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 woman in September 2014 while in the custody of HMP/YOI Drake Hall

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 woman, who died of heart failure in September 2014 while in the custody of HMP Drake Hall. She was 59 years old. I offer my condolences to her family and friends.

A clinical review of the care the woman received at HMP Drake Hall was conducted. The prison cooperated fully with the investigation.

The woman was sentenced to six years in prison in 2012 and was transferred to HMP Drake Hall on 12 April 2013. She had high blood pressure, but often did not attend healthcare appointments or take her medication. In June 2013, she had a major heart attack and suffered a collapsed lung in hospital. After some weeks in hospital, she was discharged to HMP Foston Hall, which was able to provide 24-hour nursing care. In October 2014, she was returned to Drake Hall, but her health continued to decline, partly because she did not take her medication as prescribed. On 4 September 2014, she collapsed and was taken to hospital. Doctors diagnosed end stage heart failure, but the prison did not inform her partner. On 8 September, the hospital contacted him, as she was critically ill. She died in hospital two days later.

The clinical reviewer commended the efforts healthcare staff made to encourage the woman to take her medication. I am satisfied that, although she often did not engage with her treatment, she received a good standard of care. However, the investigation identified a need for Drake Hall to improve its arrangements for liaising with the families of seriously ill prisoners.

This version of my report, published on my website, has been amended to remove the names of the woman who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2015**

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SUMMARY

1. In June 2012, the woman was remanded to HMP Styal and, in November 2012, was sentenced to six years in prison. In April 2013, she was transferred to Drake Hall.

2. On 2 June 2013, the woman had a serious heart attack. She suffered a collapsed lung and remained in hospital until 25 July.

3. When the woman left hospital, she went to HMP Foston Hall as it was considered she needed to be in a prison with 24-hour healthcare cover. On 22 October, she went back to Drake Hall. Her mobility was poor and the prison arranged for another prisoner to help her with daily tasks such as collecting her medication. Nurses saw her frequently in her house unit.

4. The woman often refused to take her medication or attend medical appointments and healthcare staff were concerned about whether she had the mental capacity to take such decisions. Assessments concluded that she did not suffer from any identifiable psychiatric disorder and she had capacity to take decisions about her treatment. Healthcare staff tried to encourage her to engage with her medical treatment, but this remained a problem.

5. On 4 September 2014, the woman collapsed in her room and was taken to hospital where doctors diagnosed end stage heart failure. Although she was seriously ill, the prison did not contact her partner. The hospital informed him four days later when her condition became critical. She died in hospital several days later.

6. The clinical reviewer considered that the woman's non-compliance with her treatment contributed to her death. However, he noted that healthcare staff at Drake Hall worked hard to manage her conditions and to engage her in treatment. They dealt appropriately with the issue of capacity and consent and he was satisfied that she received a good standard of care. We are concerned that the prison did not liaise effectively with her partner, which meant he had very little time with her before she died. We make one recommendation about family liaison.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Drake Hall informing them of the investigation and inviting anyone with relevant information to contact her. Two prisoners responded.

8. The investigator obtained copies of the woman's prison medical records and relevant extracts from her prison records. She interviewed one prisoner at Drake Hall on 23 September 2014; the other prisoner decided not to speak to her. She interviewed six members of staff on 3 November and informed the Governor of the initial findings of the investigation.

9. NHS England commissioned a clinical reviewer to review the woman's clinical care at the prison.

10. We informed HM Coroner for Staffordshire (South) of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the woman's partner, her nominated next of kin, to explain the investigation process. Her partner asked why no one had told him when she was admitted to hospital. He received a copy of the draft report and indicated that he was satisfied with the findings.

12. The prison submitted an action plan detailing what they have done to address the issues we have raised. This is included at the end of the report.

HMP and YOI DRAKE HALL

13. Drake Hall is a closed prison which holds just over 300 sentenced women. Accommodation consists of 15 house units with mainly single rooms. Each house unit has a small kitchen, a laundry room and a television lounge.

