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 man at hospital in August 2012, while a prisoner at HMP Standford Hill

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 report of an investigation into the death of a man. He died in hospital in August 2012, while he was a prisoner at HMP Standford Hill. He was 64 years old. A post-mortem examination found that the cause of death was pneumonia, stroke and heart failure. I offer my condolences to his family and friends.

A clinical reviewer carried out a review of the clinical care the man received at Standford Hill. The prison cooperated fully with the investigation. I am sorry this report is late.

In March 2011, the man was diagnosed with cardiac failure and atrial fibrillation. A number of treatment options were investigated, and he agreed to take part in a clinical trial of a new procedure to fit catheters into his heart. He was aware that there was a one percent risk of a stroke. Unfortunately, on 30 March 2012, during the operation, he suffered a stroke and his health declined further. He remained in hospital and never returned to the prison before his death, almost four months later.

The clinical reviewer has concluded that the medical care the man received was exemplary. In relation to his taking part in a clinical trial, I am satisfied that the risks of the procedure were explained to him and that he made an informed choice to take part.

However, it is disappointing that the man's next of kin did not learn that he was in hospital until just a week before his death and that an application for compassionate release was poorly handled. Despite this, he received generally good care at Standford Hill.

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 **September 2013**

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SUMMARY

1. The man was sentenced to life imprisonment in 1979 with a minimum period to serve of 20 years before he could be considered for release. He moved prisons a number of times during his sentence and transferred to HMP Standford Hill from HMP The Mount in December 2010.

2. While he was at The Mount, cardiologists saw the man a number of times to investigate heart problems. In March 2011, after he had moved to Standford Hill, he was diagnosed with cardiac failure and atrial fibrillation. Various options were considered to treat his heart condition. After being referred to a London hospital, he agreed to take part in a clinical trial which involved inserting catheters into his heart.

3. One of the risks associated with the procedure was a one percent chance of a stroke. The man fully understood the procedure and the risk and decided to go ahead. The operation was carried out on 30 March 2012, during which he suffered a stroke which affected the right side of his body.

4. The man was transferred to a number of different hospitals and specialist units as his health deteriorated. Healthcare staff at Standford Hill discussed how best his care needs could be met at a number of multi-disciplinary team meetings with hospital staff.

5. The man's scheduled parole hearing in April was deferred as he was too ill to attend. The process of applying for his release on compassionate grounds was begun but there was a lack of clarity about the procedures. His offender supervisor believed the application was progressing but in fact it had never left the prison. There were also some difficulties about whether a permanent address, other than the hospital, was needed. The prison did not seek further advice about the position and the initial application was not pursued.

6. On 14 August, the man's condition deteriorated rapidly and it was not until then that his sister was informed that he was in hospital. On 16 August, a further application for compassionate release was made but he died before it was approved.

7. This report makes two recommendations about the handling of compassionate release applications and about the need to inform families when prisoners are seriously ill.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was informed of the man's death on 20 August 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with any relevant information to contact her. No one came forward.

9. The investigator visited HMP Standford Hill on 29 August 2012 and saw the Governor. She obtained copies of the man's prison and healthcare records.

10. The local Primary Care Trust appointed a clinical reviewer to carry out a review of the clinical care the man received while at Standford Hill.

11. An Assistant Ombudsman and the clinical reviewer interviewed seven members of staff at Standford Hill on 11 January 2013. The Assistant Ombudsman carried out a further interview by telephone on 25 January.

12. HM Coroner for Mid Kent was informed of the investigation and provided the results of the post-mortem examination. The Coroner has been sent a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's next of kin, his sister. She explained the purpose of the investigation and gave his sister the opportunity to identify any matters she wished the investigation to take into account. She had the following concerns:

    - He had been on warfarin which was stopped and she did not know why

    - She was not told he was in hospital until just one week before he died, even though he had been there almost four months.

    - He had been told he needed a pacemaker while in a previous prison, but did not appear to have received this.

14. We are sorry that this report has been delayed, which was due to staff shortages.

15. The draft of this report was shared with the man's family and the Service. The Service response to the recommendations is included in this report, and the Governors specific response to the issue of compassionate release is included also.

16. The man's family did not raise any matters that require any amendment to this report. However his sister did reiterate the lack of information received by the family throughout.

