Investigation into the circumstances surrounding the death of a man at HMP Stocken in July 2011

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

This is the report of an investigation into the death of a man who was found in his cell at HMP Stocken in July 2011 having died from coronary artery insufficiency. This was caused by coronary artery atheroma (a serious heart condition where small arteries that supply blood to the heart muscle become narrow or blocked by a build-up of fats in the wall of the arteries). At the time of his death he was serving a five year sentence and had been in prison custody since September 2010. I extend my condolences and those of my colleagues to his family.

The investigation into the man's death was undertaken by an investigator from this office. A clinical review was commissioned into the medical care that the man received whilst in prison custody. I am grateful to the Governor and staff of Stocken for their co-operation with the investigation

Prior to the man transferring to Stocken, he had been investigated and monitored for blood pressure and cholesterol, although there was no record of this being followed up on arrival at Stocken. In the days before his death, he told his brother and another prisoner he had chest pains but did not raise this with staff. Wing staff spoke with the man the night before his death and raised no concerns regarding him. Although the clinical review finds that his death was not predictable, the investigation has identified a number of areas of learning for the service regarding continuity of healthcare, completion of full medical notes, first aid training for staff and ensuring all aspects of the contingency plans after a death in custody are followed. Associated recommendations are made to address these issues.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2012**

SUMMARY

1. The man was serving a five year sentence and had been in prison since September 2010. He arrived at HMP Stocken in April 2011 and died in July as a result of coronary artery insufficiency caused by coronary artery atheroma[1].

2. The man had no significant medical history. However, prior to his transfer to Stocken, he had been investigated and monitored for slightly raised blood pressure and cholesterol. Despite this, there was no mention of these checks in his medical record whilst at Stocken. It was documented in his medical record that he was a smoker who had participated in a smoking cessation programme.

3. Whilst at Stocken, the man did not describe any symptoms to healthcare or other staff that would indicate any heart related problems. A few days prior to his death another prisoner noticed he was pale and the man said his chest was tight. He had a telephone conversation with his brother and mentioned his chest pain. Both the prisoner and his brother advised him to seek help but he chose not to. Staff on the wing spoke to him the night before his death and raised no concerns about him.

4. One morning in July the man was unlocked as normal for breakfast but staff were unable to recall if he left his cell to get his breakfast. Another prisoner went into his cell and the man told him his chest hurt and he was going to stay in bed. He said he did not want anything when asked by the prisoner.

5. The man was in his cell when the roll check was completed at 9.13am and no concerns were raised by staff. He was later discovered unconscious in his cell just after 10.00am. The emergency alarm was raised and the prison doctor responded immediately. She declared him dead at 10.12am. The death in custody contingency plans were immediately opened.

[1] Coronary artery insufficiency is a condition in which the small arteries that supply blood to the heart muscle are compromised, leading to the heart being unable to function correctly. The coronary arteries become narrow or blocked by a build-up of fats (atheroma) in the wall of the arteries. Underlying issues that can increase the likelihood of a person developing diseased coronary arteries include raised blood pressure, smoking cigarettes and raised cholesterol in the blood.

THE INVESTIGATION PROCESS

6. The investigation into the man's death was opened at HMP Stocken on 2 August 2011 by an investigator from this office. He met with the Head of Residence, and the prison's family liaison officer. Notices of investigation and terms of reference had already been sent to the prison, inviting anyone with any information to contact the investigators.

7. The investigator also met and formally interviewed a number of prison staff. He visited certain areas of the prison including the wing and cell where the man lived. The man's prison records, including his medical record, were made available to the investigator. He also had access to transcripts of telephone calls made by the man. During the course of the investigation, the investigator provided verbal feedback to the Senior Officer and written feedback to the Governor of Stocken.

8. A clinical review of the man's medical care was commissioned from Leicester County and Rutland Primary Care Trust.

9. The investigator made contact with Leicestershire Constabulary and with Loughborough Coroner's office. A copy of this report will be sent to the Coroner to assist with his enquiries.

10. The Ombudsman's Senior Family Liaison Officer contacted the man's family to inform them of the investigation process however they raised no concerns or issues but wished to receive a copy of the report. We hope this report answers any questions the family may have.

