PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in February 2012 at hospital, following his release on temporary licence from HMP Standford Hill

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the death of a man. He died in February 2012, after being admitted to hospital from HMP Standford Hill the previous morning. He was 66 years old. The cause of death was recorded as a bleeding gastric ulcer. I offer my condolences to his family.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was completed by a clinical reviewer on behalf of the local Primary Care Trust (PCT). Standford Hill co-operated fully with the investigation.

Although the man had some chronic health problems, he appeared to be relatively well during his time at Standford Hill, and his death was unexpected. There was a slight delay in calling an ambulance when he was unwell on the day before his death. The investigation has identified that the prison's contingency plans were not in line with national guidance about this; there is a need for all prison staff to understand they should call an ambulance whenever there is a medical emergency without waiting for healthcare staff to attend. Nevertheless, I am satisfied that this would not have affected the outcome in his case. I am also concerned that the prison did not inform his family of his admission to hospital, so they did not have the opportunity to visit him before he died.

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 **November 2012**

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SUMMARY

1. The man arrived at HMP Standford Hill on 14 September 2011, after spending the previous five years at other prisons in the south of England. He took medication for high blood pressure and arthritic pain in his legs. He reportedly settled in well at Standford Hill, where he was remembered as a cheerful and friendly man.

2. Some friends of the man recalled that he appeared unwell and not his normal self in the days before he was admitted to hospital. Others did not notice any change and there is no indication that he reported feeling unwell to prison staff.

3. On the morning of 15 February 2012, the man fell in the shower and, shortly afterwards, told another prisoner that he was unwell. He had chest pain and was sweating profusely. The prisoner alerted an officer, who then telephoned for a nurse to attend. Healthcare staff had not officially started duty at that point, but a nurse who had arrived early for work responded. There is a significant discrepancy of half an hour between the times that the officer, nurse and prisoner recalled these events occurring. What is clear is that an ambulance was not called immediately when he was discovered with chest pain, as the clinical reviewer considers should have been the case. Local procedures for emergencies outside healthcare opening hours were not followed.

4. Local contingency plans at Standford Hill indicate that a member of healthcare staff or the orderly officer (a senior officer who responds to emergencies around the prison) should be consulted before an ambulance is called. This is not in line with national guidance. Nevertheless, we note the clinical reviewer's comment that any delay to calling the ambulance would have been unlikely to affect the outcome in these circumstances.

5. The man's family were not told of his emergency admission to hospital, as we would have expected, in line with Prison Rules. Following his death his brother was visited by the prison's deputy governor and chaplain. This was appropriate and in line with national guidance. The cause of death was established at post mortem as a bleeding gastric ulcer.

THE INVESTIGATION PROCESS

6. On 16 February 2012, the investigator issued notices announcing the investigation to staff and prisoners and invited those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.

7. The investigator visited Standford Hill on 24 April. During the visit he interviewed two members of staff. He also visited B wing, where the man lived, and spoke to three prisoners who knew him. The investigator met the Governor to provide feedback on the investigation, and followed this up in writing.

8. A review of the man's clinical care in custody was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. His final report was completed following consultation with the investigator.

9. The Ombudsman's senior family liaison officer telephoned the man's brother, his nominated next of kin, on 2 April to explain the investigation. He asked whether the condition that led to his brother's death could have been diagnosed at an earlier stage. He also said that he was not told that his brother had been taken to hospital and did not find out until the prison's family liaison officer visited to break the news of the death.

10. As part of the consultation process the man's family received the draft report. They made no comments. The report was also sent in draft to the Prison Service. Their response to the recommendations is included.

HMP STANDFORD HILL

11. Standford Hill is an open prison located on the Isle of Sheppey, holding up to 462 sentenced male prisoners. It is part of a group of three prisons, along with Elmley and Swaleside. Some prisoners at Standford Hill are employed in the prison, while others work in the community. The man worked as an outside cleaner on B wing, where he lived. Some prisoners, such as the man, who are assessed as suitable, are able to visit their family at weekends around once a month. This process, widely known as home leave, has the aim of helping prisoners to resettle and establish links in the community ahead of their release.

12. The healthcare centre is open from 8.00am to 4.30pm on Monday to Friday. There are no healthcare staff on duty during the evening, overnight or at weekends, although an out of hours service is available. A part time doctor works on Mondays, Wednesdays and Fridays. A nurse is assigned to lead on the care for older prisoners.

13. HM Chief Inspector of Prisons conducted an announced inspection of Standford Hill in December 2011. The Chief Inspector found several areas where improvement was needed, most notably in resettlement work, the core function of such an establishment. He also raised concerns about the wing environment and staff-prisoner relationships. More positively, older prisoners reported favourably on their treatment by staff and the attention given to their health needs. The Chief Inspector also reported that healthcare provision had improved from the previous inspection.

