

**Investigation into the circumstances surrounding the
death of a man at HMP Lewes in February 2006**

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

September 2006

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.

This is the report of an investigation into the death of a man. The man died from apparent natural causes on 10 February 2006 at HMP Lewes. He was 73 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 Lewes and his staff for their participation and support. Sussex Downs and Weald Primary Care Trust identified someone to undertake a review of the man's clinical care, and I appreciate her assistance.

I have noted the concerns raised by the clinical reviewer and there are clearly lessons to be learnt in the clinical management of patients in prison. I endorse the recommendations made in the clinical review.

Emma Bradley
Deputy Prisons and Probation Ombudsman

September 2006

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Summary

1. The man was born in 1932. He was 73 years old when he died on 10 February 2006.
2. The man was received into custody after being sentenced to four years imprisonment for indecent assault. He was initially held at HMP High Down, and transferred to HMP Lewes on 20 August 2004.
3. During his first reception health screen, it was noted that the man had diabetes and angina. 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 February 2006, at 5:00pm, the man was seen by a Staff Nurse. He was told the nurse that he had not taken his medication and that he felt hypoglycaemic. The man took a dextrose tablet and apparently felt better.
5. Around 8:35pm two Staff Nurses were called to the man's cell. While one nurse gave the man oxygen she requested that her colleague call for an ambulance. While the other nurse was organising an ambulance the man collapsed. Cardio pulmonary resuscitation (CPR) was commenced and this was continued by the ambulance crew after they arrived on the wing.
6. As the ambulance crew were unsuccessful in their attempts to resuscitate the man CPR was stopped at 9:46pm and the prison medical officer pronounced death at 10:48pm.
7. The clinical reviewer highlighted a number of areas where improvements could be made in the care provided to prisoners. I endorse her recommendations.
8. One of my Family Liaison Officers contacted the man's family. Their concerns are centred on the man's clinical care whilst he was in custody.

The investigation process

9. My investigator visited Lewes prison and studied all relevant prison records relating to the man. These included his main prison record, his medical records and statements from prison staff.
10. The Sussex Downs and Weald Primary Care Trust (PCT) carried out a clinical review of the care the man received while in prison. I am grateful that this review was completed in a most timely manner.
11. 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.
12. One of my Family Liaison Officers contacted the man's family. The family told him of their concerns, which are considered later in the report.
13. My investigator discussed aspects of the man's treatment and the issues raised by his family with both staff at Lewes and the clinical reviewer.

The man

14. The man was born in England in 1932. He was divorced and was the father to three children.
15. The man initially worked in printing before joining the Royal Air Force. He was in the RAF until 1969 and then worked in telecommunications before being made redundant.
16. The man was convicted on 20 August 2004 and sentenced to 4 years imprisonment. The man had one previous conviction nearly thirty years ago, but this was his first experience of prison life.
17. Before being arrested and remanded into custody the man had heart problems requiring surgery and had been diagnosed with severe arthritis and hearing difficulties.

HMP Lewes

18. Lewes is a Victorian prison built in 1853. It is a local prison which houses trial/remand and sentenced adults and additionally a small number of Young Offenders committed from local courts in the Sussex area. It has an operational capacity of 558 prisoners.
19. Throughout the forties and fifties Lewes was used as a centre for Young Offenders and eventually a Borstal experiment was tried in 1963. This worked well, but pressure on the London prisons meant that Lewes once more had to accommodate adult prisoners. In the early seventies it became a training prison (with one wing devoted to lifer prisoners), whilst retaining its remand function for the Sussex courts. This function continued until 1990 when the prison once more became a 'Local' establishment, housing mainly short – term prisoners and remands.
20. In March 2002, Lewes lost the court commitment to receive and hold Young Offenders, although a small group of such prisoners are held as a remand facility to the local Court area. As part of this change the prison has now opened a large wing (F Wing) to accommodate Vulnerable Prisoners.
21. The provision of healthcare within the prison is the responsibility of Sussex Downs and Weald Primary Care Trust. Primary care at out patients is delivered by medical staff and registered nurses and the healthcare centre has the opportunity to draw upon the broader expertise of the range of healthcare services within the local NHS Trust. 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.
22. There is an in patient ward with 18 beds and a constant watch cell. This is staffed by registered nurses and provides for both the physical and mental health needs of those patients requiring a 24 hour nursing presence.