14. Staffordshire and Stoke on Trent Partnership NHS Trust provide healthcare at the prison. There are no healthcare staff on duty at night.

HM Inspectorate of Prisons

15. The most recent inspection of Drake Hall was in March 2013. The Inspectorate found that prisoners were satisfied with the access to, and quality of, healthcare services. There was a full range of appropriate clinics and waiting times were mainly short, but staffing shortages, had affected some services such as chronic disease management.

16. There were no fully adapted cells for women with disabilities, but the prison made appropriate individual modifications. Inspectors noted that St David's House, (where the woman lived) was designated for older women and women with disabilities, but the facilities were little different from other houses.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure prisoners are treated fairly and decently. In its most recently published report for the year to October 2013, the IMB commented that previous problems caused by a shortage of healthcare staff had been resolved and services were delivered to a high standard. The introduction of a new system for healthcare appointments had successfully dealt with a problem of non-attendance at appointments.

Previous deaths at HMP and YOI Drake Hall

18. The woman's death was the first at Drake Hall since the Ombudsman began investigating deaths in custody in 2004.

KEY EVENTS

19. The woman was remanded to HMP Styal on 20 June 2012. On 13 October, she was convicted of grievous bodily harm with intent and possession of a weapon. In November, she was sentenced to six years in prison. It was not her first time in prison.

20. At her initial health screen at Styal, staff noted she suffered from hypertension (high blood pressure) and for which she took medication. The woman often did not comply with medical treatment and during the nine months, she spent at Styal, she did not attend, or walked out of appointments before seeing healthcare staff, 16 times.

21. On 12 April 2013, the woman transferred to Drake Hall. A nurse carried out an initial health screen and noted she took medication for high blood pressure and to prevent stomach ulcers.

22. On 23 April, a prison GP reviewed the woman and noted her history of poor compliance with taking her medication and advised her to take it regularly. He recorded that her blood pressure was still high and increased the dose of her medication for this. Nurses monitored and recorded her blood pressure regularly.

23. A doctor reviewed the woman again on 17 May 2013, and adjusted her medication as her blood pressure continued to be high. On 23 May, she told a prison pharmacist that she no longer wanted to take her medication and would control her blood pressure by eating plenty of vegetables. Nurses advised her against this.

24. On 2 June at 11.15am, the woman collapsed with chest pain. She said that she had begun to feel unwell the previous evening and had felt worse that morning. Staff called an ambulance and nurses administered glyceryl trinitrate spray, a treatment for angina. The ambulance arrived at 11.40am and took her to hospital. Prison staff heard her saying that she wanted to die and began to monitor her under ACCT procedures (ACCT, Assessment, Care in Custody and Teamwork, the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm.) At hospital, doctors confirmed that she had suffered a heart attack. Doctors carried out an angioplasty, where a balloon is used to stretch open a narrowed or blocked artery, and fitted a stent.

25. The hospital contacted the woman's partner on 2 June about her condition, but no one from the prison spoke to him until 5 June to update him about her condition.

26. On 6 June, the woman refused oxygen therapy and hospital staff were concerned about her mental capacity. A nurse from the hospital mental health team assessed her. The nurse had no significant concerns, but asked that she should be referred to the prison's mental health team when she returned to Drake Hall. She had a CT scan to assess if she suffered any brain damage because of her heart attack. This did not indicate anything significant.

27. On 15 June, the woman suffered a collapsed lung. Her condition deteriorated and doctors placed her on a ventilator. On 20 June, hospital staff were concerned that she would not survive and informed her partner. On 21 June, during a case review, prison staff noted that her partner was disabled and unable to travel easily. He visited her in hospital on 22 June There is no record that the prison offered him any help at the time to get to see her in hospital but records of a case conference, held on 5 July, show that the prison offered her partner financial support to help him visit.

28. On 29 June, prison staff ended ACCT monitoring as they considered the woman did not intend to harm herself. On 1 July, hospital staff took her off the ventilator. She remained on oxygen therapy and had physiotherapy to help her recovery.

