PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at hospital in October 2011 whilst in the custody of HMP Isle of Wight

Report by the Prisons and Probation Ombudsman for England and Wales

August 2012

This is the report of an investigation into the death of a man who died on in October 2011, at hospital. He was in the custody of HMP Isle of Wight when he passed away. He was 46. The loss of any family member is acutely painful, but especially so whilst they are in custody. I offer my sincere condolences to his family and friends.

The investigation was conducted by one of my investigators. A clinical review of the man's healthcare was commissioned with the local Primary Care Trust (PCT). A clinical reviewer conducted the review. Additionally, a review panel considered the health related circumstances surrounding his death, which was attended by my investigator and the clinical reviewer.

The man was in custody from December 2008, spending time at HMP Swansea, HMP Parc and HMP Bedford before arriving on transfer to HMP Parkhurst on the Isle of Wight on 1 September 2010. On 16 August 2011, he was transferred to nearby HMP Albany to engage in a training program as part of his sentence plan.

In October the man suddenly collapsed outside his cell. He was quickly attended to and found to be conscious but not responding. He was taken by emergency ambulance to a nearby hospital where it was established that he had suffered a stroke. Despite the efforts of the hospital staff, he sadly passed away in the Acute Stroke Unit, at 6.23pm. The post mortem confirmed that the primary cause of death was a left cerebral infarct (ischaemic stroke), with a left middle cerebral artery thrombosis (a blood clot on the brain).

Unfortunately, treatment which might have helped him was not available at the hospital at the time. While the provision of medical treatment outside of prison is not within my remit, I am pleased to learn that the treatment will shortly be introduced at the hospital.

The report makes three recommendations. These concern smoking cessation advice, which is important given the high risk of smoking leading to serious illness, better targeting of prisoners at risk of heart disease and notification of a prisoner's death to other healthcare providers.

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 **August 2012**

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SUMMARY

1. The man was charged with committing serious offences and remanded into custody in December 2008, at HMP Swansea. At his health screen it was noted that, apart from being a smoker, he had no other particular risk factors. He was offered smoking cessation therapy but chose to continue smoking.

2. Following his conviction in February 2009, he was transferred to HMP Parc to await sentencing. He was later given a life sentence. On reception at Parc, he was found to have no physical health issues. In March, he complained of severe abdominal pain and was referred for an ultrascan which revealed no abnormalities. He was referred to a consultant surgeon in September, but the abdominal pain was found to be completely resolved, with no treatment required.

3. In August 2010, the man was transferred to HMP Bedford, where it was noted that he smoked 20 cigarettes a day, but was found to be fit and well. He transferred to HMP Isle of Wight's Parkhurst site in September. It was noted that he smoked 10 cigarettes a day, and again he was found medically fit and well.

4. In August 2011, he was accepted to attend the sex offender treatment programme, and he willingly transferred to the nearby Albany site in order to attend this programme. During his reception there, he was again found to be medically fit for normal location, work and cell occupancy.

5. In October, whilst returning to his cell, the man suddenly collapsed having suffered a massive stroke. He was taken by emergency ambulance to hospital, where scans confirmed the stroke. His condition continued to deteriorate. The next day he passed away on the Acute Stroke Unit ward at the hospital. He was 46 years old.

6. We make three recommendations as a result of this investigation. One of these is aimed to ensure that all smokers are offered smoking cessation advice, which is important given the risk of serious illness associated with smoking. The second recommendation is intended to ensure that GPs target prisoners at greater risk of cardiovascular disease, and the third to ensure that, if a prisoner dies, healthcare staff notify other relevant health providers.

THE INVESTIGATION PROCESS

1. This office was notified of the man's death on 12 October. Notices announcing the investigation were supplied by this office and displayed by the prison to staff and prisoners, who were invited to contribute any relevant information. No prisoners or staff made contact.

2. The investigation was opened on 18 October, when the investigator visited HMP Isle of Wight (Albany). He met the liaison officer, familiarised himself with the general environment of the prison, visited the man's cell, spoke with members of staff and prisoners who knew him and collected the prison documents relating to him. We apologise for the slight delay in issuing this report, which has been caused by workload pressures within this office.