Key Findings

23. The man arrived at Lewes on 20 August 2004 and, after induction, it was decided that he should be given Vulnerable Prisoner status because of his age and the nature of his offence.
24. During his health screen interview it was noted that the man had diabetes and angina. Due to his health problems, the man was prescribed a range of medication, which he kept in his possession
25. On 10 February 2006 at 5:00pm, the man was seen by a Staff Nurse as he was feeling drowsy and tired. The man told the nurse that he had not taken his medication and that he felt hypoglycaemic (deficiency of glucose in the blood). After the man took a dextrose tablet he felt better.
26. Around 8:35pm two nurses were called to the man's cell. They found the man sitting on the edge of the lower bunk in his cell. The man was breathless and perspiring profusely, he also had pale and cyanosed (blue) lips. While one nurse gave the man oxygen she requested that her colleague call for an ambulance. While this was being organised, the man collapsed. Two prison officers and the two nurses lowered the man onto the floor of his cell and then commenced cardio pulmonary resuscitation (CPR). One nurse assumed responsibility for the man's airway and the other carried out chest compressions.
27. When the ambulance crew arrived they took over responsibility for CPR. As they were unable to resuscitate the man resuscitation attempts were abandoned at 9:46pm. The man was pronounced dead by the prison medical officer at 10:48pm.
28. The Duty Governor and a representative from the prison's Chaplaincy visited the man's family to inform them of his death and to offer their condolences and support.
29. The prison maintained contact with the family and made arrangements for the funeral. The prison's chaplain conducted a service on the residential unit on which the man had been located.
30. The post mortem states that the cause of death was due to natural causes as a consequence of myocardial infarction (heart attack), due to coronary arterial thrombosis (blood clot within the arteries) and coronary arterial atheroma (a degenerative change in the middle and outer coats of the arteries).

Issues raised by the family

31. The man's family told my Family Liaison Officer that their concerns were focussed on the clinical care provided during his time in Lewes. Their concerns were:
 - I. Whether the man had purposely not been taking his medication.
 - II. What systems were in place in relation to the administration and management of medication at Lewes.
32. My Family Liaison Officer agreed to forward their concerns onto the clinical reviewer.
33. The family also described the representative from the chaplaincy at Lewes as having been "fantastic" and drew attention to some of the positive practices he employed. These included:
 - I. His many visits to the family including when he was on annual leave.
 - II. Arranging for the man's younger son to visit his father's cell.
 - III. Handing back the man's belongings in a timely manner.

Clinical Review

34. The man had suffered from significant long-term chronic diseases, including diabetes and angina. The man appeared to have a good knowledge to manage these prior to his imprisonment. Whilst the man saw health care professionals on a regular basis to manage and control these conditions, it is not evident that there was a formalised and documented pathway of care.

As part of the National (Health) Service Framework for Long-term Conditions/Chronic Disease Management, all prisoners with diabetes must have a care plan which considers how their diabetes will be managed whilst in custody and on resettlement to ensure their health is managed where possible by the prisoners themselves but monitored regularly by the Prison Healthcare Service.

As part of the National (Health) Service Framework for Long-term Conditions /Chronic Disease Management, all prisoners with chronic cardiac/heart conditions must have a care plan which considers how their condition will be managed in a seamless way whilst in custody and on resettlement to ensure their health is managed where possible by the prisoners themselves but monitored regularly by the Prison Healthcare Service.

35. The medical record did not always provide clear evidence of who had delivered care to the man. Furthermore, the entries in the medical record are not always easy to read.

All Healthcare staff must be encouraged to write legibly in the Inmate Medical Record (IMR), especially the medical staff.

There must be a record sheet in every IMR, which clearly records the name of the individual against their signature. This sheet should be available at the front of the IMR and each member of staff making an entry in the IMR for the first time should record their name and signature for future identification purposes. If electronic records are implemented a record of staff names and their signatures should be kept on file in an appropriate place.

36. The layout of the establishment and custodial processes can make it difficult for staff to monitor prisoners with chronic diseases on a regular basis. Whilst the man saw healthcare staff on a regular basis, it was primarily when the need arose and not always as part of regular monitoring and screening.

Implementation of Wing Nurses must be progressed as soon as resources allow to improve the monitoring of prisoners' health on a day-to-day basis making it easier to access Healthcare and ascertain true activity of daily living needs of prisoners with health needs/impairments.

37. There are systems in place in relation to medicines management. When prisoners arrive at the prison they are assessed for competency and safety in terms of providing them with in possession medication. This enables the prisoner to have an element of control in administering their medication, as they would in the community. This medication is provided in small quantities to improve monitoring and minimize the risk of selling drugs as a form of prison currency.
38. It is clear that Healthcare staff were aware that the man did not always collect his medication, his prescription chart stated that his medication should be taken to him if he did not collect it. Furthermore, the man was provided with a dossett box as a memory aid and given his in possession medication on a weekly basis. The reviewer concluded that all these measures facilitated a pro-active system of medicines management.

Non-compliance of medication (and diet) must lead to closer monitoring by perhaps reviewing use of in possession medication and periods between dispensing same for those at-risk. Various tools can be used to assess likelihood of compliance.

Implement pharmacy-led clinics when resources available to offer advice and education to prisoners regarding their medication and compliance.

