Investigation into the circumstances surrounding the death of a man at HMP Swaleside in September 2011

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the death of a man who died in September 2011, whilst in custody at HMP Swaleside. He was 67 years old. I offer my sincere condolences to the man's family and friends.

The investigation was conducted by one of my investigators. A clinical review of the man's healthcare was carried out by a clinical reviewer on behalf of Eastern and Coastal Kent Primary Care Trust. I apologise for the delay in issuing this report.

The man was given a prison sentence in Ghana in 2004. In 2008, he was diagnosed as having heart disease. He applied for repatriation to the U.K. and returned to England on 15 September 2010. He was transferred to Swaleside on 6 October 2010, to complete his sentence. During his reception, it was noted that he walked with a crutch due to arthritis of the spine and was suffering from cardiac problems and prostate cancer. He was referred to a doctor who referred him to a cardiologist. He was prescribed long-term medications for his various problems and was regularly seen by nurses and doctors. He was also referred to an urologist in April 2011, and three months later his prostate cancer was found to be in remission.

At 9.30am on a day in September, the man was found slumped on his bed. Nurses immediately attended to him but they found no signs of life. They worked hard to resuscitate him until an ambulance crew arrived and took over. However, all resuscitation efforts were unsuccessful and he was pronounced dead. The post mortem confirmed that the man's death was the result of heart disease.

The investigation found that the man was well looked after by staff at Swaleside, and the clinical reviewer confirms that he was given a high standard of care. However, he also points out an issue which he believes that Swaleside should review. While, in this instance, a defibrillator arrived on scene quickly, the clinical reviewer believes that there should be more defibrillators around the prison. I am pleased to note the very positive comments from the man's family about the quality of family liaison at Swaleside. The family have asked that this report be forwarded to another prison, which currently holds another family member, so that they are aware of the family history of heart disease.

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.

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Prisons and Probation Ombudsman **July 2012**

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SUMMARY

1. The man was diagnosed with advanced prostate cancer in November 2002 and had an operation in the USA, in September 2003. On 7 January 2004, whilst living in Ghana, he was arrested for importation of drugs into Ghana. He appeared at the High Court, Accra, on 27 October 2004, when he was sentenced to 20 years imprisonment. This was reduced to 15 years with hard labour following an appeal on 26 March 2009.

2. Whilst in prison in Ghana, the man was diagnosed as having ischaemic heart disease. On 14 September 2010, he was transferred from Nsawam Medium Security Prison, Ghana, to Her Majesty's Prison (HMP) Wandsworth, following his successful application for repatriation. On reception at Wandsworth, it was noted that he was on medication for prostate cancer, heart problems and back pain.

3. The man was transferred to Swaleside on 6 October 2010. During his reception his medical conditions were noted. He walked with the aid of a crutch due to spondylosis (spinal osteoarthritis), had cardiac problems and prostate cancer. He was referred to a doctor who noted that he had suffered from heart palpitations for the past four years. The doctor referred him to a cardiologist.

4. The man was prescribed long-term medications for his various conditions and had regular contact with nurses and doctors. He was also referred to an urologist in April 2011 and by July his cancer was in remission.

5. At 9.30am on a day in September, the man was found slumped on his bed, nurses immediately attended but there were no signs of life. They worked hard to resuscitate him. An ambulance crew arrived and took over, but their efforts were also unsuccessful and he was pronounced dead.

6. We make one recommendation as a result of this investigation.

THE INVESTIGATION PROCESS

7. This office was notified of the man's death on 5 September 2011. Notices announcing the investigation were displayed around the prison inviting any relevant information. No prisoners or staff made contact.

8. Prison records relating to the man were studied by the investigator. They included his main prison record, medical records and statements made by staff. A family liaison officer made contact with the man's niece, who acted as next of kin on behalf of his family. This gave the opportunity to discuss the purpose of the investigation and raise any concerns or questions that they may have about the care their relative received.