HMP STOCKEN

11. HMP Stocken opened in 1985 as a young offender institution (YOI) and is now a Category C closed training prison. All adult male prisoners are classified on reception and put into one of four security categories based on likelihood of escape and the risk to the public if they did escape. The categories are:

    - Category A: prisoners who would be highly dangerous to the public, police or national security if there were to escape.
    - Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult.
    - Category C: prisoners who cannot be accommodated in open conditions but who are unlikely to make a determined escape attempt.
    - Category D: open conditions, prisoners who can be trusted not to try to escape.

12. The prison has recently expanded and it can hold up to 842 prisoners across eleven residential units. At the time of his death, the man was located on E wing. E wing delivers the Kainos course, which is a six month behavioural programme. It offers prisoners therapeutic offending behaviour interventions, supportive community living and social development and is also known as the 'Challenge to Change' programme.

HM Chief Inspector of Prison's report

13. The most recent inspection of Stocken by Her Majesty's Chief Inspector of Prisons was an announced inspection in August 2010. In a report published in February 2011, his comments included:

    > "Stocken is going through a demanding period of transition and it is therefore commendable that this full announced inspection found a prison that was both reasonably safe and focused on its resettlement tasks. However, some areas such as healthcare were struggling and, particularly for a rapidly expanding training prison, there was a need to improve purposeful activity. We observed some positive staff-prisoner interactions but prisoners reported negatively about staff and this needed to be more fully investigated and improvements made to mechanisms for consultation and engagement. The healthcare environment was spacious and clean. Despite this, staffing shortfalls had an impact on all aspects of the primary health care service and a full range of clinics had yet to be established".

Independent Monitoring Board report

14. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. In it's report to the

Justice Secretary for the year 2009 to 2010, the Independent Monitoring Board said it was satisfied the Governor was committed to achieving improvements in areas on which the Board had previously commented:

> "The Board has seen the outcome of structure changes made in recent years which demonstrates the changing way a prison operates. Although a few still see it as taking staff away from the "front line" an expertise is developing in areas which can benefit the prison and prisoners".

Reception screening

15. All prisoners go through reception procedures when they enter a prison. A cell sharing risk assessment (CSRA) is opened by the reception officer who completes the initial details. The form is first handed to First Night Centre staff who conduct a confidential interview. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells. An initial healthcare screen is also undertaken which concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

Suicide and self harm monitoring

16. The Assessment, Care in Custody and Teamwork (ACCT) system is the prison service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself.

17. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff believe the risk of harm to be very high, the prisoner may be constantly supervised, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of supervision may be several times an hour or day. Supervision can also take place during the night. As part of the process, a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings[2]. Wherever possible, the prisoner at risk is also included in review meetings.

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[2] Multidisciplinary teams are groups of staff and professionals from diverse disciplines who come together to provide comprehensive assessment and consultation.

Roll check

18. The roll check is a physical count of the number of prisoners in each prison. They occur at a specified times throughout the day and night. Staff count each prisoner to ensure they are in their cell. If staff cannot see a prisoner they must open the cell and be satisfied the person is in their cell.

Emergency codes

19. A code blue is an emergency code used to summon staff when there is concern that someone could be unconscious or having breathing difficulties.

Incentives and Earned Privileges scheme (IEP)

20. The IEP scheme provides incentives to reward good behaviour in prisons. There are three levels, basic, standard and enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell and community visits. Each prison sets its own criteria to obtain each level.

KEY EVENTS

Prior to the man's arrival at HMP Stocken

21. In September 2010, the man appeared at the Crown Court for an offence of robbery and was remanded into custody at HMP Lincoln. He was seen by reception nurse for the initial healthcare screen and no obvious problems were recorded. He said he knew how to access healthcare if he needed to. The records reveal he drank alcohol in the community but he did not feel this was a problem and he smoked approximately 15 cigarettes daily.

22. As part of healthcare provision for older prisoners, a specific older prisoner's assessment was completed with the man on 26 October but no issues were raised in relation to his health. A document with the man's name on it called 'personal care needs assessment' was completed on 26 October that asks "is there anything that you are worried about?" and the reply is ticked "yes". Underneath this is a handwritten entry: "says blood pressure …is high. Is putting application in for re-check". The man's medical records show he had his blood pressure checked at his request on 29 October and it was slightly raised. He was to be reviewed in two weeks.

