PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at a hospital, while in the custody of HMP Channings Wood in February 2013

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, a prisoner at HMP Channings Wood. He died of multi-organ failure in February. He was 76 years old. I offer my condolences to his family and friends.

An investigator carried out an investigation. A clinical reviewer conducted a clinical review of the standard of healthcare the man received at Channings Wood.

The man had a number of chronic medical conditions when he first arrived in prison in July 2010. He was 74 and had a history of mini-strokes, diabetes, swollen arteries, an autoimmune disease that caused inflammation in the muscles, and non-Hodgkin's lymphoma (which was in remission).

On the morning of 12 February 2013, the man was found on the floor of his cell. He told the prison officer who found him that he had slipped when getting out of bed and that he just felt cold, so he was helped back to bed. The prison doctor assessed him later that morning and was concerned about his condition. He was taken to hospital, where he was admitted to the intensive care unit. He had a heart attack in hospital, was diagnosed with multi-organ failure and later died. His family were with him when he died, but I consider that greater efforts should have been made to contact them as soon as he was taken to hospital on 12 February.

The clinical reviewer notes that the man's death was not preventable and I am satisfied that he received a satisfactory standard of care at Channings Wood, which was equivalent to that he could have expected in the community.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2013**

CONTENTS

SUMMARY

1. The man was sentenced to 8 years imprisonment on 15 July 2010, and was taken to HMP Exeter. In reception, he was identified as diabetic and in remission from non-Hodgkin's lymphoma. He was a smoker, but declined help to stop smoking. Throughout his time in prison, he had regular blood tests and was seen by specialists as part of his diabetic care plan.

2. On 5 July 2011, the man collapsed because of low blood pressure and was taken to hospital. He had a similar episode on 17 August, but refused to see a doctor. He transferred to Channings Wood on 7 October 2011. He had another dizzy episode in December caused by low blood pressure. In September 2012, blood tests showed that he had raised cholesterol and he was encouraged to improve his diet, stop smoking and exercise as much as his condition allowed. His cholesterol reduced over the next few months.

3. On 18 January 2013, the man was prescribed antibiotics for a chest infection. Officers were concerned that he was not getting better and, at their request, he was seen by a nurse on 6 February. The next day, a prison doctor diagnosed an ongoing chest infection and prescribed alternative antibiotics. On 9 February, a nurse examined him. His observations were normal and he told staff he thought his chest infection was improving. The next day his cough and wheeze had improved, although he said that he was still breathless.

4. On 12 February, the man was found on the floor of his cell at 7.24am during the morning roll check. He was helped back to bed and told staff that he was cold, but otherwise fine. He had a pre-arranged appointment with the doctor later that morning, but following an attack of diarrhoea he was seen as a priority. A doctor examined him and recorded that he had poor oxygen levels, had noticeably lost weight and needed rehydrating. An ambulance was requested at 10.32am and he was taken to hospital. He had low blood sugar, was severely dehydrated and was admitted to the intensive care unit. At 12.35am he had a heart attack. His family were informed that he had multi-organ failure and that he was not going to recover. His condition deteriorated and he died at 10.15am. His family was with him at the time.

5. The clinical reviewer concludes that the man received a satisfactory level of care at Channings Wood. We make one recommendation to ensure the prompt notification of a prisoner's next of kin when they are taken to hospital in a serious condition.

THE INVESTIGATION PROCESS

6. The Ombudsman was notified of the man's death on 13 February. The investigator issued notices informing staff and prisoners at HMP Channings Wood of the investigation and asking anyone with relevant information to contact her. No one responded.

7. The investigator visited Channings Wood on 5 March 2013. She met the Governor and staff, as well as prisoners who had known him. She obtained copies of his medical and prison records. She also visited the wing where he had lived and the healthcare unit.

8. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care at Channings Wood.

9. The investigator conducted telephone interviews with two staff on 27 March and returned to Channings Wood on 4 April to interview five members of staff and one prisoner. She fed back to the Governor throughout the investigation and confirmed her feedback in writing on 8 April.

10. Devon Ambulance Service provided details of the contact they had with the prison on 12 February.

11. HM Coroner for Torbay and South West Devon was informed of the investigation and a copy of the report has been sent to him.

12. One of this office's family liaison officers contacted the man's next of kin on 25 February to explain the purpose of the investigation. They asked for the following questions to be considered:

    - Were telephone calls with his family, when he discussed his health, recorded and available?
    - Why was he not hospitalised sooner, as his health was failing?
    - What did healthcare staff do about his weight loss?
    - Did he receive appropriate care and was he prescribed the correct medication?
    - What time was he found on 12 February?
    - Why were his family not told that he had been admitted to hospital until 7.00pm on 12 February?

