Investigation into the death of a man at HMP Usk, on 2 April 2005

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

DECEMBER 2005

This is the report of an investigation into the death of a man. This man died in HMP Usk on 2 April 2005, having reported feeling unwell the previous evening.

The man had been returned to custody on 11 September 2004 as he had breached his licence conditions. This was not, therefore, his first experience of prison life. He was held at HMP Usk and it was there that he died on 2 April 2005.

This investigation has been undertaken by one of my investigators. I would like to thank the Acting Governor of Usk Prison, and his staff for their participation in the investigation. I am particularly grateful to the Head of Residence, for his assistance with the arrangements. My deputy ombudsman was commissioned to undertake a review of the man's medical care.

The loss of a loved one is always distressing. I would like to add my condolences to those already expressed by my Family Liaison Officer, on behalf of the office.

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

CONTENTS

Summary

1. The man was born in 1951 and was 54 years old when he died from natural causes on 2 April 2005.

2. He arrived at Usk on 28 October 2004, after initially being received at HMP and Youth Offenders Institute Parc. During his First Reception health screens at both prisons no concerns were highlighted about his physical or mental health.

3. During the evening on 1 April 2005, the man complained to staff of having stomach pains. A Night Orderly Officer contacted the duty nurse, by telephone. The Nurse asked to speak to the man to make an assessment of his condition but this was not possible as the prison was in patrol state at that time. She therefore advised that the man be given fluids and some Rennies (an anti-acid preparation).

4. After taking the medication the man vomited but this seemed to ease the pain and he then lay down to watch his television. The Night Orderly Officer spoke to the man just before midnight and he confirmed that the pain was easing and that he was now going to sleep. An Operational Support Grade (OSG) noticed at 1:30am that the man was asleep with his light on.

5. At 7:40am the next day, a Senior Officer entered the man's cell and discovered that he had died during the night.

6. The clinical review concludes that the man's care was appropriately managed while he was in custody.

7. On 13 May 2005, one of my Family Liaison Officers contacted the man's family. They did not express any concerns about the care and treatment given to him by the prison. Although, after receiving a copy of the draft report the family did express concerns about his care and treatment by the prison.

Background

8. The man was born in Wales in 1951. He had been received into custody on 11 September 2004 as he had breached his licence conditions by going abroad to Ireland without informing the authorities. He had surrendered himself at the earliest opportunity following his return from Ireland.

9. This was not the man's first experience of prison life and he had served a number of terms in prison. He had six previous convictions, all of which, apart from a conviction for theft in 1988, gave cause for serious concerns regarding public safety. The man had been remanded in custody from 1999 until he was sentenced to six years imprisonment in March 2003. When he appeared in court he decided to plead guilty to a lesser charge. This meant that due to the length of time the man had spent on remand, he served only a short period in custody as a convicted prisoner before being released on licence in May 2003.

10. Again because of the short period of time he spent as a convicted prisoner, he had not undertaken any offending behaviour courses prior to his release on licence in 2003.

HMP Usk

11. HMP Usk has a long and varied history as a penal establishment since opening in 1844 as a House of Correction. Since 1990, it has been an Adult Category C Prison for Vulnerable Prisoners. The accommodation at Usk comprises of four wings - A, B C and D, in two storey blocks which are connected to a central hall. The current population is 250 prisoners.

12. During the evening, when patrol status is in force, the night staff are given a hand over by the staff going off duty, together with a sealed packet containing cell keys to be used in an emergency. In the morning, the day staff are also given a hand over and the sealed packet is returned before the night staff go off duty.

13. Healthcare is provided by a medical officer and four nursing staff who also work in HMP Prescoed Open Prison, which is nearby.

14. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an unannounced inspection of Usk in January 2002. The inspection report described Usk as "a safe prison, with a strong sense of ownership and pride in the prison amongst staff and prisoners".

Conduct of the investigation

15. My investigator studied all relevant prison records relating to this man. These included statements from prison staff, his main prison record and Inmate Medical Record (IMR). My investigator also studied instructions at Usk on the arrangements to be followed when a death occurs in the prison.