9. The man's niece spoke very positively about the help and support her family received following her uncle's death, particularly from their family liaison officer. She said that the prison were forthcoming with information and answered all of their questions. His family visited the prison and met with the prisoner who had been with their relative until the end. The man's niece said this had been of great comfort and they were very grateful to the prison for their willingness to facilitate this. The man's niece said the support and kindness shown by the prison had been instrumental in helping her family come to terms with their relative's death. She asked that this feedback be reflected as she felt it was important to share their positive experience. His niece said she felt satisfied that everything had been done to care for her uncle and, and at this stage, she had no issues to raise about the care he received.

10. The man's niece asked whether there was any learning that might be usefully shared with the prison where her uncle's nephew is currently in custody, as the family was concerned that the cause of his death might be hereditary. She was concerned that staff there have every opportunity to understand the illness and, where possible, prevent the same thing from happening to another family member. The post mortem confirmed the cause of the man's death as ischaemic heart disease which is narrowing of the coronary artery(s) sufficiently to prevent adequate blood supply to the heart. A known family history of heart problems can be an important risk factor when managing heart disease. Given the man's family's concerns a copy of this report has been shared with the head of healthcare at the relevant prison to assist with the ongoing care of the man's nephew while in prison custody.

11. A clinical review of the man's healthcare was undertaken by a clinical reviewer on behalf of Eastern and Coastal Kent Primary Care Trust. We would like to thank him for his review, which we received on 29 January 2012.

12. Her Majesty's Coroner was contacted by the investigator to inform her of the nature and scope of this investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist her enquiries into the man's death.

13. The investigator visited HMP Swaleside on 3 November, to familiarise himself with the general environment where the man was located when he died. He visited the man’s cell and talked to staff and prisoners, including the officer and prisoner who first attended to him.

14. On 15 December, the investigator returned to Swaleside where he interviewed a nurse and a doctor, together with the clinical reviewer. Both interviews were recorded and a transcript was made of each.

15. Following the issue of the draft report, we received feedback from both NOMS and the man’s family. NOMS accepted the recommendation, and their response has been attached to that section of the report.

16. Having considered the investigation findings, the man's sister said she felt everything possible was done at Swaleside to care for her brother and expressed her gratitude to staff who she felt looked after him well. She was, however, critical of the cardiologist who saw her brother at outside hospital who she believes should have referred him for an angiogram.

17. The man’s sister explained that, prior to her retirement, she was a qualified nurse specialising in coronary care. She said that, in her professional opinion, her brother's symptoms, coupled with the findings of the first ECG and their family's history of heart disease, was enough to warrant an angiogram. She felt that had this been done, the blocked artery found during the post mortem would have been seen and a stent could have been fitted to open the blockage. The man’s sister felt he was denied a simple procedure that could have potentially prolonged his life. She noted that the prison doctor was also surprised that an angiogram was not requested and was concerned that the reluctance to offer these procedures was because he was a prisoner. The man’s sister acknowledged that it is not within the Ombudsman's remit to comment on the actions of the cardiologist, as the man was under the care of the hospital at this time. She has asked the Coroner that this matter be considered as part of the inquest.

18. The man's sister confirmed that their father had died suddenly from coronary heart disease aged 64. Another family member has also suffered with chest pains and arrhythmia, but was fitted with a stent when a blockage was found in his right artery during an angiogram. He continues to live an active life some ten years later.

HMP SWALESIDE

19. HMP Swaleside opened in 1988 and is a modern purpose built prison which forms part of the Sheppey cluster of three prisons, together with Elmley and Standford Hill. The establishment is primarily a lifer main centre but also holds prisoners serving shorter sentences. As a category B training prison for adult male prisoners (a category B prison is for prisoners who do not maximum security, but for whom escape should be made very difficult), it runs a number of educational, practical and offending behaviour courses.

20. The healthcare centre has an 18 bed in-patient unit, providing 24 hour care for the most seriously ill prisoners. There is a GP service Monday to Friday, with out of hours care provided by South East Health.

Previous deaths at HMP Swaleside

21. There have been 20 deaths at the prison since April 2004, when the Ombudsman became responsible for their investigation. 15 deaths have occurred through natural causes. The circumstances of previous investigations are not similar to those in this case.