14. The prison's Independent Monitoring Board (IMB, a group of unpaid local people who independently monitor and report on the prison) report for 2010-11 commented on the difficulties caused by a number of recent changes to the senior management team at Standford Hill. However, they considered that healthcare staff at the prison provided a good and efficient service, and reported on healthy relationships between staff and prisoners.

15. Until February 2012 no prisoners had died at Standford Hill since 2007. Two prisoners then died within a week of each other. The man was the second of these. While the first prisoner also died as a result of apparent natural causes, there are no significant similarities between the deaths.

KEY EVENTS

16. The man arrived at HMP Lewes on 10 June 2006 as an unconvicted remand prisoner. At the time of his imprisonment, he took the medication amlodipine for high blood pressure. He had had a pin and plates inserted into his leg around seven years earlier, which affected his mobility.

17. Later in the year, the man was convicted and sentenced to 12 years imprisonment for drugs offences. He subsequently moved to HMP Parkhurst in February 2007. In his first two years at Parkhurst, he had surgery to remove a lipoma (a non-cancerous tumour) on his forehead. Other than this he reported no significant concerns about his health. By late 2009, his blood pressure medication had changed to doxazosin and lisinipril. He was also now prescribed simvastatin, for high cholesterol, and tramadol, a strong pain killer for arthritis in his knee and ankle.

18. The man moved to HMP Camp Hill in April 2010. In his first few months at the prison, his blood pressure increased significantly, which he attributed to the pressures of having to share a cell. His medication was increased in strength and he was allocated a single cell. His blood pressure then returned to normal levels. The following spring, his blood pressure began to increase again. His medication was changed to include felodipine, after which his blood pressure returned to the normal range.

19. On 14 September 2011, the man moved to Standford Hill. His blood pressure was checked on arrival and, at 120/92, was slightly high. He was referred to the prison's hypertension (high blood pressure) clinic. A week after his arrival, he was reviewed by a nurse and his blood pressure had fallen to the normal range.

20. The prison's disability liaison officer (DLO, an officer whose role is to act as a source of information and advice on issues of disability affecting prisoners), visited the man on 30 September. They discussed his mobility and any help available, all of which he declined. Although his mobility was affected by his arthritis, he was able to work as an outside cleaner on B wing. His officer reported that he carried out this work to a good standard. The officer recalled that he was a cheerful man who was always in good spirits.

21. On 3 October, the man saw a prison doctor. He asked that he be given a different painkiller as he was worried that tramadol was addictive. The doctor changed his medication to diclofenac. However, he found that he suffered indigestion as a result of taking diclofenac and, two weeks later, was prescribed tramadol again.

22. In late October, the man completed his first weekend of home leave. He stayed with his brother one weekend a month over each of the following three months, including over the New Year.

23. The man saw the doctor on 19 December. He told the doctor that the weather was affecting the arthritis in his joints, and was given aqueous cream to apply. On 9 January 2012, he had a routine abdominal aortic aneurysm screening. (An

abdominal aortic aneurysm is the widening of the artery in the abdomen, usually on account of high blood pressure. This can balloon and rupture, which can be fatal. All men in England aged over 65 receive a routine screening.) The outcome is not recorded in his medical record.

24. On 23 January, the man's blood pressure was checked by a prison nurse. At 123/81 it was very slightly above the normal level. He visited his brother on home leave on 23 January, returning on 26 January.

25. Other than collecting a batch of medication on 3 February, the man had no further recorded contact with healthcare staff. (He kept his medication 'in possession', which meant he collected several weeks medication at a time to keep in a locked cabinet in his cell.) Two prisoners who knew him told the investigator that the man looked unwell and drowsy in the days before his death. They thought he seemed quieter than normal, but did not think he told anyone he felt unwell. Another prisoner, Prisoner A, who knew him, did not notice any change in the man's health at this time.

26. Prisoner A told the investigator that he saw the man walking to the showers on B wing at around 7.00am on the morning of 15 February. Shortly afterwards, he heard the sound of someone falling over. The man came out of the shower, sat down next to him and said he felt unwell. The prisoner recalled that he was sweating profusely and holding his chest as if he were in pain. He alerted an officer, and recalled that the time was now around 7.15am. The prisoner said that the officer and another prisoner helped him back to his cell.