13. The draft report was issued to the man's family as part of the consultation process. They remain concerned at the length of time it took to notify them of his admission to hospital. They said they had contacted the prison to raise their concerns of his health previously but felt the communication was poor.

They believe he was not treated quickly enough when he developed a chest infection.

The family would like to express their thanks to the chaplain and staff who helped the man. Other points the family raised have been addressed in separate correspondence and factual inaccuracies have been amended.

HMP CHANNINGS WOOD

14. HMP Channings Wood is a category C training prison near Newton Abbott in Devon. It holds over 700 convicted adult prisoners, a large proportion of whom are considered vulnerable, mainly due to the nature of their offences.

15. Health services at Channings Wood at the time the man was there were commissioned by the NHS, and provided by a Partnership Trust. Since 1 April 2013, health services have been provided by a NHS University Trust. There is no inpatient unit and clinics are run like a community GP practice. Nurses are available everyday, including weekends, and an out of hours GP service is provided by a private company.

HM Inspectorate of Prisons

16. The last inspection of Channings Wood was in September 2012. The Inspectorate report noted that the prison continued to perform reasonably well against most of the inspectorate's tests. The provision of healthcare was assessed as satisfactory, but services had been disrupted by the absence of a healthcare manager and staff vacancies. Prisoners' access to nurses and a GP was judged to be reasonable.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board, (IMB) made up of unpaid volunteers from the community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. Its annual report for the year to 31 August 2012, noted that there has been deterioration in the overall performance of the healthcare unit. The frequent use of agency nurses had led to difficulties when emergency cover was required. The IMB concluded:

> "The unfamiliarity of temporary medical and nursing staff with both prisoners and prison systems has resulted, in our view, in a failure of prisoners' rights (i.e. their right to receive a standard of medical care consummate with that received by the wider community). Additionally, it is the belief of the Board that long term medical care, particularly of prisoners presenting with chronic conditions, can slip under the radar as a result of the above problems."

Previous deaths at Channings Wood

18. The man's death was one of five deaths from natural causes at Channings Wood in the past year. There are no direct similarities in the circumstances of these deaths. However, in previous cases we have been critical of the unnecessary use restraints in hospital. We are pleased to note that he was not restrained.

KEY EVENTS

19. The man was sentenced to eight years imprisonment at Crown Court on 15 July 2010, when he was 74 years old. He had not been to prison before.

HMP Exeter

20. At his initial health screen, the man told the prison doctor that he had suffered an abnormal aortic aneurysm (a swelling of the artery) and carotid artery occlusion (a blockage in the neck which increases the risk of stroke) in 2001, and strokes in 2003 and 2006. He was diagnosed with non-Hodgkin's lymphoma in 2008, and had glaucoma and cataracts, polymyositis (an auto-immune disease that causes inflammation in the muscles) and type 2 diabetes. He smoked but declined help to stop. His blood pressure and pulse were normal at 110/70 (the normal range for blood pressure is 100/70 to 140/90), his pulse was normal at 76 bpm (beats per minute – the normal range is 60-80). His weight was not recorded. He was prescribed various medications to manage the symptoms of his illnesses and to help reduce the risk of further strokes.

21. On 22 July, the man was categorised as security category C and requested a move to Channings Wood prison to be closer to his family. Due to the lack of space at Channings Wood at the time, he transferred to HMP Dartmoor on 18 August 2010.

HMP Dartmoor

22. At his initial health screen at Dartmoor, a nurse referred the man to the prison doctor for a review of his medication, which a doctor completed on 27 August. An officer assessed his needs on the wing. He signed a disability declaration form, stating that he wanted to look after himself, was aware of the available support if required and had no problems. At Dartmoor, he lived on the ground floor due to his age and reduced mobility. He had monthly blood tests (to monitor his lymphoma).

23. On 21 March 2011, a nurse carried out a routine health check. He recorded that the man's blood pressure was slightly low, his pulse normal (144/68 and 64bpm) and that he weighed 68kg. A doctor reviewed his medication on 13 April 2011 and, as directed by the consultant, continued to reduce the prednisolone medication. Over the next few months, he saw a dentist, and an ophthalmologist. He was encouraged to stop smoking, but he told a nurse that he did not feel ready.