HMP STANDFORD HILL

17. HMP Standford Hill is an open prison on the Isle of Sheppey, Kent, holding up to 462 male prisoners. It is part of a group of three prisons along with HMP Elmley and HMP Swaleside. As an open prison, prisoners are routinely trusted to move around the site unescorted and to travel on their own to work placements and hospital appointments. Healthcare staff work between 8.00am and 5.00pm from 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.

Independent Monitoring Board (IMB)

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Standford Hill covers the year ending April 2012. The Board commented:

> "The prison has benefited from good, stable and, in some cases, innovative management. The Board feels the prison is well run and moving forward."

HM Inspectorate of Prisons (HMIP)

19. HMIP completed an announced inspection of Standford Hill in December 2011 and reported:

> "Until relatively recently, Standford Hill appears to have been coasting. Outcomes are reasonable in most areas but the prison is exposed by some significant areas of concerns. Reassuringly, almost nothing we said in our immediate feedback to the new governor came as a surprise and work had already started to address the concerns we identified. It was overdue and it is hoped that a period of more stable management will enable the prison to make the rapid progress required."

Previous deaths at Standford Hill

20. There were four deaths at Standford Hill in 2012, including that of the man, all were from natural causes. In one of these, we made a recommendation, which was accepted by the prison, about informing the next of kin promptly when a prisoner is taken to hospital. We make a similar recommendation in this report.

KEY EVENTS

21. The man was sentenced to life imprisonment in 1979 at Crown Court. He moved prisons a number of times during his sentence. He was at HMP The Mount before being moved to HMP Standford Hill on 16 December 2010, as part of his preparation for release.

22. In August 2008, while at The Mount, cardiologists at a hospital began investigating issues with the man's heart. He was referred for tests to find out if he had coronary heart disease.

23. In January 2009, the man was told that he needed a further cardiac referral and, in February, a cardiologist suggested that it was possible that he needed a pacemaker to regulate his heart beat. There is no further mention of the need for a pacemaker in his records but the possibility of an implantable cardioverter defibrillator, which is implanted in a similar way to a pacemaker, was later considered.

24. The man had a magnetic resonance imaging (MRI)[1] scan, in June 2009, which showed that he had previously had a heart attack, but his coronary arteries were not blocked. He was taken off beta-blocker medication (which slows the heart rate) as his was already considered to be slow.

25. In December 2010, when the man arrived at Standford Hill his past medical history, including his heart condition and a previous injury to his eye, was noted at an initial health screen. His medication was recorded as furosemide (diuretic or water tablet), ramipril (used to treat heart failure) and spironolactone (used to treat fluid retention).

26. In January 2011, the man was referred to cardiologists at hospital. He was seen on the 24 March, and an electrocardiogram (ECG)[2] confirmed that he had cardiac failure and atrial fibrillation. This is a disorder which causes an irregular and, sometimes, abnormally fast heart rate. Cardioversion, a procedure which can convert the heart rhythm to a normal pattern, was considered. Further tests were needed to establish if this would be possible.

27. On 23 May 2011, tests at hospital indicated that the man's heart rhythm was of a type that could lead to sudden death. He was referred back to the cardiac clinic to see whether he needed an implantable cardioverter defibrillator (ICD). An ICD is a small battery powered electrical impulse generator that is implanted into patients who are at risk of sudden cardiac death. The device is programmed to detect sudden irregular heart rythym and correct it by delivering a jolt of electricity.

28. On 7 June, a consultant cardiologist at the hospital wrote to the prison healthcare department explaining that he did not consider an implant to be necessary as the man had not had episodes where he lost consciousness

[1] MRI scan provides detailed images of the organs in the body
[2] ECG – a test that measures the electrical activity of the heart

and there was no evidence of coronary artery disease. The doctor acknowledged that cardioversion might be required at a later date.

29. On 30 June, the cardiologist referred the man to a consultant at another hospital. He wanted the consultant to assess the various treatment options available to him. The cardiologist also arranged for him to start taking warfarin (an anticoagulant, which lowers the clotting level of the blood). Arrangements were made for him to be seen regularly by specialist heart failure nurses from the community cardiology service**.**

30. Records show that the man had regular blood tests to check his clotting levels (known as the INR - international normalised ratio and is used to monitor patients taking warfarin).