23. A prison doctor noted the man's medical records on 16 November that his blood pressure reading was above the recommended levels and explained the risks of this to him. He had further medical tests on 24 November which found he had raised blood cholesterol. A second prison doctor noted that he required "cholesterol lowering lifestyle advice". There is also an entry on 10 December which states "seen by doctor" but there is no record of the consultation.

24. The medical record entry on 11 January said he had raised cholesterol and slightly raised blood pressure. He was given lifestyle advice which included an assessment of his diet, weight, alcohol, cigarettes and exercise. He was also referred to be seen by the smoking cessation advisor on 14 January. The man had an electrocardiograph[3] on 20 January and the clinical review notes the result was normal although this "neither confirms nor excludes the presence of coronary artery disease".

25. The medical records say the man attended the smoking cessation clinic for a few weeks and wore patches. He told healthcare staff he had started smoking again on 7 March. He cancelled his appointment with the clinic for the following day.

26. In April 2011 the man appeared at Nottingham Crown Court and was sentenced to five years imprisonment for robbery. He was transferred to HMP Woodhill. His medical record entry notes his history of alcohol abuse and that he told them he had been diagnosed with high blood pressure but had not started any

[3] A test of a patient's heartbeat that involves placing leads, or detectors, on the patient's chest to record electrical impulses in the heart.

medication. He was advised to book an appointment with the doctor. A cell sharing risk assessment (CSRA) was also completed and no concerns were raised about the man.

27. The following day, he was seen by a nurse who referred him to the dentist and recorded he was a smoker. He also noted that the man had concerns about his eyesight and a pain in his right knee.

The man's arrival at HMP Stocken

28. The man was transferred from Woodhill to HMP Stocken in April. The Person Escort Record (PER)[4] form states no current mental or physical health risks. An initial health screen was completed which noted he was a smoker and was not prescribed any medication. It said he was "fit for normal location, work and any cell occupancy". He also completed a self assessment OASys[5] form that day and stated he thought his risk of re-offending was low as he intended to work on release and hoped to have his own accommodation.

29. The man moved onto the Kainos community[6] on E wing in May. His prison records state his behaviour was positive and he was on the IEP enhanced regime. He was a willing worker who helped to clean the wing.

30. The man saw healthcare on a further two occasions for dental health problems but missed a third appointment with them on 1 July.

31. A fellow prisoner who was a friend of the man told the investigator that a couple of weeks before his death he noticed a difference in the way he looked saying he was: "pale all the time, he was struggling. It took him ten minutes to get down the stairs". The man told him on occasions that his chest was hurting and the prison and friend told him to go to healthcare to get it checked out but he "laughed it off". The prisoner's friend said his condition was noticeable but the man still carried on with his daily routine. He said in interview that the man had quite a good relationship with staff and there would have been no barriers for him telling them other than his pride.

32. Following the man's death, the investigator received copies of summaries of the telephone calls he made before his death. In July he telephoned his brother and told him he had pains in his chest. His brother told him to make an appointment

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[4] The PER form accompanies staff on all prisoner escorts and it provides a chronological record of the escort, e.g. meals served, times journey started etc. It also serves as a communication tool about risks a prisoner poses on escort or transfer.
[5] Offender Assessment System is the principal risk assessment and management system used by the National Offender Management Service (NOMS). It identifies static and dynamic risk factors generating a score in order to assess the likelihood of reoffending.
[6] Kainos Community runs the Challenge to Change programme. Challenge to Change is a six month community based programme designed to reduce reoffending.

with the doctor. He also made another call that day to his friend and one the following day to his sister, but he did not mention any chest pains.

33. The man requested a transfer to HMP Ranby to be nearer to his parents who were both unwell. On 27 July, the officer who helped him with the transfer paperwork and said in interview that the man was “absolutely fine, raised no concerns” and “looked as he always looked to him”. Another officer told our investigator that, prior to his death, the man worked on the unit which he was painting. The prisoner and friend said he “was just normal. He was a bit pale and that but we’d come to accept that”.

Thursday 28 July 2011

34. On 28 July at approximately 7.45am, the man’s cell was unlocked by a landing officer. She told our investigator that she had never met the man so did not know what he looked like but that there were no issues with any of the prisoners she unlocked that morning.

35. The prisoner’s friend went to the man’s cell to get a magazine once the cells had been unlocked. The man said he was going to stay in his bed as his chest was hurting and asked the prisoner’s friend to come back at 10.00am when he would be on his break. The prisoner’s friend asked him if he needed anything and he said no. The prisoner’s friend told our investigator that he was unsure if the man came out of his cell.