Her Majesty's Inspectorate of Prisons

22. HM Chief Inspector of Prisons made an unannounced inspection of HMP Swaleside between 4 and 7 July 2011. In the report of his inspection dated September 2011, referring to health services there, he wrote,

> "Following the move back to the newly refurbished health care centre, prisoners had access to a good outpatient department with the facilities to ensure privacy and decency for all those undergoing treatment.
>
> "Prisoners had good access to primary care health services with a range of procedures to monitor delivery, including the health care application process, health care forum and the electronic patient record."

Independent Monitoring Board (IMB)

23. Each prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community, whose role is to ensure standards of decency and care are maintained. They have full access to prisoners and every aspect of the establishment. In its latest annual report, covering the period from 1 May 2009 to 30 April 2010, Swaleside's IMB says,

> "Swaleside is a well run prison and the Governor and Senior Management team need to be praised for this. Staff and prisoner relationships are good and the personal officer scheme is effective."

Repatriation

24. In 2010, 89 prisoners were repatriated to England and Wales to continue sentences imposed abroad under the Repatriation of Prisoners Act 1984. Returning prisoners become eligible for release once they have served half the “balance” of their sentence. In this man’s case, when he returned to the UK in 2010, he had served six years of a 15 year sentence, and therefore had a “balance” nine years. He had a further four and a half years before he would be eligible for release.

KEY EVENTS

25. In November 2002, the man was diagnosed with advanced prostate cancer. In 2003, he was working as an office manager in the tuna industry in Ghana, West Africa where he lived. On 1 September, he went to America for private medical treatment. During an operation in San Antonio, Texas, radioactive seeds were implanted into his prostate gland for localised treatment of his prostate cancer.

26. On 7 January 2004, whilst still living in Ghana, he was arrested for importation of drugs into Ghana. He appeared at the High Court, Accra on 27 October 2004, when he was sentenced to 20 years imprisonment.

27. Whilst in prison in Ghana, the man complained of palpitations (cardiac irregularities) on 7 December 2008, and was referred to the National Cardiothoracic Centre, Ghana for cardiac ultrasound investigation. This showed that he had a minimally reduced ejection fraction (inability of heart to pump blood adequately around the body) and a hypokinetic apex of the heart (part of heart not adequately contracting). A diagnosis of ischaemic heart disease (reduced flow in the coronary arteries supplying the heart) was made and he was put on medication to improve the blood flow to the heart and to stabilise this situation.

28. Following an appeal against his conviction on 26 March 2009, the man's prison sentence was reduced by the judge to 15 years with hard labour. He also applied for repatriation back to the UK. On 14 September 2010, he was transferred from Nsawam Medium Security Prison, Ghana, to HMP Wandsworth, London, following his successful application for repatriation.

29. Arriving at Wandsworth on 15 September, the man complained of missed heart beats. He was given an electrocardiogram (ECG, a test which measures the electrical output of the heart) which showed no evidence of this, nor did the ECG show any evidence of acute changes suggestive of ischaemic heart disease. The medication he had been prescribed by the medical staff in Ghana was continued by the prison doctors at Wandsworth.

30. Three weeks later, on 6 October, the man was transferred to Swaleside. At his reception screening, he was noted to be walking with a crutch due to spondylitis (arthritis of the spine) and that he was suffering from cardiac problems and back disease. He was referred to a doctor.

31. The prison doctor reviewed the man on 14 October. The doctor obtained a history from him that he had intermittent palpitations (irregular heart beats) for the past four years and that when these occurred he experienced a tight feeling in his chest. The doctor requested an ECG and advised the man to inform medical staff if he had a further recurrence of these symptoms.

32. The man was referred by the prison doctor to a cardiologist at outside hospital on 21 October, for an opinion on his cardiac symptoms.

33. A consultant cardiologist reviewed the man at outside hospital on 29 October, regarding his history of palpitations, which the cardiologist thought was due to extra abnormal cardiac beats (ectopics). Examination of his cardiovascular system showed no abnormality and the ECG also showed no abnormality. It was arranged for him to have a 24 hour ECG, which might detect these ectopic beats and whether he had a structural heart defect.

