of the approach taken in the clinical review.

6. My report makes two recommendations and draws attention to one area of best practice.

Investigation Methodology

7. All the initial indications were that this was a death from natural causes.

8. My investigator visited HMP Elmley and was given access to all of the man's prison records, including his medical records. My investigator also met with the man's cellmates. They confirmed that they had nothing to add to the statement they had given to the Principal Officer on 8 September 2005.

9. Notices to staff and prisoners were sent to the prison's liaison officer to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.

10. A clinical reviewer carried out a clinical review on behalf of the Swale Primary Care Trust into the management of the man's health needs while in custody.

11. The man had no next of kin details in his prison record and he was listed as having no fixed address. One of my family liaison officers has written to the address found in his court records. However, there has been no response from any family members. After his conviction, it seems that he had no contact with his family.

12. Since issuing my final report one of my family liaison officers has had contact with the man's brother. He has asked me to pass on his thanks to the prison and to his brother's cellmates for all that they did to help him. He was also very pleased to be informed of his brother's death in person so promptly and would like to pass on his appreciation to the prison for this. I am happy to include his views here.

HMP Elmley

13. Elmley is a purpose built prison serving all courts in the County of Kent. The prison opened in 1992 and includes a Category C Unit of some 240 prisoners built in 1997 and a Vulnerable Prisoner Unit delivering the Sex Offender Treatment Programme. Elmley is one of the six ‘Bullingdon’ design prisons, and is one of three adjacent jails forming a cluster on the Isle of Sheppey.

14. Her Majesty’s Chief Inspector of Prisons carried out a full inspection in 2001. Her report described a prison that had lost direction and was stalling. The latest follow up inspection in May 2003 showed that senior managers had identified the problems and taken effective action to stop, and reverse, the drift. Given the pressures that they were under, and in particular the fact that a third of the prison’s population were now remand prisoners, this was considered no mean feat.

Events leading up to the man's death

15. The man was sentenced to five years imprisonment in June 2005. Following sentencing he was taken from the Crown Court to HMP Elmley.

16. The man was given a reception health screen on his arrival where he was asked about his current health needs. He indicated during the reception screen that he had no concerns about his health. However, he explained that he had been taking medication (enalapril tablets for hypertension) before arriving at Elmley. This medication was not re-prescribed.

17. He was referred to see the doctor. There is no evidence in his medical records to say that he met with the doctor.

18. The man was considered fit enough for any normal location, work and cell occupancy. He asked to be placed on prison rule 45 (this is a protected regime for vulnerable prisoners) for his own protection due to the nature of his offences. He was then located to house block 4. He attended work in the prison laundry and settled into the prison regime quite quickly, choosing to keep himself busy.

19. At 5.35pm on 3 September, the man complained of chest pains and was seen in his cell on house block 4 by the nurse. The man explained that he had suffered from hypertension in the past and had been taking medication before arriving at Elmley. An appointment was made for a detailed assessment and investigation into his medical needs.

20. The nurse was called back to house block 4 to see him at 6.00pm because his chest pains had returned. He was moved to the Healthcare Centre. On arrival, he was described as having good colour and no shortness of breath. He was settled onto the bed and given 300mg of aspirin, then asked to rest. At 7.00pm, it was decided that he would remain in the Healthcare Centre overnight for observation. He was asleep when he was next checked at 7.40pm.

21. The man was seen by the prison doctor on 4 September. His condition had improved - even though he had been sick in the night - and he reported feeling better with no chest pains. He was asking to return to his cell on house block 4. The doctor recorded no diagnosis in his medical record, but did issue him a prescription for enalapril and allowed him to return to the house block.

Events of 7 September

22. There were two prisoners who shared B1/13 on house block 4 with him. The cell is on the ground floor of the block. In the early evening of 7 September, he was cleaning his teeth at the sink, and all three men were laughing and joking. He suddenly collapsed onto the floor, hitting a chair as he fell. The two cellmates thought he was having an epileptic fit and placed him in the recovery position. They then noticed that he had gone blue and was not breathing. One of them began to press on his chest while the other rang the cell bell and kicked the door to attract the attention of the staff.

23. At approximately 7.10pm, an officer was on the second floor landing area of house block 4 when he was called by another prisoner, who said that there was an inmate who had collapsed in cell B1/13. The officer went straight to the cell and, on entering, saw the man on the floor lying in the recovery position where he had been placed by his cellmates. Thanks to the efforts of his cellmates, the man was still breathing although his skin was blue in colour. The prison officer called to a wing officer to radio for medical help which he did, using the term code blue to alert healthcare staff that someone had collapsed. The wing officer then entered the cell. The prison officer then left, taking the cellmates with him, to make room in the cell for the healthcare staff. Both prisoners were strip searched and their clothes were placed in sealed bags to preserve any evidence for the police.