29. On 12 July, prison healthcare staff and hospital staff discussed the woman's nursing needs after the hospital discharged her. As Drake Hall did not have nurses on duty at night to administer her night medication or easily accessible toilet facilities (her mobility was limited) the prison staff decided that HMP Foston Hall would be better equipped to meet her needs. They arranged for her to go there after she left hospital.

30. On 25 July, the woman left hospital and went to Foston Hall. The healthcare staff at Foston Hall were aware that she had often not attended health appointments and on 26 July, a doctor referred her to the mental health team as the hospital nurse had advised. A nurse from the mental health team assessed her on 19 August and on 23 August and had no significant concerns about her mental capacity.

31. Throughout the rest of July and August, healthcare staff reviewed the woman frequently and took blood tests, referred her to cardiology specialists and adjusted her medication as necessary. Her blood pressure reduced to normal but she was frequently breathless.

32. On 28 August, a doctor noted that the woman's physical state was deteriorating. She was often drowsy and her blood pressure had increased. The doctor recommended a chest X-ray and regular monitoring. On 29 August, a nurse saw her after she had a panic attack because she was breathless. The nurse referred her to a doctor, who was concerned about her breathlessness and arranged for her to go to hospital as an emergency. At hospital, doctors diagnosed heart failure and narrowed arteries and she stayed in hospital for three weeks. She had an angioplasty on 13 September and went back to Foston Hall on 18 September.

33. The woman said that she wanted to go back to Drake Hall. Drake Hall healthcare staff, including a physiotherapist, assessed her but concluded that this was not possible at the time, because of her poor physical condition. While she was at Foston Hall, records show that she did not attend 30 healthcare appointments. On 22 October, after a further assessment, she transferred back to Drake Hall.

34. Healthcare staff at Drake Hall put a care plan in place for the woman. This included a requirement for her to attend the healthcare unit to collect her medication and for staff to assist her to comply with her medication regime and get to the dining room. She lived in St David's, a house unit for elderly and infirm prisoners. She was able to get about the unit but used a wheelchair to get around outside. Staff appointed another prisoner to help her with daily tasks and to push her in her wheelchair to collect her medication. However, she often refused to go.

35. On 21 November, a prison GP saw the woman and discussed his concerns about her poor compliance with taking her medication. He referred her for a mental health assessment.

36. On 2 December, a psychiatric nurse assessed the woman and discussed the results at a case conference with a psychiatrist and other healthcare staff on 4 December. The assessment showed no specific mental health or capacity issues but the team decided to refer her to a memory clinic and to occupational health. The nurse continued to see her frequently.

37. On 11 December, a prison GP discussed the woman's healthcare needs and poor compliance with treatment with her. He advised her about the importance of taking her medication regularly and arranged to see her every four weeks to encourage and monitor this.

38. On 19 December, a multidisciplinary team meeting, including healthcare staff and the community mental health team, discussed the results of a mental health examination. This had shown that she had deficits in recollection and orientation, and that she found the dosette box she had been given to help her remember when to take her medication, very confusing. They decided to refer her to neuropsychiatry and agreed that, as she was not collecting her medication, nurses should continue to visit her daily and take her medication to her.

39. On 30 December, a doctor referred the woman to the neuropsychiatry service at the hospital and noted concerns about her mental capacity, either as the result of cognitive decline or because of a personality disorder. A subsequent CT scan of her brain showed evidence of an old stroke and a history of past head injury, but indicated nothing else significant.

40. Healthcare staff met the woman ten times in December 2013 and January 2014 to try to encourage her to engage with her treatment. Sometimes she complied with treatment and investigations and appeared to have a good understanding of her physical health conditions, but she was often resistant and nurses continued to take her medication to her in her unit.

41. On 3 January 2014, healthcare staff referred the woman to Staffordshire memory service and said that were concerned that she did not have capacity to make decisions about her medication and physical health. However, she refused to attend the memory clinic and signed a disclaimer on 10 March.

Records show that her demeanour often fluctuated between engaging with treatment and refusing. Healthcare staff made decisions about her care based on her best interests.