3. The prison records relating to the man were studied by the investigator. They included his main prison record, medical records and statements made by staff.

4. One of the Ombudsman's family liaison officers made contact with the man's family on 9 November. This gave them the opportunity to discuss the purpose of the investigation and provide an opportunity to raise any concerns or questions that they wanted to be addressed as part of the investigation. His mother said the family were very satisfied about the way they were treated by the prison after he died. Unfortunately they didn't get to the hospital in time before he died, but prison staff were there to meet them. The family would have liked the prison chaplain to be there to pray with them, but they were told that she was not on shift, which they found disappointing.

5. A clinical review of the man's healthcare was commissioned with the local Primary Care Trust (PCT). A doctor led the review. Additionally, a review panel, consisting of various health professionals on the Isle of Wight, considered the health related circumstances surrounding his death.

6. Her Majesty's Coroner was contacted by the investigator to inform him of the nature and scope of the 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 his enquiries into the man's death.

7. A clinical panel review meeting was held on 8 December, attended by the investigator, the clinical reviewer, the prison doctor, the healthcare manager, the acting deputy governor of the prison, Head of Prison Healthcare and other members of Isle of Wight NHS PCT. The healthcare of the man was discussed and specific issues raised by the investigator and the clinical reviewer was considered. Three recommendations resulted and are included in this report.

HMP ISLE OF WIGHT – ALBANY

8. HMP Isle of Wight was formed on April 2009, by the merging of three former establishments, HMP Albany, HMP Camp Hill and HMP Parkhurst. The prison accommodates approximately 1,700 prisoners on the three sites, with each site having its own Director who reports to the Governor.

9. The Albany site consists of five wings located off one main corridor, almost identical in design and which hold 94 to 96 prisoners in single cells. Each wing contains four floors, each with three spurs of eight cells. A modern unit of two more wings was opened in May 2003, consisting of single cell accommodation with en-suite facilities, housing up to 80.

10. The Albany site provides a category B training prison function with an integrated population of vulnerable offenders and mainstream prisoners, offering a varied regime with education and several offending behaviour programmes. It has an operational capacity of 567.

11. Health services at HMP Isle of Wight are commissioned and provided by the local Primary Care Trust (PCT). A new Inpatient Healthcare Unit was opened in October 2009 and is situated on the Albany site. It has 12 beds and caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs. These include acute care and recovery post-discharge from emergency treatment, or planned secondary care and treatment at the local hospital.

Previous deaths at Albany

12. This office has investigated 32 previous deaths at what was HMP Albany, now part of HMP Isle of Wight, of which 25 were caused by natural causes. However, the circumstances of the man's death do not reflect the circumstances of any of the previous deaths.

Her Majesty's Inspectorate of Prisons

13. HM Chief Inspector of Prisons last visit was an unannounced inspection of HMP Isle of Wight between 4 and 15 October 2010. In respect of primary care, he wrote:

> "There were inconsistencies between the sites (Albany, Parkhurst and Camp Hill) in the clinics offered and in some cases there was no correlation between the prevalence of clinical conditions and the services provided. For example, data on SystmOne (computerised medical record system) indicated that there were over 100 prisoners at Albany with high blood pressure. The primary care department there did not have a blood pressure check clinic, unlike both of the other sites, and only 36 patients were on a waiting list for a hypertension clinic appointment, some of whom had been waiting over six months. Neither Albany nor Camp Hill had a nurse-led service for those with coronary heart disease, even though SystmOne indicated that 59 prisoners at Albany had a diagnosis of coronary heart disease.

"Smoking cessation services were provided by PE (physical education) staff in all three sites, and prisoners could be referred to the GP for alternative nicotine replacement therapy if patches were unsuitable. However, not all clinical staff were aware of the service provided by the PE departments. The PE departments also ran a range of healthy living courses and health promotion activities."