16. The Deputy Ombudsman carried out a Clinical Review of the care provided to the man.

17. 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.

18. One of my Family Liaison Officers contacted the man's family. They initially raised no concerns about his treatment whilst in custody. After reading the draft report the family added their concerns to my own with regard to the on-call nurse being unable to speak to the man before his death and the access restrictions during patrol status. The family felt that the lack of medical care provided to the man amounted to negligence by the prison service.

19. My investigators visited Usk and discussed aspects of the man's treatment with a range of senior staff at the prison. These included the Head of Heath Care, the Night Orderly Officer, and a Nurse. The clinical review found that the man's clinical care was appropriately managed while he was in custody. However, I do however have concerns that the on-call nurse is unable to speak to prisoners once the establishment is in a patrol state.

Key findings

20. The man was initially received into custody at HMP Parc and was transferred to Usk on 28 October 2004. The First Reception health screens, which were carried out at both prisons, did not highlight any concerns about his physical or mental health.

21. On 1 April 2005 at 7:37pm, the man requested and was issued with two paracetamol by an Officer. Around 9:30pm, the man rang his cell call light/bell complaining of chest and stomach plains. A Night Orderly Officer responded and confirmed that the man had already taken two paracetamol.

22. The Night Orderly Officer contacted the Duty Nurse, and advised her of the man's symptoms. The Nurse advised that he should sip plenty of water and should be offered some Rennie (an anti-acid preparation) tablets.

23. The Night Orderly Officer gave the man the tablets. He swallowed the tablets and immediately vomited twice. He then told the Night Orderly Officer that the pain had eased and that he was going to lie down to watch his television.

24. At 11:55pm, the Night Orderly Officer spoke to the man who told him that the pain was easing and that he was going to sleep. The Night Orderly Officer told him that, if the pain returned or got any worse, he was to push his cell call light for assistance. An Operational Support Grade noticed at 1:30am that the man was asleep with his light on.

25. At around 7:50am the next morning, a Senior Officer entered the man's cell to check on him as he appeared to be asleep. The Senior Officer noticed that he looked quite pale so she touched his skin, which was very cold. The Senior Officer then felt his neck for a pulse and again found this area quite cold. Believing that he had been dead for quite a while, the Senior Officer asked two other Officers to check for signs of life. After the officers confirmed that there were no signs of life, the Senior Officer locked the cell and an Officer remained at the door to the cell.

26. At 8:03am, an ambulance was called. When the paramedics arrived at 8:30am, they confirmed that the man was dead. At 8:45am, he was pronounced dead by the prison doctor.

27. The duty governor was immediately informed of the man's death. The prison attempted to contact the man's next of kin but they were abroad at the time. The prison subsequently maintained contact with the man's family. Assistance was offered with the funeral arrangements but the family did not take up this offer.

28. The post mortem states that the cause of death was due to natural causes as a consequence of a ruptured aneurysm of the thoracic aorta (a burst blood vessel in the heart).

29. The Clinical Reviewer concluded that the man's care while he was in prison was appropriately managed from his reception into custody at Parc and after transfer to Usk. The man's high blood pressure reading prompted timely rechecks to ensure it was returning to normal without further interventions.

30. The use of the on-call nurse system for out of hours clinical advice is to be commended and ensures that staff are able to access timely and appropriate support. However, I do have concerns that the on-call nurse is unable to speak to prisoners once the establishment is in a patrol state.

31. Blood samples were taken from the man for a cholesterol test in November 2004. It is unclear who or why this test was ordered. On receipt of the results, they appear to have been seen by the doctor but then filed with no apparent action identified to treat and manage the abnormal findings. Whilst it would have no bearing on the outcome of this case, and while I believe no formal recommendation is required, staff should be reminded of the need to keep accurate records, document appropriate actions and plans of care.

Recommendations

The Governor should review arrangements for night staff to contact the duty nurse and to enable the nurse to speak to the patient and obtain full clinical details.