24. At this point, the wing officer says that the prisoner was shallow breathing and gurgling. After about three minutes, he noticed that he was turning blue and not breathing. He checked his response to pinching, his breathing and pulse but found nothing. He alerted a senior officer, who was in charge of the wing and standing outside the cell. At this point, healthcare staff arrived. The senior officer was then told by the orderly officer to lock up the remaining prisoners on the wing.

25. At 7.15pm, a healthcare officer and a nurse arrived at the cell and the nurse started cardio pulmonary resuscitation (CPR). The wing officer took out a resusiade (this is a small device to stop any transfer of bodily fluids during mouth to mouth resuscitation) from the pouch on his belt, and began to assist in CPR.

26. The healthcare officer prepared an airway and secured it to an airbag. The nurse and the wing officer then continued the CPR. After a short while, the airbag broke and the wing officer went back to using his resusiade. At one point, the man's chest did not rise, so the healthcare officer checked and cleared his airway with a suction pump and then resuscitation continued.

27. At 7.20pm, the log keeper in the prison control room telephoned the paramedics. At 7.30pm, the paramedics arrived at the cell and took

over the chest compressions from the nurse. They also supplied a new airbag and the wing officer continued to assist in CPR.

28. Despite all their efforts, at 7.45pm the paramedics pronounced the man's death. At this point, the wing officer left the cell, leaving any equipment behind. The paramedics left the cell and it was sealed at 7.55pm by the senior officer.

29. The Coroner was informed of the prisoner's death at 8.02pm. A Detective Inspector, a Detective Sergeant and a Detective Constable arrived at the cell at 9.21pm, and left shortly after. The undertakers arrived at the cell at 11.45pm to remove the man from the prison.

30. The post mortem report concluded that the prisoner died as a result of a heart attack.

Clinical Review

31. The clinical reviewer completed a clinical review into the care the man received at Elmley. He concluded that the nursing interventions were of an adequate standard. He added that the evaluation of the anginal episode on 3 September was to a good clinical standard as was the record keeping.

32. The reviewer makes two recommendations in his review:

    - There is a need for clinical leadership at HMP Elmley or at the Sheppey cluster of prisons.

    - There is also a need for a clinical governance committee, where untoward incidents can be investigated in a non judgmental blame free atmosphere, and where key findings are translated to time-tabled action with post-incident reviews. This committee should be chaired by a senior manager or governor grade directly reporting to the governing Governor or the senior management team. Clinical governance should be a standing item on the senior management agenda. The CGC should take reports from sub committees concerned with suicide prevention, serious untoward incidents, risk management, medical cover/complaints, request/complaints from patients, IMB health concerns and Drugs and Therapeutics. This is the structure in most NHS Trusts, where, virtually complaints of this nature are replied by the governing Governor (sic).

33. I have some concerns about the quality of the clinical review.

    - First, it does not explore why the man did not continue to receive medication for hypertension in June 2005, when he was first received into Elmley, or the impact this may have had on his condition.

    - Second, it does not explore why the man appears not to have seen a doctor when he arrived at Elmley, despite the fact that a referral was made.

    - Third, it is not clear how the recommendations follow from the findings of the review.

34. Prison Health may wish to commission a further investigation into these matters. They may also wish to advise Swale PCT as to their expectations as to the level of detail that should be found in a clinical review.

Findings and Conclusion

35. The post mortem report concluded that the man died of natural causes as a result of a ruptured myocardial infarction (Heart Attack).

36. Prison Service Order 2710 sets out what action must be taken following a death in custody. Elmley fully complied with this order.

37. All necessary information was collated for the purposes of this investigation.

38. The clinical reviewer considers that the care the man received was of an acceptable standard. However, the review failed to address two key questions about the way his health needs were dealt with when he arrived at Elmley – the apparent failure to review his medication and the apparent failure to ensure he was seen by a doctor.

39. A comprehensive review of clinical matters is essential to most of my fatal incident investigations, but especially those where death was from natural causes. With colleagues in Prison Health, I shall continue to keep a close eye on both the timeliness and quality of the clinical reviews that PCTs commission on my behalf.

Recommendations and Best Practice

40. I recommend that Prison Health considers whether it should commission a further investigation into the healthcare the prisoner received while in prison.

41. I commend staff and prisoners at Elmley for the efforts made in trying to resuscitate the man and recommend that the Governor writes accordingly to those concerned.

42. The use of the term Code Blue to summon help to medical emergencies is good practice. It alerts everyone carrying a prison radio and those within hearing distance that urgent medical assistance is required.