Independent Monitoring Board report

14. Each prison is required to have an Independent Monitoring Board, members of which are appointed by the Secretary of State for Justice and who are members of the local community. The IMB has access to all parts of the prison, and meets with the Director regularly to express any concerns. The IMB is also required to formally report on the prison every year.

15. The first report from the combined IMB for Isle of Wight covered 2010. In the section on healthcare, they noted that the waiting lists to see healthcare had reduced. They also noted that the "major problem facing Albany is its ageing population".

KEY EVENTS

16. The man was remanded into custody on 5 December 2008. He was initially held in HMP Swansea, where it was noted that apart from being a smoker, he had no other particular risk factors identified. When offered stop smoking therapy, he chose to continue smoking.

17. Convicted on 13 February 2009 for serious offences, he was transferred to HMP Parc, Bridgend to await sentence. On reception at Parc on 2 March, he had no physical health issues, but on 14 March he complained of severe abdominal pain. His blood pressure was recorded as 150/110 (which is high), having been normal previously. Following blood and urine tests in the healthcare centre, on 27 March, the doctor referred him for an ultrasound scan.

18. On 17 April, at Crown Court, the man was sentenced to life imprisonment, with a minimum tariff (amount of time to be served before release would be considered) of five and a half years.

19. Following an ultrasound scan on 7 May, which revealed no abnormalities, he was then referred to a consultant surgeon. When seen on 24 September, his abdominal pain was found to be completely resolved with no treatment required, so he was discharged by the surgeon back to Parc.

20. He was transferred to HMP Bedford on 19 August 2010. During his reception health screen it was noted that he smoked 20 cigarettes a day and his blood pressure was recorded as 130/95. He was found fit for normal location, work and any cell occupancy.

21. Following his transfer from Bedford to HMP Isle of Wight on 1 September, the man was initially seen by a pharmacy technician, at HMP Parkhurst. She found he was medically fit and well and referred him to a nurse. A nurse saw him on 3 September, when she noted that he smoked ten cigarettes per day. She offered him a hepatitis B (an infectious inflammatory illness of the liver) vaccination, which he accepted. His blood pressure was recorded as 118/75 (which is within the normal range).

22. The first dose of hepatitis B vaccination was given to him on 28 October, the second dose given on 4 November, with the final third dose given on 18 November. He started work in the gardens on 4 October, and he settled in on the wing, where he was noted by officers to be quiet and always polite.

23. For a week following 26 July 2011, the man was assessed for the Sex Offender Treatment Programme (SOTP, a programme which addresses sex offending behaviour). He was keen to progress with his sentence plan and work towards his release. The assessment indicated that he was best suited to the core programme, which he wished to complete at Albany. On 13 August, he was accepted to attend the SOTP.

24. Three days later on 16 August, he transferred from Parkhurst site to Albany site. A nurse saw him on his arrival at Albany and noted that he was calm, had no concerns and found him to be medically fit for normal location, work and cell occupancy. He was allocated a single cell on A wing.

25. A nurse saw him on 24 August, when he complained of having wax in his ears. The nurse gave him some waxsol (eardrops) to put in his ears and arranged a follow up appointment to review a possible need for him to have his ears syringing. When the nurse saw him again on 1 September, his ears had improved.

26. On 6 September, when seen by a nurse, the man's earwax was dispersing. A doctor also examined him and noted there was no offensive discharge, no hearing problems and no pain in his ears.

27. At approximately 11.30am on Sunday 9 October, the man collapsed on the wing, whilst on his way back to his cell. Nobody witnessed him fall. He fell against the cell door of his neighbour. The prisoner opened his door and saw that he had collapsed. He put his pillow under his head, whilst another prisoner from the opposite cell called for staff and put him into the recovery position.

28. A nurse immediately responded and attended to the man. The nurse found him in the recovery position, conscious but not responding and called for an emergency ambulance to attend. The nurse noted that his pupils appeared sluggish (slow to react to stimulus) and there was some arm movement. He recorded the following observations for him: blood pressure 140/90 (high), pulse 74 (within normal range), temperature 37.5 (at the high end of normal), and blood oxygen saturation (a measure of the amount of oxygen in the blood) 96%.

