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 on 22 June 2014, while in the custody of HMP Brixton

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 man, who died on 22 June 2014 at King's College Hospital while in the custody of HMP Brixton. The man had been in hospital since November 2013 and never recovered from a serious heart operation and a subsequent heart attack. He was 74 years old. I offer my condolences to his family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man received a five year prison sentence in March 2012. In February 2013, he transferred to Brixton. He suffered from heart and lung problems and frequently went to hospital for heart consultations.

In November 2013, the man went to hospital for a heart bypass operation. A week after the operation he had a heart attack and suffered additional complications. After this, he needed help with daily living and could not walk, swallow or talk. In February 2014, the hospital informed prison staff that he would never be well enough to return to prison. He remained in hospital until his death in June.

I am satisfied that, while the man was in prison, he received clinical care equivalent to that he could have expected in the community. However, the investigation identified some areas for improvement at Brixton. He missed one hospital appointment because of administrative errors, communication between the hospital and the prison should have been better, and an application for his early release was unnecessarily delayed.

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 **January 2015**

PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

CONTENTS

SUMMARY

1. The man was sentenced to five years imprisonment in March 2012 and was sent to HMP Norwich. He was transferred to HMP Blundeston on 12 April. In December, he became a category D prisoner and was transferred to HMP Brixton on 7 February 2013.

2. When the man arrived at Brixton, a nurse noted he had a history of ischaemic heart disease, COPD (chronic obstructive pulmonary disease – used to describe a range of lung diseases) and high blood pressure.

3. In July, the man went for a hospital cardiac appointment. Doctors made a further appointment for September, to assess his heart function more thoroughly. The hospital doctors reviewed his condition and on 28 October, offered him a heart bypass operation. He had missed an earlier hospital appointment because of an administrative error at the prison.

4. The man was released from prison on temporary licence for the operation. He went to hospital on 18 November and was expected to be there for five days. Prison healthcare staff phoned the hospital for an update on 25 November and hospital staff told them that the man was doing well. There is no other recorded contact until healthcare staff phoned the hospital on 2 December, when they were told he had suffered complications and was in the ITU (intensive therapy unit). No one from the prison contacted the man's family.

5. As a result of the complications, the man needed 24 hour care. He was paralysed and unable to perform daily tasks. Prison and hospital doctors requested that the prison apply for early release on compassionate grounds. However, the prison never submitted an application and he remained in custody at the hospital until he died on 22 June 2014.

6. The clinical reviewer is satisfied that the man's care in prison was equivalent to that he could have expected to receive in the community. However, we are concerned that he missed a hospital appointment because of an administration that an application for early release on compassionate grounds was never completed. We also consider that there should have been more effective communication with the hospital and with his family. We make four recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Brixton informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed three members of staff at the prison in August and interviewed two by telephone. She informed the Governor of the initial findings of the investigation.

9. NHS England commissioned a doctor to review the man's clinical care at the prison.

10. We informed HM Coroner for Inner South London District 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 wrote to inform the man's wife of the investigation. We received no response.

12. The investigation has assessed the main issues involved in the man's care, including his location before he went to hospital, security arrangements for hospital appointments, liaison with his family and whether compassionate release was considered.

13. The man's family had not responded at the time of issuing this report. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP BRIXTON

14. HMP Brixton is a resettlement prison which houses up to 800 medium and low security category prisoners in five main residential units. Care UK coordinates healthcare services at the prison, with a number of different providers, including the South London and Maudsley NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust. A GP service runs from 8.00am until 5.00pm on weekdays. Nurses are on duty between 7.00am to 7.30pm daily.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Brixton was in July 2013. The Inspectorate found that the needs of older prisoners were generally well met and health services were generally good. External appointments were well managed and coordination between providers effective. However, inspectors assessed chronic disease management as poor.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to 31 August 2013, the IMB noted that healthcare services at the prison were generally good, but there was a need for more mental health services and that the provision for older prisoners needed to be monitored.

.

Previous deaths at HMP Brixton

17. The man was the third prisoner to die from natural causes in the last two years at HMP Brixton. We have raised the issue of missed hospital appointments before.

KEY EVENTS

18. On 20 March 2012, the man was sentenced to five years in prison for tax offences. He went to HMP Norwich and moved to HMP Blundeston on 12 April 2012. In December 2012, he was recategorised as a category D prisoner (the lowest security category). He moved to HMP Brixton on 7 February 2013.

19. At the man's reception health screen, a nurse noted he had a history of ischaemic heart disease, COPD (chronic obstructive pulmonary disease) and hypertension. She referred him to the GP, who continued the man's existing prescriptions. The GP did not see the man, but made an appointment for the next week. He prescribed ipratropium bromide (an inhaler), aspirin, alfuzosin (for prostate conditions), rosuvastatin (a statin, to lower cholesterol) and valstartan (for hypertension). The man was allowed to keep his medication in his possession.