31. On 14 July, the hospital wrote to the man to say that he had been put on the waiting list for cardioversion. The appointment was eventually arranged for 15 December 2011.

32. On 12 December, three days before the planned cardioversion, the man signed a disclaimer to say that, against medical advice, he had decided not to have the cardioversion procedure. He had been told that after the operation he would have to stay overnight stay at HMP Elmley to be observed in their inpatient facility, because he would be recovering from an anaesthetic. He said he had heard bad things about Elmley and he refused to stay there. He could not be persuaded to change his mind.

33. On 23 February 2012, a hospital doctor contacted the prison doctor about the possibility of the man taking part in a clinical trial which involved inserting catheters into the heart to see if, when combined with an MRI scan, the likelihood of dangerous heart rhythms could be predicted. (An MRI scan shows internal structures, such as organs, in detail.) The procedure carried a variety of risks including a one percent chance of inducing a stroke. The Head of Healthcare took advice from the National Offender Management Service (NOMS) Headquarters and all agreed that it was his decision whether to be involved in the clinical trial. His offender supervisor discussed the implications with him.

34. The man agreed to go ahead with the trial. He told his offender supervisor that he was pleased to have the opportunity to do something that might help others in the future. He was released on temporary licence and the operation took place on 30 March. At 12.36pm the hospital called the prison and told them that he had possibly suffered a stroke and that he was being transferred to another hospital as an emergency. The hospital asked that his family should be informed. A prison administrator gave the offender supervisor the contact details of his sister, his next of kin.

35. The prison extended the man’s release on temporary licence from 30 March.

36. The man moved to the other hospital where a brain scan revealed that he had suffered a large, left-middle cerebral stroke. On 2 April, a note was made on

his medical record that a governor had tried to contact his next of kin. The note does not say when this was done or what the outcome was. He transferred back to the first hospital for further care on 13 April. His right hand side was paralysed and he struggled to use language effectively. He was fully dependent for care and personal tasks and was not expected to make a full recovery.

37. On 12 April, a nurse at Standford Hill had contacted the stroke unit at the second hospital asking for a medical report so that early release on compassionate grounds (ERCG) could be considered. At first, the hospital agreed but then declined to provide a report because the man was not able to provide informed consent. As he was being moved to the first hospital the next day, the nurse was advised to liaise with them.

38. The man's offender supervisor took up the liaison with the first hospital and on the 19 April she visited the man to get his consent for a medical report outlining his diagnosis and prognosis. A consultant at the hospital filled out the medical part of the form, and he gave his consent. All present were satisfied that he was able to give informed consent.

39. On 20 April, the man's offender supervisor took the papers relating to the application to the Governor's office for the information to be sent on to the Public Protection Casework Section (PPCS) at NOMS headquarters which deals with compassionate release applications. At interview, the offender supervisor recalled that the documents included his consent, healthcare's report and her report. She believed that the application had gone forward at that point.

40. A scheduled Parole Board hearing for 20 April, which the prison had expected would direct the man's release, did not take place because he was too ill to attend. His solicitor made representations for the panel to go ahead in his absence, but the Parole Board decided not to proceed.

41. On 30 April, the man was transferred to another hospital, but a week later his discharge to another hospital (once transport could be arranged) was agreed.

42. On 22 May, the Head of Healthcare at Standford Hill had a meeting with the ward sister at the hospital, a speech therapist and a member of the prison's Occupational Medicine Unit. The man had not yet arrived at the hospital. They discussed his longer-term needs and it was noted that he was making a little progress and he would need social care support. It was agreed that eventually a nursing home would be the most suitable option. The meeting recognised that the Parole Board would need to be involved and a further meeting was arranged for four weeks' later. He moved to the rehabilitation unit at the hospital on 31 May.

43. On 26 June, a multi-disciplinary team meeting (MDT) was held at the hospital, which the Head of Healthcare attended. The aim was to discuss his progress and his discharge. Progress had been limited. It was decided that he was likely to need nursing care and probably in Kent as he was a resident there.

As he was at the time in the care of the Prison Service, funding was considered to be a potential problem as the County Council were likely to refuse financial help. It was also thought that the Parole Board would be unlikely to approve release without a suitable discharge address.