27. The officer, on the other hand, recalled that it was slightly later, around 7.45am, when the prisoner alerted him that the man was unwell. He told the investigator that he then went to the reception area of the wing and found the man in pain and sweating. The man said that he had chest pain and felt dizzy. The officer said that he therefore returned to the wing office to telephone healthcare for assistance, and believed that this was at around 7.47am (he explained that while healthcare staff did not officially start work until 8.00am, a nurse routinely arrived for work much earlier than that). The officer returned to the man and helped him back to his cell so he could lie down. He recalled that the nurse arrived at around 7.55am and there was no change to the man's condition in this time.

28. In discussion with the investigator, the nurse confirmed that healthcare staff at Standford Hill formally start work at 8.00am. However, she usually arrived at the prison at around 7.30am and was sometimes called to assist prisoners before 8.00am. She recalled that she received a call asking her to go to B wing at around 7.35am on 15 February. She told the investigator that she arrived at the wing at around 7.40am.

29. On arrival, the nurse found the man sweating and in pain, which he described as a "stabbing pain" to his chest. She took his pulse rate, which was rapid, and oxygen saturation levels (a measure of how much oxygen is carried in the blood), which were a little under the normal range. She gave him an aspirin tablet and a spray used to ease angina pains.

30. The nurse recalled asking for an ambulance to be called shortly after her arrival. (The officer was in agreement with this.) The prison's control room log, and the Ambulance Service log, both record that the ambulance service was called at 8.00am and an ambulance arrived at the prison at 8.15am. She told the investigator that the man continued to experience severe pain before the arrival of the paramedics; she therefore gave him another puff of the spray. He was taken to the ambulance, which left at 8.30am. Although he continued to be in pain, he remained conscious and she recalled that he was aware of what was happening and asked another prisoner to get him some clothes to wear.

31. As he was a category D prisoner, the man was released on temporary licence to go to hospital. (Release on temporary licence [ROTL] is a form of release usually used to enable prisoners to participate in activities outside the establishment that directly contribute to their resettlement into the community. For example, he was released on temporary licence to stay with his family on home leave.) This meant that he was unaccompanied, and no restraints were used.

32. The man was taken to Medway Hospital. Following a deterioration in his condition, he was moved to the hospital's coronary care unit. He died at around 1.40am the following morning.

33. The deputy governor and a prison chaplain visited the man's brother on the morning of 16 February to break the news of his death. An officer told Prisoner A that the man had died. The staff involved when he was taken to hospital were satisfied with the support they received. The funeral was held on 16 March and the prison contributed to the costs in line with national guidance. A memorial service was held at Standford Hill for staff and prisoners.

ISSUES

Clinical care in prison

34. The man's brother asked whether the condition that led to his death could have been identified at an earlier stage. The full post mortem report is not yet available, although the initial finding is that he died as a result of a bleeding gastric ulcer.

35. During his time at Standford Hill, the man saw healthcare staff occasionally in relation to his long-standing high blood pressure and arthritis. Other than experiencing side effects following a change to his painkiller in October 2011, which was promptly dealt with, he reported no new symptoms. Two of his friends on B wing suggested that he had not appeared his normal self in the days before he was admitted to hospital, although others did not notice any change. Either way, there is no indication that he told staff that he was unwell and there is no indication that his condition could have been identified earlier. The clinical reviewer comments that the "only possible concern" from a clinical perspective is the initial management of his symptoms when he was taken ill on 15 February 2012.

Events of 15 February 2012

36. Three people were interviewed by the investigator about the events of 15 February, all of whom recalled different timeframes. Prisoner A said that he called the officer for assistance at about 7.15am. The nurse remembered that she was called at 7.35am and arrived at the wing at 7.40am. The officer recalled that he was alerted by the prisoner at 7.45am and that the nurse arrived at 7.55am. It is not unusual for there to be a discrepancy of a few minutes between individual recollections of a series of events, but half an hour is a significant difference. We are unable to say which version of events is correct. We note that the nurse recorded an account of the events, including the times stated, in the man's medical record just a few minutes after the ambulance left Standford Hill. On the other hand, the officer's account of when the ambulance was called correlates most closely with the ambulance service log, which can be considered accurate. Moreover, the nurse's evidence was that she asked that an ambulance be called shortly after she reached the man. This might suggest that the officer's timings are more reliable.

37. The important factor is whether staff acted promptly and appropriately when they were alerted. The man was experiencing significant chest pain and other symptoms that are associated with a heart attack, such as sweating and shortness of breath. The clinical reviewer comments:

> "It is now accepted as standard practice that if a person is complaining of severe acute chest pain an ambulance should be immediately called, as the presumption is the person may be suffering from an acute life threatening condition such as a heart attack which may progress to cardiac arrest … Therefore in the situation that occurred with the man an ambulance should have been called as soon as possible by the prison officer."