34. Following completion of the cardiological tests, the man was again reviewed by the consultant cardiologist in the cardiac clinic at outside hospital on 16 February 2011. The ECG showed no structural abnormalities, but the 24 hour ECG showed quite frequent ectopics, although these did not appear to cause any symptoms. In conclusion the consultant cardiologist did not think the ectopics were serious or a sign of underlying problems. As a consequence the cardiologist decided that no further investigations or specific treatment was required, and only reassurance was needed.

35. A prison doctor saw the man on 12 April as he complained of having back pain 'for ages.' The doctor thought that his back pain might be due to metastatic disease (the man's prostate cancer spreading to his spine), and he referred him to an urologist.

36. A consultant urologist reviewed the man at outside hospital on 14 June. He noted that he had a normal PSA test (prostate specific antigen, which is a marker for prostate cancer). He was urinating every hour during the night which the urologist thought was due to treatment he had received for his carcinoma of the prostate, so he prescribed medication to try to alleviate this.

37. The urologist also arranged for the man to have a bone scan to detect whether his prostatic cancer had spread to the bony component of his spine. The consultant urologist also arranged for him to have a flexible cystoscopy, which would give a view of the internal structure of his bladder and determine whether there was an obstruction which could cause urinary frequency.

38. A prison doctor reviewed the man again on 26 July, as he was again complaining of severe back pain. The man requested that he be given a TENS (transcutaneous electrical nerve stimulator) machine. This machine delivers small electrical impulses to the body via electrodes placed on the skin, in order to give pain relief. He said that this therapy had improved his back pain in the past. The doctor agreed to this and he received a TENS machine on 29 July. On 27 July, he had a whole body and lumbar spine bone scan at outside hospital.

39. Shortly after 9.00am on a day in September, the man telephoned his wife. Following the call he went and collected his breakfast together with another prisoner. They both returned to the man's cell and the prisoner left the man in order to put a kettle on to make them some tea. When the prisoner returned approximately 10 minutes later he found the man collapsed on his bed. He called to another prisoner who immediately informed the landing officer.

40. At approximately 9.30am on a day in September, a prison officer was on duty as landing officer on F wing when a prisoner told him that the man appeared to be dead in his cell. The officer immediately went into the man's cell, FW-1-23, where he saw that he was unconscious and did not appear to be breathing. The officer immediately made a Code Blue emergency call (which signifies an emergency in which someone is not breathing) over his radio to summon assistance. Another prisoner assisted the officer and checked the man's pulse. He could not detect it.

41. A nurse immediately attended and on arrival found the man slumped on the bed. On checking him she found that he was grey in colour and cyanosed (bluish discolouration of the skin). She found no signs of breathing, no pulse, no pupil response and no response to verbal commands or pain. Several members of discipline and healthcare staff also quickly arrived on scene.

42. An emergency ambulance was summoned. The man was placed onto the floor, cardiopulmonary resuscitation (CPR) was commenced, his airway was opened and a defibrillator (a device which can administer an electric shock which, in certain circumstances, can restart the heart) was attached to him. The defibrillator advised 'no shock' and to continue CPR, and oxygen was given via an ambu bag. CPR was given continually by healthcare and discipline staff until the ambulance crew of three paramedics arrived on the wing at 9.50am.

43. The man was moved onto the concourse to allow more room and CPR continued. An ECG was performed by the ambulance crew and the result showed that he was in asystole (which means there was no cardiac electrical activity). CPR was discontinued and a paramedic pronounced the man had died at 10.15am. He was put back onto his bed and the duty doctor was called. A prison doctor arrived at 11.00am and following his examination, which found no vital signs of life, he certified the man dead at 11.06am.

44. Shortly after the man's death, the prison activated its death in custody contingency plan. The Police, the Governor, the Coroner, the IMB and this office were informed. The duty governor telephoned the man's wives in Ghana, his daughter in Germany, his sister in Turkey and his niece in Wales and informed them of his death. A prison family liaison officer was appointed.

45. On 7 September, a memorial service was held in the prison chapel and 50 prisoners attended. The following day, his daughter and niece attended the prison where they visited the man's room on F wing and met with his cellmate and other friends. The man's family were very appreciative of the support given to them by Swaleside.

46. At interview, the nurse who attended to the emergency call for assistance confirmed that she was offered care and support, as she had been following similar incidents. She also attended a meeting to discuss any issues of concern. All staff, and prisoners who knew the man were offered support.