42. On 13 March, the psychiatric nurse recorded details of another case conference, which concluded that the woman's capacity varied but she currently had capacity to make decisions about her health needs. She was booked to see the psychiatrist for a second opinion but she did not attend two appointments, on 25 March and 1 April.

43. A multidisciplinary case conference between healthcare staff, mental health staff and offender management staff on 11 June, decided to discharge the woman from the prison's mental health in-reach team as there was nothing further they could do for her. Staff agreed to continue monitoring her medication and to develop a care plan to help her mobility.

44. On 1 August, a doctor saw the woman who was having breathing difficulties. He was concerned she was suffering from pneumonitis (inflammation of lung tissue) combined with a broader decline in her heart's condition and sent her to hospital. At hospital, doctors diagnosed a chest infection and discharged her back to prison the same day with a prescription for antibiotics.

45. On 29 August, officers were concerned that the woman was finding it difficult to breathe. A nurse took her clinical observations, which were within the normal range. However, because of her medical history, she sent her to hospital. The hospital diagnosed a chest infection and she returned to prison the same day with antibiotics to treat the infection.

46. On 3 September, the woman told her friend that she felt unwell. At 2.00am on 4 September, she went to her friend's room crying and complaining of pain in her legs and her chest. She would not let her friend alert staff to her condition. Her friend told us that she could see her heart beating in her chest and that the "rhythm was wrong". She stayed in her friend's room until some time between 7.15am and 7.40am.

47. Shortly after the woman left her room, her friend heard a thud. She went to her room and found her lying on the floor. Another prisoner placed her in the recovery position and alerted staff. Officers responded. At 7.55am, one of the officers radioed a code blue (to indicate a prisoner is unconscious or not breathing) and the control room called an ambulance immediately.

48. An officer found the woman lying on her left side, breathing normally and able to speak. She gradually became more responsive. She did not have any signs of injury and was not bleeding. Two nurses arrived shortly after the officers and brought a resuscitation bag with them. One nurse noted that the woman was able to respond to all her verbal commands; she said she had no pain in her chest, back or arms and had not hurt herself when she fell. All her clinical observations were within the normal range. The nurses gave her oxygen to help her breathing. An ambulance took her to hospital. Two officers escorted her but they did not use restraints.

49. Hospital doctors diagnosed end stage heart failure and admitted the woman to the cardiac care unit. No one from the prison informed her partner but, on 8 September, the hospital contacted him and told him that her condition was critical and that he should consider coming to the hospital. Her partner spoke to hospital staff again the next day, to check how she was.

50. At approximately 10.00am a few days later, a hospital doctor informed one of the escorting officers that the woman's condition had deteriorated significantly and she now needed palliative care. At 1.05pm, the doctors gave her morphine as she was in pain.

51. An acting custodial manager, who was acting as the prison's family liaison officer, telephoned the woman's partner at 2.00pm on 10 September. This was the first time anyone from the prison had contacted him. Her partner was already on his way to the hospital at the time as hospital staff had let him know that her condition was critical. He arrived at the hospital at 2.45pm and was with her when she died shortly afterwards, at 3.05pm.

52. On 12 September, the custodial manager telephoned the woman's partner to offer condolences and arranged to visit him on 15 September. The funeral was on 24 September. The prison contributed towards the cost, in line with national guidance. On 2 October, there was a memorial service at Drake Hall for staff and prisoners.

53. A Governor's notice informed staff and prisoners of the woman's death and offered appropriate support. A senior manager debriefed the staff involved in the emergency response and offered support if they needed it. Staff informed the woman's friend and the other prisoner who had helped her on 4 September, personally and offered additional support. Staff checked prisoners considered at risk of suicide or self-harm, in case they had been adversely affected by her death

Post-mortem

54. A post-mortem report found the cause of the woman's death was end stage cardiac (heart) failure; ischaemic heart disease (a blockage or narrowing of the arteries that supply blood to the heart muscle) and coronary artery atherosclerosis (clogged arteries in the heart).