24. The man collapsed during an education class on 5 July. He was taken by ambulance to hospital and was diagnosed with low blood pressure. The hospital completed tests to establish if he had suffered another stroke or if he had developed heart problems. There was no information recorded on the medical record about the outcome of these tests, what treatment he received or when he returned to Dartmoor from the hospital. On 17 August, he told

staff that he had experienced a similar episode earlier that day, but he refused to see the GP.

HMP Channings Wood

25. The man moved to Channings Wood on 7 October 2011. When he arrived he had another health screen and told a nurse his medical history. His blood pressure was still low (50/70) and he now weighed 64kg.

26. On 11 December 2011, the man had a dizzy episode. A nurse examined him and found his blood pressure was normal (100/70) but he had a fast pulse (128bpm). He told the nurse that he felt better, had no chest pain or shortness of breath. The nurse asked him to let officers know if he felt unwell again. The next day the nurse examined him. His blood pressure and pulse were normal (100/70 and 64bpm) and she referred him to the prison doctor for review. The next day, a doctor examined him and a full set of blood tests were requested. The results were received on 16 December and were all within the normal range taking into account the medication that he was prescribed.

27. Over the next few months, the man continued to have regular blood tests was seen by a podiatrist and ophthalmologist as part of his diabetic review. He had a negative bowel cancer screening test. He attended routine consultant appointments as part of his chronic disease management and was treated for minor ailments such as vomiting and diarrhoea.

28. On 27 September 2012, a prison doctor reviewed the man as his blood test results indicated that he had raised cholesterol (The recommended level is less than 5 and his was 6.2). The doctor encouraged him to stop smoking. His next blood tests over the next few months showed that his cholesterol had reduced. On 31 January 2013, it was recorded as 5.5.

29. The man was diagnosed by a doctor with a chest infection on 18 January 2013 and prescribed antibiotics. He was reviewed on 22 January by a doctor, who noted his chest was clear.

30. Telephone calls are not routinely monitored by staff, but are recorded and retrievable for a time. The investigator listened to a telephone call the man made to his family on the morning of 27 January. He asked them not to visit as he was feeling unwell and did not think he would make the walk to the visits hall as he was breathless. He told his daughter that he had a ‘bug’ and a phlegmy cough, but he had booked an appointment to see the doctor. He made a second telephone call to his family the same day in the afternoon. He told his wife that, following a telephone call made by his family to the prison, an officer had gone to his cell to explain that he would have to wait for a routine appointment, and that a telephone call from his family would not speed this up. He had a brief conversation with his wife the next day and told her that he was all right.

31. On 30 January, the man telephoned his family. During the call, he told his daughter that he was still waiting to see the doctor, that he was not eating much as the food was 'bloody awful' and that there was only 'rubbish food' available to buy that he could not make a meal with.

32. The next contact with his family was on 2 February, when he told his wife that he had still not seen the prison doctor, but had been examined by a consultant neurologist at hospital the previous day. He had attended for a routine check up relating to his polymyostis and lymphoma. The consultant wrote to the prison after this appointment and noted that his creatinine kinase blood test results were within normal range (raised levels indicate damage to the organs). He told his wife that the consultant had told him that he looked better. His wife pressed him to tell the prison that his request to see the GP was urgent. He did not respond to this and told his wife that he would contact her again in a few days. This was his last telephone call.

33. On 6 February, officers asked healthcare staff to review the man as he was still poorly. A nurse examined him in his cell, who told him that he was short of breath, wheezing at night and still coughing up phlegm. He did not complain of chest pain. His blood pressure was normal (130/72) but his pulse high (110bpm) and the nurse referred him to the prison doctor for review. His daughter wrote to Channings Wood the next day, 7 February, stating that his family were concerned about his health, the unusual lack of contact from him and requested they be kept informed of his condition. A doctor examined him the same day and diagnosed an ongoing chest infection. She prescribed different antibiotics and said he should be given extra pillows to help with his breathing at night.

34. On 9 February, a nurse reviewed the man as officers were concerned that he was losing weight. The nurse recorded that there was no sign of dehydration and he told the nurse his chest infection was improving, but he was still short of breath. The nurse examined him again in the healthcare unit the next day. His blood pressure and pulse were normal (130/80 and 76bpm), there were no signs of dehydration and he weighed 65kgs. He told the nurse that he still got breathless, but his chest infection was improving and his cough and wheeze at night had gone. The nurse recorded that there was no obvious cause for concern and made an appointment for him to be reviewed by the prison doctor on 12 February.