36. At approximately 8.45am, the officer locked up prisoners who were not required to be out of their cells. She saw the man through the observation hatch lying on his bed partially dressed and told the investigator: “as far as I could see there was no cause for concern”. The officer who locked up then closed the hatch and moved on.

37. The officer who helped with the transfer paperwork conducted the roll check just after 9.00am and prison records show it was completed at 9.13am. He told our investigator that he looked through the man’s cell and is almost certain he was sitting on his bed watching television. The officer said after the roll check he was getting out equipment for the cleaners on the wing and then went to try and get prisoners out of their cells who were not due to be anywhere else. At 10.10am, he said he opened the man’s cell door, saw him lying on the bed with his “face towards the door on his front…his head was wedged in between the bed frame” with “his left leg hanging from the bed”. He said the man’s face was discoloured. He said he put his hand on his shoulder and called his name. He then called a code blue on his radio and shouted to a prisoner to go and get staff. He said the 2nd officer on the scene came within 30 seconds, closely followed by a doctor on scene. He said he stayed outside of the cell to ensure no one else entered. The officer who helped him with his transfer paperwork told the investigator that he had not had any recent first aid training.

38. The 2nd officer on the scene said he was in the office when he heard a code blue over the radio. As he left the office, a prisoner asked him to go upstairs as the officer who helped the man with his transfer paperwork wanted to see him. The 2nd officer on the scene told our investigator that he went upstairs. The officer who found the man was standing outside the man's cell and said "I think he's dead". The 2nd officer on the scene said the man was "half in and out of bed" and his face was discoloured. He then went into the cell and put his hand in front of his face "to see if there was any breathing but there was nothing on there". At this point healthcare staff arrived and he left the cell to clear the area of prisoners. The 2nd officer on the scene told our investigator that he had not had any first aid or resuscitation training.

39. A registered Nurse was the designated Hotel 1[7] that day and said she was in the segregation unit when she heard the code blue on the radio. She immediately made her way to E wing and put a call out to the healthcare department for someone to meet her on the wing with the emergency bag[8]. She said when she arrived at the wing the doctor on the scene was just behind her.

40. The doctor responded to the code blue as she was alerted to this by an officer in the healthcare department who had heard it over the radio. She arrived at the man's cell at the same time as the nurse designated Hotel1 and saw the man lying on his front in bed. The doctor examined the man and found no signs of life. She declared him dead at 10.12am.

41. A Senior Officer responded to a code blue over the radio and said she arrived at the cell within a minute. On arrival, she said the 1st doctor on the scene was in the cell and declared the man dead.

After the man's death

42. The Senior Officer who responded to the code blue activated the prison's death in custody contingency plans with the Head of Residence. All the necessary agencies were informed that there had been a death in custody. The Samaritans and Listeners[9] were informed immediately and instructions were given to staff to review all prisoners with open ACCTs.

43. A hot debrief[10] meeting was held later that day in the chapel with staff involved in the incident. Staff said they felt supported after the death and had access to the prison care team.

[7] Hotel 1 is the radio call sign used to alert the designated nurse responsible for attending emergencies.
[8] The emergency bag contains medical emergency equipment including bandages, suction aids, Guedel airways, oxygen, blood pressure, temperature, pulse monitors, knives, and aspirin.
[9] Samaritans offer a confidential service for those who are experiencing feelings of despair and distress. Prisoners should have access to this service. Listeners are prisoners who are trained by the Samaritans to provide a confidential peer support service for other prisoners.
[10] A hot debrief is a meeting that takes place immediately after the death in custody to discuss any issues.

44. The man had named his mother as his next of kin. The prison's family liaison officer, and the Head of Residence visited the man's mother at her home later that day and told her about her son's death. They gave her information about what would happen next, including contact with the Coroner and discussed how the prison could assist with the cost of the funeral.

45. On 1 August, the Governor wrote to the man's family to offer his personal condolences and invited them to the prison to see where their son lived. Financial assistance was also provided to the family for the funeral. The prison's family liaison officer stayed in contact with the man's mother and had a telephone conversation with her daughter on 4 August.