44. The meeting agreed a number of actions: an officer from Social Services would liaise with her managers about funding; stroke services would assess the man's mental capacity and his community based probation officer would contact the Parole Board and report on the current position.

45. On 14 July, the man returned to hospital as he was suffering from chest pains. The chest pains were not cardiac related and the hospital considered that he was fit to be discharged from the acute bed. However, there was no longer a vacant bed at the community Hospital. The stroke team at the hospital agreed to arrange an assessment to see if he could be referred back to them. On 31 July, the officer confirmed that the County Council would not fund a place for him while he was technically still in custody and his care was the responsibility of the Prison Service.

46. On 7 August, the Head of Healthcare attended another multi-disciplinary meeting at the hospital to discuss ways forward. These included transferring the man back to a prison healthcare department, such as at Elmley. The possibility of his returning to another hospital with a view to moving to a nursing home in due course was also considered.

47. On 14 August, the hospital contacted the prison to inform them that the man's condition had deteriorated rapidly. He had been put on an end of life care pathway and the hospital asked that his next of kin should be informed. The Head of Healthcare contacted the man's sister that day to let her know. The next day, 15 August, the Head of Offender Management, who was acting as the prison's family liaison officer, noted that she had spoken to his sister and explained her role.

48. On 15 August, a doctor sent a letter to the Parole Board explaining that the man's condition was such that he was unlikely to survive for more than a couple of months. He did not want any further active treatment or interventions and the doctor was satisfied that the man had the capacity to make this decision. (The doctor had written previously to the Parole Board, on 10 August, to outline his condition and level of dependency at that point.)

49. The Head of Healthcare and the Head of Offender Management at the prison went to visit the man on 15 August. They discussed whether a new application for release on compassionate grounds was required or whether an addendum to the previous application would suffice. On 16 August, the Head of Healthcare asked PPCS whether a new application for compassionate release was needed or whether they would accept additional information about his prognosis. At that stage, she learnt that the PPCS had never received an earlier application for compassionate release for him.

50. On 16 August, the prison sent an application for release on compassionate grounds to the PPCS, but release was not agreed before the man died.

51. The man's sister visited him on 19 August before he died.

52. After the man's death, the Head of Offender Management stayed in contact with his sister to assist with the funeral arrangements. The prison offered financial assistance towards the funeral, in line with national guidance.

Post-mortem report

53. A post-mortem examination was carried out by a consultant pathologist on 28 August 2012. He recorded the cause of death as:

1a – bilateral pneumonia
1b – left sided cerebral infarct (stroke)

2 – atrial fibrillation

ISSUES

Clinical Care

54. The clinical reviewer considered that the care the man received in custody was at least equal to that he would have expected to receive in the community.

55. He said:

> "From a clinical perspective, the medical care that he received was exemplary, particularly with respect to the management of his cardiac condition. With excellent liaison between the healthcare departments at the two prisons … and the cardiology departments of two hospitals."

The man's warfarin

56. The man's sister was concerned that his warfarin had been stopped. We examined his prison clinical record and this shows that he stopped taking warfarin on 22 March in preparation for the cardiac procedure on 30 March. This was on the advice of hospital clinicians. We are satisfied that his warfarin was appropriately managed while he was in prison and he had regular blood tests to check his clotting levels. It is possible that his warfarin was no longer prescribed while he was in hospital, but we are not able to check this as treatment in hospital is not within the remit of the Prisons and Probation Ombudsman.

Clinical Trial

57. We are satisfied that the man was fully aware and understood the risks associated with the clinical trial. A doctor gave him a patient information sheet which set out the risks involved, including the slight chance of a stroke. He also received a copy of the trial's protocol describing the aim, patient recruitment, inclusion and exclusion criteria and the methodology.

58. The man's offender manager discussed the trial with the man at length. They went through the information in detail and she was certain he fully understood what the trial involved and the risks involved. She said:

> "He was an avid reader; he was very knowledgeable about things. If he was going to look into something he would look into it 100 per cent. He kept copies of everything. So he looked into this fully and he was happy to go ahead with it."