Events on 12 February

35. On 12 February, Officer A started the morning roll check at 7.23am (officers are required to check each cell and count the number of prisoners). He looked into the man's cell at 7.24am and CCTV (closed circuit television) showed that he spent time talking to him through the cell door. He was then joined by Officer B and they unlocked the cell at 7.26am and went in. Officer A told the investigator when he looked into the cell the man was on the floor. He was conscious and did not complain of being in pain, but said that he had fallen getting out of bed and was cold. He called Officer B, who helped him

get the man back into bed. They told him that they would arrange for him to be seen by the doctor later that morning and left the cell at 7.31am.

36. Officer C unlocked the cells on the man's wing at 8.05am. He went into his cell and spoke to him, as he had been told he had been found on the floor earlier that morning. The officer visited him again at 8.41am to check on him. He told him that a doctor's appointment had been arranged and that he would get assistance to take him over to the healthcare unit in a wheelchair.

37. At 9.30am, Officer C and a prisoner who was helping with the wheelchair arrived at the man's cell to take him for his doctor's appointment. He was not ready, so they waited outside his cell to allow him some privacy to get dressed. Every few minutes, the officer knocked on the door to check him. The prisoner chatted to him in the doorway at 9.38am. At 9.45am, they again checked him. The prisoner went into the cell and saw that he had tried to use the toilet but had soiled himself.

38. At interview, both the officer and the prisoner said until the point that the man had become incontinent, they were not too concerned about his health and just thought he was poorly. They said that they were very concerned about him, because of his diarrhoea. The prisoner helped him clean himself up and get dressed, while the officer went to get help. At 9.53am, he was helped by officers into a wheelchair, wrapped in a blanket and duvet, and was taken to his appointment in another houseblock.

39. When they arrived, Officer C went straight to the doctor's office to request that the man was seen urgently. A doctor examined him, and recorded that he had cyanosis (a lack of oxygen), that he had lost weight since she last saw him and that he needed rehydrating. She also noted that there was a minor injury to his leg. At interview she said that this was a minor red mark, which had not broken the skin. It had been caused when he fell getting out of bed and did not need any medical treatment.

40. The doctor asked prison staff to call an emergency ambulance to take the man to hospital for treatment while she continued her assessment. The ambulance was requested at 10.32am and arrived at Channings Wood at 10.42am. Paramedics spent some time with him assessing his condition. They tried to administer fluids, but were unable to do so. The ambulance left the prison at 11.22am. The ambulance went via the Ambulance Station, where at 11.29 am, another paramedic tried to administer fluids intravenously but was unable to do so. They left the ambulance station at 11.53am. He arrived at hospital at 12.05pm.

41. The man was accompanied by a Senior Officer (SO) and an officer and no restraints were used. Before leaving the prison he told the SO that he would like his family told that he was being admitted to hospital. This message was relayed to the duty governor, but his family were not notified.

42. The man was taken to the Accident and Emergency Department. Over the next few hours, he was treated for dehydration and warmed up. He had

various tests, and was admitted to the intensive care unit at approximately 6.45pm. The prison did not tell his family that he had been admitted to hospital until 7.00pm, after he had been admitted to the intensive care unit. Throughout this time, he was described by the SO as quiet, but alert and coherent. A consultant in critical care noted that he had untreatable multi-organ failure and could not be treated, although nurses would ensure that he was pain free.

43. At about 11.00pm, the man told nurses that he was becoming more breathless. At 12.20am on 13 February, the nurses told the prison escort staff that his condition was deteriorating and asked for the details of his next of kin. He had a heart attack at 12.35am. Escort officers contacted the prison to get the correct telephone number for his family, but hospital staff had got the number by this time. The hospital contacted the family to say that his condition had deteriorated and they arrived at the hospital a short while later. His condition continued to worsen and he was pronounced dead at 10.15am by a hospital doctor.

Liaison with the man's next of kin

44. An officer was appointed as the prison family liaison officer the next morning. Before she had time to arrange a visit with the man's family, she was told that he had died. The duty governor met the family at the hospital. His family said that they did not want to meet with the family liaison officer, or want a home visit from prison staff, but agreed to meet the prison chaplain the next day.

45. The chaplain and the Governor met the man's family at the hospital on 14 February. The family said that they were concerned about his treatment. The family liaison officer arranged to return his belongings but, as his family did not wish to meet her, all subsequent contact with the prison was made through the chaplain.

46. The chaplain conducted the man's funeral on 28 February. At the request of his family, no other prison staff attended. The prison contributed to the funeral costs in line with national guidance.