Post mortem report

46. A post mortem and toxicology was provided by the Coroner's office to the Ombudsman's office. It said in relation to the man's cause of death that: "showed significant disease to be present to the coronary arteries" and "the degree of narrowing present is recognised to be a cause of sudden, unexpected cardiac death". The toxicology report showed no alcohol or drugs in his system. The Coroner could not give an exact time of death but concluded the man died "as a consequence of acute myocardial insufficiency (through a cardiac arrhythmia) as a consequence of coronary artery atheroma".

ISSUES

Clinical care

47. The clinical review was completed and is annexed to this report. The clinical reviewer believes the overall standard of clinical care that the man received was very good. His review highlights areas of good practice in healthcare delivery in Lincoln, Woodhill and Stocken.

48. The review states that his death was not predictable. Although he was a smoker with raised blood pressure and cholesterol, he writes: “these factors increase the likelihood of a person developing coronary artery insufficiency but how and when a person does (or does not) develop symptoms or complications is unpredictable”. The man never made staff aware of any symptoms consistent with coronary artery insufficiency.

49. The clinical review does raise concern about the lack of reference to the man’s blood pressure and cholesterol whilst he was at Stocken. The man was not prescribed medication however, there was reference to his conditions in his medical records and this should have been investigated further on his admission to Stocken. The investigation team discussed this with the Head of Healthcare and we understand changes have since been made regarding the medical information gathered on admission. Nonetheless, the following recommendation seeks to ensure healthcare staff investigate previous medical problems with all new prisoners:

    The Head of Healthcare at HMP Stocken should ensure healthcare staff investigate all previous medical problems with all new prisoners.

50. The clinical review says that medical records at HMP Lincoln were not fully completed after each consultation with the man. The clinical reviewer recommends that the Head of Healthcare should ensure all medical staff complete full notes after consultations. This report will be shared with HMP Lincoln.

    The Head of Healthcare at HMP Lincoln should ensure full medical notes are completed after every consultation with a prisoner.

Emergency response to the man’s cell

51. The officers and healthcare staff responded immediately to the code blue, although the officers who were first on scene did not have up to date first aid or CPR training. Although this would have made no difference to the man we consider it essential that uniformed prison officer staff, who are usually the first responders to medical emergencies, have up to date first aid training. We refer to a letter written by Mr Michael Spurr on 20 October 2010 to all prison governors. The letter highlights the need for each establishment to review the first aid arrangements for prisoner related incidents and remedy any shortfall.

    The Governor should ensure that, in line with Michael Spurr’s letter of 20 October 2010, sufficient staff are trained in first aid and basic life support.

Death in custody contingency plans

52. Upon the discovery of the man’s, the death in custody contingency plans were begun. A requirement of this is for staff to complete incident statements but this was not done:

    The Governor should ensure that all elements of the contingency plans are adhered to by staff after a death in custody, which includes the completion of incident statements.

CONCLUSION

53. Although heart related deaths make up a significant number of deaths by natural causes, successful prevention of such deaths can often depend on prisoners coming forward and telling staff of their symptoms. Prior to his death, he told another prisoner and his brother about pain in his chest and both advised him to seek medical help but there is no record of him making staff aware. The clinical review states that, although he had factors which increased the likelihood of developing coronary artery insufficiency, his death could not have been predicted.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Stocken should ensure healthcare staff investigate all previous medical problems with all new prisoners.

   The National Offender Management Service accepted this recommendation, writing:

   “Reception screen has since been reviewed and improved. A standard operating procedure is in place for reception screening. This includes reviewing past medical history, and includes checking everybody’s blood pressure in reception when the patient comes into HMP Stocken. All staff working in reception have read and signed to say they have understood this guidance. The guidance also sign posts staff on how to refer to special clinics in the department for example hypertension.”

2. The Head of Healthcare at HMP Lincoln should ensure full medical notes are completed after every consultation with a prisoner.

   The National Offender Management Service accepted this recommendation, writing:

   “*Healthcare consultations are now recorded electronically on systm1. Every consultation is documented.*”

3. The Governor should ensure that, in line with Michael Spurr’s letter of 20 October 2010, sufficient staff are trained in first aid and basic life support.

   The National Offender Management Service accepted this recommendation.

4. The Governor should ensure that all elements of the contingency plans are adhered to by staff after a death in custody, which includes the completion of incident statements.

   The National Offender Management Service accepted this recommendation.