38. The officer explained at interview that he did not call an ambulance immediately because he wanted healthcare staff to assess the man first. He added that he "was not struggling desperately at that stage".

39. Local contingency plans at Standford Hill explain that "on discovering a prisoner you believe to be seriously ill" staff must contact the prison's communications room by telephone or radio, using the relevant local incident code. (Code red indicates an emergency involving loss of blood, code blue indicates another medical emergency.) Communications room staff are then required to contact healthcare staff to attend the scene (during healthcare opening hours) and call for an ambulance following advice from either healthcare staff or the orderly officer (a senior officer who is tasked with responding to incidents around the prison).

40. If the officer had followed these instructions it would suggest he should have contacted the communications room for assistance rather than telephoning healthcare, as officially the healthcare department does not open until 8.00am. However, it is a concern that the prison's local contingency plans do not appear to follow national guidance, as they require the orderly officer or a member of healthcare staff to be consulted before an ambulance is called. In February 2011, the Chief Executive Officer of the National Offender Management Service (NOMS, the organisation responsible for the Prison and Probation Services in England and Wales), wrote a letter to governors in response to a report issued by this office in relation to deaths from cardiac diseases. He reminded governors that of previous guidance issued in 2004 and said that:

> "It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the prison healthcare team to attend the scene before emergency services are called … The most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner."

The letter required governors to review their existing protocols immediately.

41. The clinical reviewer comments that any delay to calling the ambulance appears to have made no difference to the final outcome, as the man died several hours later in hospital and from a bleeding ulcer, rather than a heart attack. However, there are lessons that could be learnt at Standford Hill from these events. Staff who are first on the scene to an incident should have the authority and confidence to ask for an ambulance immediately.

The Governor should amend the local contingency plans and ensure that all staff understand that if they are first on the scene of a medical emergency they should call an ambulance immediately, without waiting for a member of healthcare or the orderly officer to attend.

Contact with the man's family

42. The man's brother told our family liaison officer that he was not informed of his brother's hospital admission, and was not aware of this until told of his death the next day. Prison Rule 22, about the notification of illness or death, 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."

43. The man was taken to hospital with severe chest pain in an emergency ambulance, and his condition did not improve. The news of his death was broken to his brother in person by appropriate members of prison staff on the morning of his death. However, our view is that his brother should have been informed of his admission to hospital as soon as possible. The failure to do so meant that his family did not have the opportunity to visit him in his final hours.

    The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.

44. In response to our draft report, Standford Hill said that they will inform the next of kin at the earliest opportunity when a medical professional advises that they should. However, they go on to say that in the man's case they were advised that he would be staying in hospital one night and then returning to custody.

45. We accept that it is not practical to inform the next of kin every time a prisoner goes to hospital unexpectedly. However, as we have noted above, the man was taken to hospital in an emergency ambulance suffering severe chest pain. When a prisoner is admitted via emergency ambulance we believe the conditions of Prison Rule 22 apply and the next of kin should be informed.

CONCLUSION

46. The man saw healthcare staff only occasionally during his time at Standford Hill, in relation to his long-standing high blood pressure and arthritis. Although there is some indication that he was unwell in the days before his death, there is no evidence that he reported this to prison staff. There is a significant difference in the recollection of three key witnesses about the time that he was taken ill and when healthcare assistance was first called. Either way, it does not appear that an ambulance was not called as promptly as should have been the case. As he died several hours after hospital admission, it appears that any delays would not have made a difference to the final outcome. Nevertheless, it is important that prison staff have the authority and confidence to call an ambulance immediately on discovering a serious medical incident. It is a matter of regret that his brother was not informed of his admission to hospital.

RECOMMENDATIONS

1. The Governor should amend the local contingency plans and ensure that all staff understand that if they are first on the scene of a medical emergency they should call an ambulance immediately, without waiting for a member of healthcare or the orderly officer to attend.

   Accepted - Contingency plans have been amended to improve levels of emergency aid response, particularly when healthcare staff are off duty. A notice has been issued reminding staff of coded healthcare emergencies. Emergency first aid training has been improved also to provide more continuity of service through Senior Officers, and awareness of what to do in a medical emergency. All staff are aware of when to call an ambulance, although in practice this will often involve the Orderly Officer or someone else on the scene speaking to the ambulance service to determine the level of response, given that there is no A&E on Sheppey.

2. The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.

   Accepted - Where there is an indication from a medical professional that the next of kin should be advised we will inform them at the earliest opportunity.

   In the man's case we were advised that he would be staying in hospital one night and then returning to custody.