39. The man was receiving treatment for his leg/foot ulcers and pain. The man had been seen by an external consultant in vascular surgery, who had intended to carry out further clinical investigations. The man was receiving strong pain relief medication, which was reviewed regularly. Healthcare staff were aware of the condition of his legs and feet and this is clearly documented.
40. The clinical reviewer notes that access to specialist clinical services, such as a diabetic nurse, tissue viability nurse and dietician would improve patient outcomes, through a more comprehensive multi-disciplinary approach to chronic disease management.

Further nursing resources are required to ensure improved Healthcare provision is available to prisoners. Access to a tissue viability nurse, diabetic nurse and dietician, who could all provide sessions at HMP Lewes, would be advantageous to both staff and prisoners.

41. The clinical reviewer drew attention to the post mortem report which appeared to indicate that the man may have suffered a heart attack on 9 February 2006. The reviewer stated that this would have been picked up on an electro cardio gram (ECG), had it been taken at the time and would have resulted in the man's admission to hospital. This is usual procedure with a patient who shows similar symptoms when attending a GP practice in the wider community. It is not possible to say whether this would have altered the outcome, however the reviewer felt that an ECG should be routine in repeated episodes of angina.
42. The reviewer concluded that, with the benefit of hindsight, the man should have been transferred to hospital on 9 February when he had been experiencing angina attacks. This did not happen as the man's condition appeared to improve after treatment. The reviewer added that medical staff had considered transferring the man to hospital, should his angina have continued.

A review of when to undertake an electro cardio gram (ECG) recording and establish a subsequent protocol must be developed in terms of complaints of chest pain or angina. This would also empower nursing staff as part of their triage and management roles following agreed algorithms, as medical staff are not always onsite.

Conclusion

43. The man died from natural causes. Comments made by staff and prisoners at Lewes, show that he was a respected and well liked man. His popularity was further demonstrated by the many prisoners who attended his memorial service and who made donations towards a remembrance tree in his memory.
44. After talking to both staff and prisoners, neither my investigator nor the clinical reviewer could find sufficient evidence to suggest that the man was intentionally not taking his medication.
45. In light of the findings of the Clinical Review, and my own investigation, I conclude that the man's medical care was not entirely satisfactory. I make nine recommendations to the Sussex Downs and Weald Primary Care Trust to address in partnership with the Governor of Lewes.

Recommendations

Medical

- 1. As part of the National (Health) Service Framework for Long-term Conditions/Chronic Disease Management, all prisoners with diabetes must have a care plan which considers how their diabetes will be managed whilst in custody and on resettlement to ensure their health is managed where possible by the prisoners themselves but monitored regularly by the Prison Healthcare Service.**

Accepted - Charge Nurses G grade appointed and already in place. Progressing CDM register, asthma, diabetes, and heart failure clinics which are up and running.

- 2. As part of the National (Health) Service Framework for Long-term Conditions /Chronic Disease Management, all prisoners with chronic cardiac/heart conditions must have a care plan which considers how their condition will be managed in a seamless way whilst in custody and on resettlement to ensure their health is managed where possible by the prisoners themselves but monitored regularly by the Prison Healthcare Service.**

Accepted

- 3. All Healthcare staff must be encouraged to write legibly in the Inmate Medical Record (IMR), especially the medical staff.**

Accepted

- 4. There must be a record sheet in every IMR, which clearly records the name of the individual against their signature. This sheet should be available at the front of the IMR and each member of staff making an entry in the IMR for the first time should record their name and signature for future identification purposes. If electronic records are implemented a record of staff names and their signatures should be kept on file in an appropriate place.**

Accepted

- 5. Implementation of Wing Nurses must be progressed as soon as resources allow to improve the monitoring of prisoners' health on a day-to-day basis making it easier to access Healthcare and ascertain true activity of daily living needs of prisoners with health needs/impairments.**

Accepted - Staff vacancies being currently recruited and once in post and effective this new role will be commenced.

- 6. Non-compliance of medication (and diet) must lead to closer monitoring by perhaps reviewing use of in possession medication and periods between dispensing same for those at-risk. Various tools can be used to assess likelihood of compliance.**

Accepted - Considering Pharmacy Lead Clinic in next 6 to 12 months. Tools being looked into to measure compliance.

- 7. Further nursing resources are required to ensure improved Healthcare provision is available to prisoners. Access to a tissue viability nurse, diabetic nurse and dietician, who could all provide sessions at HMP Lewes, would be advantageous to both staff and prisoners.**

Accepted - PCT has agreed to increase resources as agreed cost pressure, which are being recruited to now. With PCT reconfiguration it is hoped access to specialists will be forthcoming.

- 8. Implement pharmacy-led clinics when resources available to offer advice and education to prisoners regarding their medication and compliance.**

Accepted

- 9. A review of when to undertake an electro cardio gram (ECG) recording and establish a subsequent protocol must be developed in terms of complaints of chest pain or angina. This would also empower nursing staff as part of their triage and management roles following agreed algorithms, as medical staff are not always onsite.**

Accepted