29. The ambulance took him to a nearby hospital, together with a set of his prison medical records, at around 12.00 noon. At the hospital, he was sent for a CT scan (x-ray computed tomography that reveals a 3D image of the body's interior). The scan showed showed substantial evolving non haemorrhagic infarct in the left middle cerebral artery interior (ischaemic stroke, often caused by a blood clot).

30. The man was transferred to the stroke unit at 4.30pm, where a stroke pathway proforma was completed (this is designed to follow the patient's journey throughout the hospital stay, from admission to discharge). At 8.00pm, he was seen on the ward round and it was noted by the doctor that he was able to respond to commands but that a thrombolysis service was not currently available at that hospital. (Thrombolysis is a treatment used to try and dissolve the blood clot that has obstructed the coronary artery but is not currently available at every hospital.)

31. During the following morning, 10 October, it was noted that the man's level of consciousness was deteriorating and he was reviewed by the registrar and his airway safety was checked by an anaesthetist (doctor who specialises in pain management). The anaesthetist found that intubation (insertion of a tube to add or remove fluids or air) was not required.

32. As he was semi-conscious when he left Albany, a closeting chain (a long chain with a cuff at either end) was used as a restraint. This was removed following a further risk assessment at 4.50pm the following day.

33. A repeat CT scan of the man's brain confirmed extensive infarction of the left middle cerebral artery territory (stroke) with evidence of resulting swelling and raised pressure in the brain. At 4.55pm, the doctor caring for him spoke to his mother by telephone, and informed her that, because of his deteriorating condition, he might not survive the night.

34. At 5.00pm, the consultant in charge of the case made the decision that the man was not for resuscitation in view of his extensive stroke and sudden deterioration in his consciousness, and recorded this in his medical notes. Soon after he passed away on the Acute Stroke Unit ward at the hospital.

35. Shortly after the man's death, the prison activated its death in custody contingency plan. The police attended the hospital and he was removed to the mortuary. A Senior Officer (SO) attended the hospital and offered support to the prison staff who were present at the death. A hot debrief (a meeting to establish whether there are any urgent issues that need to be resolved, and that staff are given support) also took place.

36. The man's parents rang the hospital and spoke to the SO. The man's mother said that she was on her way to the hospital with her husband and other family members to visit her son. The SO broke the news to her that her son had recently passed away. The officer, together with a governor, then facilitated the family's visit to the hospital to see the man in the Chapel of Rest.

37. The following morning, the SO arranged for prisoners on A wing to be informed of the man's death and appropriate support was offered to the prisoners and staff via the care team.

38. A Home Office Forensic Pathologist carried out a post mortem examination on the man on 12 October. He gave the cause of death as left cerebral infarct (ischaemic stroke) with left middle cerebral artery thrombosis.

39. The prison offered costs towards the funeral, in line with national prison guidance. The funeral took place at 1.30pm on 25 October.

ISSUES

Clinical care

40. The man was found to be medically fit when he came into custody and on each subsequent occasion when he was transferred to another prison. He was investigated for abdominal pain and had a normal ultrasound scan in March 2009. He was referred to a consultant who found the problem was resolving with no treatment being required. He was vaccinated against hepatitis B and had been able to access primary care for his ear problems, which were effectively treated, and had a dental check, with nothing required to be done.

41. A 46 year old cigarette smoker, he suddenly collapsed having suffered from a massive stroke. There were no warning symptoms of his illness. However, apart from being offered stop smoking therapy at Swansea on entering custody in December 2008, there is no record of him being offered stop smoking advice or being prescribed treatment for it at Parc, Bedford, Parkhurst or Albany. Given the known link between smoking and many fatal diseases, we make the following recommendation to HMP Isle of Wight, but will also notify Parc and Bedford

The Heads of Healthcare should ensure that all prisoners who smoke are offered smoking cessation advice when they arrive at the prison.