ISSUES

Clinical care

55. The woman declined to attend numerous health appointments both in prison and at hospital from the time she started her sentence. She often did not take her medication as prescribed, despite advice and guidance from healthcare staff. As a result, for much of her time in prison, her blood pressure was poorly controlled. The clinical reviewer noted that high blood pressure is a recognised risk factor for heart attacks and said it was likely that her poorly controlled blood

pressure contributed to the heart attack she suffered in June 2013 and subsequent heart failure in September 2014.

56. Healthcare staff at Drake Hall, including GPs, nurses and a psychiatrist, and hospital staff, repeatedly attempted to address the issue of the woman's non-compliance with healthcare advice and treatment. Healthcare staff used different approaches to try to encourage her to comply with her treatment, but not always successfully.

57. The clinical reviewer concluded that staff at Drake Hall followed the main principles of the Mental Capacity Act (2005). The healthcare staff presumed that the woman had capacity in the absence of clear evidence to the contrary. They gave her sufficient information and time to help her make her decisions and respected her right to make decisions, even if these were against advice. They appropriately referred her to mental health services for assessment. Staff offered health screening and preventative healthcare, although she often refused to participate.

58. The clinical reviewer concluded that the woman's health declined due to a combination of high blood pressure, a heart attack, heart failure and underlying ischaemic heart disease (muscle damage in the heart). This was compounded by her consistently poor compliance with her medication, failure to allow investigations into her health and attend appointments, despite repeated attempts by healthcare staff to help her engage in appropriate treatment. He found no fault in how healthcare staff managed her health needs at Drake Hall and how staff managed the issues of capacity and consent to treatment. He was satisfied that she received appropriate care. We agree with this conclusion.

Family liaison

59. Prison Service Instruction 64/2011 states that where a prisoner is refusing treatment, it is important to involve the prisoner's family (subject to consent from the prisoner), in the ongoing support of the prisoner. There is no indication in any of the records that staff considered involving the woman's partner or discussed this with her, apart from one occasion when staff encouraged her to ask her partner to attend a hospital appointment, which she later refused to attend. The instruction also requires prisons to have an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill. The prison did not appoint anyone to engage with her family, although she had been seriously ill for some time.

60. Prison Rule 22(1) states:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

61. When the woman went to hospital in June 2013, her condition was very serious. The hospital informed her partner that she had been admitted, but no one from the prison contacted him until three days later.

62. When the woman was taken to hospital after collapsing on 4 September, it was clear that she was seriously ill. However, no one from the prison contacted her partner at that time; the hospital informed him four days later when her condition became critical. The duty governor did not contact the woman's partner until 10 September, the day that she died. He told us that the prison contacted families after an admission to hospital, only when a crisis point was reached and relied on the hospital to indicate when this point came. We do not consider that this approach is in line with Prison Rule 22; someone from Drake Hall should have informed her partner when she was first admitted to hospital on 4 September.

63. The woman's partner was in poor health and had limited mobility. He lived a long way from the prison and hospital. However, the prison did not contact him or offer any help to get him to the hospital, except on 10 September when the prison offered to arrange a taxi from the bus station. He arrived just 20 minutes before she died.

64. We consider that the prison's family liaison was inadequate. We were told that Drake Hall does not have any trained family liaison officers and that the duty governor was asked to carry out the function with little or no advice. We make the following recommendation:

    The Governor should ensure that there are sufficient trained family liaison officers who keep in touch with the families of seriously ill prisoners and inform them promptly when they are admitted to hospital.

RECOMMENDATION

The Governor should ensure that there are sufficient trained family liaison officers who keep in touch with the families of seriously ill prisoners and inform them promptly when they are admitted to hospital.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Governor should ensure that there are sufficient trained family liaison officers who keep in touch with the families of seriously ill prisoners and inform them promptly when they are admitted to hospital.	Accepted	One liaison officer who is now fully trained. Another three further course places for liaison staff have been identified to ensure sufficient staff are suitably trained.	May 2015