Cause of death

47. A consultant in anaesthesia and critical care medicine at the hospital recorded the man's cause of death as congestive cardiac failure (when the heart is unable to sufficiently pump blood around the body), acute renal failure (when the blood supply to the kidneys is suddenly interrupted or when the kidneys become overloaded with toxins) and acute hepatic failure (the rapid development of liver dysfunction).

Support for prisoners

48. The man had been at Channings Wood since October 2011. He was a quiet member of the wing and was well liked by other prisoners and staff. A notice

to prisoners was issued by the Governor on 13 February which announced his death and expressed condolences. This notice reminded prisoners of the available support, from wing staff, the prison chaplaincy and Listeners (prisoners trained by the Samaritans to provide confidential support to other prisoners).

49. The chaplain conducted a memorial service for the man at 2.00pm on the day he died for those prisoners who wished to pay their respects.

Support for staff

50. The duty governor held a hot debrief with the escort staff who were who were with the man when he died. (A hot debrief is a meeting immediately after an incident, designed to reassure staff, and provide them with support.)

ISSUES

Clinical care

51. The clinical reviewer's review concludes that the medical care and treatment the man received at Channings Wood was appropriate and equivalent to care in the community. In November 2012, three months before his death, blood tests showed that his kidney failure was marginal and a referral to secondary care would not have been appropriate.

52. The clinical reviewer noted :

> "In his final illness, the man was seen and examined appropriately by two different doctors. They both diagnosed a chest infection. He was admitted when there was a clear deterioration and alteration in his vital signs. After his admission to hospital his blood pressure dropped dramatically, and it would appear likely that he suffered some major cardiac event. However as no post-mortem has been performed this must remain conjecture. He was seen on the 6th, 9th and 10th of February by a nurse. He concurred with the doctor's diagnosis and treatment plan. His weight on admission and in his final illness did not differ greatly (1kg)."

53. The man presented with symptoms of a persistent chest infection in the weeks before his death, which appeared to be responding to antibiotic medication. His observations were taken regularly and were within normal range. The clinical reviewer is satisfied that he had no other symptoms that suggested organ failure.

Response on 12 February

54. When the man was discovered on the floor of his cell during morning roll check, Officer A with the help of Officer B opened the cell and checked on his well being. The man told Officer A that he was cold, but otherwise all right and he was helped back into bed. He already had a doctor's appointment that morning, but recognising that he was very poorly, Officer C arranged for him to be examined urgently. The doctor quickly requested an ambulance to take him to hospital, and telephoned them in advance to tell them that he was on his way.

55. The clinical reviewer has concluded that the man's care was comparable to the treatment he would have received in the community. He does not consider that he would have been admitted to hospital any earlier if he had not been in prison.

56. We are satisfied that there was an appropriate response to finding the man on the morning of 12 February. Staff made regular checks on him before his doctor's examination. Officer C wanted to maintain his dignity by allowing him privacy to get dressed, arranged for him to be assisted to the healthcare unit, and acted quickly when he had a severe bout of diarrhoea. We agree

with the clinical reviewer that there were no unnecessary delays in taking him to hospital for treatment.

Notifying the man's family

57. Prison Rule 22 requires governors to inform the prisoner's spouse or next of kin when a prisoner 'becomes seriously ill'. The man's condition was sufficiently serious for the prison to have called an emergency ambulance on 12 February and we would have expected his family to have been notified at that stage.

58. The SO asked the man if he wanted his family told that he was being taken to hospital before he left the prison by ambulance at 11.22am. He told her that he would, and she passed this on to the duty governor. Escort officers were contacted at 6.00pm for a routine update on his condition and to clarify if he wanted his family told that he had been admitted to hospital. The SO explained this request had been conveyed earlier that morning and was surprised his family had not already been notified. The duty governor told the investigator that the prison had tried to telephone the man's wife a number of times during the day, but there was no answer and they did not think it was appropriate to leave a message. There is no record of these telephone calls.

59. The man's family were not informed of his admission to hospital until later in the evening of his admission, after he had been taken to the hospital's intensive care unit. We do not consider that the prison appropriately fulfilled its responsibility to contact them promptly when he was admitted to hospital.

The Governor at Channings Wood should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.

RECOMMENDATIONS

1. The Governor at Channings Wood should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.

   Accepted - *Head of Ops/Security has updated contingency plans to ensure the next of kin are notified as soon as possible and all attempts to contact family are to be logged. Completed 14.06.13*