47. A post mortem examination was carried out on the man on 8 September by a forensic pathologist, who concluded that the cause of death was ischaemic heart disease.

48. The man's funeral was held on 22 September. Swaleside offered and paid towards the costs of the funeral in line with Prison Service guidelines.

ISSUES

Clinical care

49. A set of the man's medical notes relating to the time he spent in prison in Ghana were obtained and on review they were found to be incomplete and difficult to read as they had been photocopied. On reviewing the medical records of when he was at Swaleside, they were found to be detailed and comprehensive.

50. A prison doctor obtained a history from the man that he had a feeling of tightness in his chest when he was having an episode of palpitations, which is a classic symptom of angina due to ischaemic heart disease. The doctor referred him to a consultant cardiologist who, after performing a series of tests, concluded that he was experiencing ectopic beats (extra heart beats) which he would perceive as palpitations, but that these were not a sign of any serious underlying pathology and, in this man's case, reassurance was all that was needed.

51. In view of the man's age, clinical history, the findings of the ECG done in Ghana and the 24 hour ECG tape, the clinical reviewer felt the he could have been sent for an angiogram, a test which would have showed if he had a significant blockage of his coronary arteries which might have been amenable to treatment. He was not referred by the cardiologist to have an angiogram. As the actions of the cardiologist are not within the Ombudsman's terms of reference, we do not make a recommendation about this issue.

52. The clinical reviewer has described the standard of the care provided at Swaleside to the man as "of a high professional standard, and at least equivalent to that which could have taken place in the community."

Location of defibrillators

53. At Swaleside, the medical centre, which is where the defibrillator used on the man was kept, is central to all the wings. This means that in an emergency, medical staff can respond rapidly to every part of the prison, as they did in this case.

54. The clinical reviewer suggests that, ideally, there should be defibrillators on each wing where prison officers, trained in their use, could start any resuscitation process earlier. In this case, it seems that the defibrillator arrived quickly and there is no suggestion that there was any delay in the resuscitation attempt. However, we believe that the Head of Healthcare should take this opportunity to review the provision of defibrillators at Swaleside, and we make the following recommendation:

    The Head of Healthcare should ensure that the provision of defibrillators is sufficient to enable staff to immediately respond to emergencies in all parts of the prison

CONCLUSION

55. The medical records of the man whilst he was at Swaleside were detailed, comprehensive and of a standard comparable with an external provider. Referrals of the man by the medical staff at Swaleside to outside hospitals, regarding his cardiac and prostatic problems, were both appropriate and timely.

56. The man had a history of carcinoma of the prostate cancer dating back to 2003, which was treated successfully with localised radiotherapy. This remained in remission whilst he was at Swaleside. Because of his persistent back pain he was referred to an urologist to determine whether his prostatic cancer had spread. He died before these investigations could be carried out. The post mortem findings showed no evidence of spread within the pelvis of the prostatic cancer.

57. Ischaemic heart disease was diagnosed in 2008, whilst the man was in prison in Ghana. When seen in Swaleside in October 2010, he said that for four years he had had intermittent palpitations associated with tightness in his chest, and he was referred to a cardiologist. After a series of tests the cardiologist concluded that he was experiencing extra heart beats but that these were not serious.

58. On a day in September 2011, the man was found slumped on his bed and non-responsive. Despite all the correct procedures being carried out regarding cardiac pulmonary resuscitation, this was not successful and he was pronounced dead at 11.06am.

59. The overall management and care of the man, whilst he was a prisoner at Swaleside was found to be of a high professional standard, and at least equivalent to that which could have taken place in the community.

60. We have no criticism of the care provided to the man, or the attempt to resuscitate him. However, the clinical reviewer has raised the issue of the provision of defibrillators, about which we make a recommendation.

RECOMMENDATION

1. The Head of Healthcare should ensure that the provision of defibrillators is sufficient to enable staff to immediately respond to emergencies in all parts of the prison

In response, NOMS accepted the recommendation. They made the following comment:

“The Governor has commissioned the head of healthcare and an operational manager to review the provision and report back with recommendations to the senior management team meeting on 18th April 2012”.