Compassionate Release

59. There were two routes by which the man could have been released. As he had served his tariff (the minimum term before he could be considered for release) the Parole Board could have directed his release on the grounds that he was no longer a risk to the public. Unfortunately a scheduled parole

hearing on 20 April was cancelled because he was too ill to attend. His solicitors asked for the hearing to go ahead in his absence but the Parole Board decided against this. The actions and decisions of the Parole Board and its Secretariat are outside the remit of the Ombudsman so we are unable to comment on this decision.

60. Another route would have been through the compassionate release process. The procedures for compassionate release for prisoners serving an indeterminate sentence are set out in Prison Service Order (PSO) 4700. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS). There appeared to be some confusion about the two processes as information about his condition was sent to the Parole Board rather than the PPCS after the Board had cancelled his hearing.

61. The man's offender supervisor at the prison prepared an application for compassionate release shortly after he suffered a stroke. She left the application in the Governor's office and believed it had been sent to the casework section at NOMS headquarters for consideration. However, it appears that this original application was never sent to the PPCS. We have been unable to establish exactly what happened to the application after that. It is not clear whether the application did not progress because of poor communication and management of the process or whether it was held up because the prison believed that, without an offer of accommodation, the application would not be considered. Whatever the reason, we consider that the original application was unnecessarily delayed. The PPCS has confirmed that, following the acceptance of a previous recommendation from this office, a hospital would now be considered as a suitable address for prisoners in the same circumstances as his.

62. An application was eventually made on 16 August, just days before the man's death. The application was approved, but sadly by that time he had died. We make the following recommendation:

The Governor should ensure that there is a clear and effective process for managing applications for compassionate release promptly when a prisoner is terminally ill.

63. Following receiving the draft report, the Governor of HMP Standford Hill made the following response:

"The Governor was not handed the papers for compassionate release, and there is no trace of any papers from the time. There was a long exchange between the PCT and the prison, as the PCT was insistent that the prison should continue to fund the man's care and whether a hospital bed was an acceptable address for compassionate release. This can be evidenced in an

email from the case manager from the Hospitals Team dated 31 July 2012. It was his Community Offender Manager's responsibility to look at finding suitable accommodation and not that of the prison's – however we were fully involved and pushing hard to release him. PPCS would not consider a hospital bed as a release address until in mid-August they agreed that they would release to an end-of-life bed, at which point the application was submitted".

Liaison with the man's family

64. The man's sister told us that she did not know about his admission to hospital until a week before he died. This was almost four months after he suffered his stroke.

65. It seems that there were was some attempt to contact the man's sister when he had first had a stroke on 30 March, as there is an entry in his medical record on 2 April saying that the duty governor at the time had tried to contact his next of kin. The duty governor said that messages were left on his sister's answer-phone about his admission to hospital. Her recollection was that his sister had left a message in reply, saying that she was aware of the situation. However, there is no record of this anywhere and nor is there any indication that anyone in the prison tried to follow this up in the weeks or months that followed until his condition deteriorated seriously in August.

66. Prison Rule 22 requires the next of kin to be informed at once if a prisoner becomes seriously ill. Further guidance is given in Prison Service Instruction 64/2011 which states that prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin of prisoners who are terminally or seriously ill and that it is good practice for an appropriate log to be maintained. We are not satisfied that the prison made sufficient efforts to make or maintain effective contact with the man's sister when he became seriously ill. We make the following recommendation:

The Governor should ensure that the next of kin of prisoners who become seriously ill prisoners are informed quickly and that a suitable member of staff is appointed to engage with their families and keep a log of all contact.

RECOMMENDATIONS (Service response below)

1. The Governor should ensure that there is a clear and effective process for managing applications for compassionate release promptly when a prisoner is terminally ill.

   Accepted: *We believe we were already compliant with this at the time of the man's death, and worked very hard to attain compassionate release for him. The delays were due to funding from the PCT for the care and PPCS refusal to accept a hospital address as a final discharge address. We feel we could have done no more.*

2. The Governor should ensure that the next of kin of prisoners who become seriously ill prisoners are informed quickly and that a suitable member of staff is appointed to engage with their families and keep a log of all contact.

   Accepted: *We supplied the PPO with evidence that we contacted the next of kin (the man's sister) in April regarding him (his stroke was in March). This was 4 months before his death and we made contact with the next of kin throughout his illness. We were not aware of the existence of his son until after he died – he never made us aware of this relative.*