42. The man was never risk assessed for cardiovascular disease and there is no record of him being offered a cholesterol check. At 46, he would not normally have been targeted for this in routine primary care in the community, but as has been discussed at other death in custody reviews, including on the Isle of Wight, prisoners are at a higher risk of cardiovascular disease than their biological age would suggest (this issue is discussed in more detail in the Ombudsman's report "Learning from PPO Investigations – Deaths from Circulatory Diseases", which was published in 2010 and is available on the PPO website). In order to ensure that this is recognised, we make the following recommendation:

The Head of Healthcare should ensure that GPs target prisoners thought to be at increased risk of cardiovascular disease, and offer primary prevention as indicated.

43. During the panel review, the panel discussed the issue of removing the patient from the NHS national record database following their death. It was agreed that by ensuring removal, the risk of reminders and letters being sent by the NHS inappropriately in the future would be reduced. It would also reduce the opportunity for identity fraud. The following recommendation was made, which we endorse:

The Head of Healthcare should ensure that, following death of a prisoner, the registered GP is notified in order to remove the patient from the national record database.

CONCLUSION

44. The man was a 46 year old smoker who suddenly and unexpectedly collapsed having suffered from a massive stroke. There were no warning symptoms of his illness. When he was found collapsed he was taken promptly to hospital, where his condition was diagnosed early by CT scan and he was admitted to an acute stroke unit. He was managed conservatively.

45. In many stroke units, the man would have been given thrombolytic treatment. However this was not available at the nearest hospital to Albany. At 46, previously fit and well, and with early diagnosis of a thrombotic stroke, he would have been an ideal candidate for thrombolytic treatment. In the coming months this treatment will be available to all patients presenting in this way.

46. He suffered a premature cardiovascular death. Apart from smoking, he had no other particular risk factors identified. His care was equivalent to that which he would have received from a GP in the community.

RECOMMENDATIONS

1. The Heads of Healthcare should ensure that all prisoners who smoke are offered smoking cessation advice when they arrive at a prison.

NOMS accepted the recommendation and commented: "The Reception Screening template on SystmOne (the prison healthcare clinical record system) includes a smoking cessation advice code and on the second Reception Screen current smoking status/consumption is identified and recorded, smoking cessation advice is given and guidance provided on how to access the smoking cessation courses available within HMP Isle of Wight via the gymnasiums."

2. The Head of Healthcare should ensure that GPs target prisoners thought to be at increased risk of cardiovascular disease, and offer primary prevention as indicated.

NOMS accepted the recommendation and commented: "We are in the process of implementing a prison based version of the NHS Healthcheck programmes for those between 40 and 74 years of age. Statistically, all prisoners have an increased risk of cardiovascular disease simply by virtue of being prisoners. This is a whole system responsibility to ensure people are encouraged into healthy lifestyles and a number of wider workstreams involving health promotion are already underway. Our most recent Qualities and Outcomes Framework (QOF) figures reflect significant improvements on primary prevention during 2011/12.

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3. The Head of Healthcare should ensure that, following death of a prisoner, the registered GP is notified in order to remove the patient from the national record database.

NOMS partially accepted the recommendation and commented: "As was explained for a previous recommendation of this nature (LP 28/09/2010), Prison Healthcare Services within HMP Isle of Wight are provided by Isle of Wight NHS Trust and are covered by a full range of organisation wide policies and procedures. Notification of the death of any patient in hospital is made to his/her General Practitioner (where this is known) by the Hospital Bereavement Advisor by telephone on the day of death (or the next working day if the death occurred out of hours). This is followed up by an email confirmation. These arrangements would apply equally to any prisoner who dies in hospital.

However, some prisoner deaths occur in prison and so would not automatically be known to the hospital services. In such cases (and where this information is known) Prison Healthcare staff undertake to advise the prisoner's former General Practitioner or community medical practice of the individual's death within the same parameters as those of the hospital. A guidance note to this effect has previously been provided to Prison Healthcare staff – 24/01/2011. In addition, the local Registrar of Births, Deaths and Marriages registers and notifies all deaths to appropriate authorities.