20. On 15 February, a doctor examined the man and noted that he had previously had a heart attack and used a GTN spray for angina. The doctor prescribed GTN spray. He also noted that the man had a sprained ankle and foot, the cause of which was unknown. He referred the man for a chronic disease assessment, ten days later. The doctor saw the man on 25 February and did routine blood tests which were all normal. There is no record of a chronic disease review.

21. At the end of April, the man suffered from exacerbation of his COPD. He was treated with antibiotics.

22. On the evening of 7 May, the man told a nurse that he had pain in his left arm, which his GTN spray did not relieve. He wanted to go to hospital, but the nurse considered that was not necessary. She spent time with him and took his clinical observations, which were normal, apart from high blood pressure. He said that the pain had reduced and the nurse asked wing staff to contact her if it got worse again. She checked the man after half an hour and noted he was relaxed and feeling better.

23. On 20 May, the prison received a summary of the man's medical history from his community GP. It confirmed his chronic medical conditions (heart disease and COPD), stated he had suffered a heart attack in 1999 and that he needed lifelong medication.

24. On 15 July, the man went to an outpatient cardiac appointment at King's College Hospital, accompanied by one officer. The hospital wrote to the prison, saying the man needed further investigation of his heart. From 8 August, the prison approved him for release on temporary licence. This allowed him to go on town and family visits and meant he could attend hospital appointments on his own. On 25 September, he had a transthoracic echocardiogram, to assess his heart function.

25. Hospital doctors discussed the man's test results on 4 October, and arranged an appointment for 14 October, to offer him a heart bypass operation. He missed this appointment as he said prison staff did not give him the letter informing him of his appointment until 15 October, although it had arrived in

the prison on 11 October. On 28 October, he attended a rearranged appointment. He discussed the risks with hospital doctors and decided to have the bypass operation. On 8 November, the hospital confirmed the operation date would be 18 November.

26. On 18 November, the man was released on temporary license until 22 November for his operation, (later extended to 29 November.) He had frequent contact with his family, but there is no record that anyone from the prison spoke to them about his admission to hospital. The prison phoned the hospital for an update on 25 November. A nurse said he had undergone the surgery and was stable with no major concerns. The hospital expected to discharge him by 1 December. (While the man was in hospital, the prison reviewed and extended his licence approximately every two weeks.)

27. On 2 December, a nurse from the prison phoned the hospital for an update. The hospital said that the man had transferred to the Intensive Treatment Unit (ITU). The prison notes indicate that he had suffered a heart attack when they were discharging him and that he would be moved back to the ward when he was stable. There were no further details. The post-mortem report indicated that the man had the bypass operation on 19 November and on 26 November, he had a heart attack. This had resulted in lack of oxygen to the brain which caused paralysis of all four limbs and difficulty swallowing. He had also bruised his spine, as he had fallen, when he had the heart attack.

28. A prison manager visited the man on 3 December. She noted he was unwell, could not speak and that his family visited him regularly. She also noted she would contact the prison's family liaison officer to ask them to contact his family, but there is no record that this was done.

29. Prison healthcare staff continued to telephone the hospital for regular updates about the man's condition during December and January. On 10 December, healthcare staff noted that he was progressing more slowly than the hospital had expected. On 16 December, a further note indicated that he was 'nil by mouth', unsteady on his feet and required a lot of rehabilitation.

30. On 16 January 2014, a nurse recorded that the man needed neurological rehabilitation in a specialist unit. This was not expected to happen soon, as the NHS needed to move him to another catchment area and funding was an issue. She noted that he was immobile and needed full assistance with his daily living.

31. On 7 February, a prison GP recorded that she was expecting a letter from the hospital multidisciplinary team so the prison could proceed with an application for early release on compassionate grounds. A letter, received on 12 February, detailed the man's needs and progress. It concluded that there had been some improvements, but he required ongoing intensive rehabilitation in a specialist setting and would need assistance at all times. After this, there were few recorded updates about the man's condition in his prison medical records or general prison record.

32. On 5 June, a letter dated 15 May, was scanned into the man's prison medical records. A doctor from King's College Hospital had written asking for early release for the man so he could move to a nursing home. He could not speak

or swallow safely and was fed through a tube. The letter noted he had an uncertain prognosis, suffered frequently from pneumonia and there was no possibility of him becoming well enough to return to a prison environment. On 19 and 22 June, most of an application for early release was completed, but the application was never submitted.

33. The man became ill with pneumonia in June and continued to receive care in hospital. His health deteriorated and he died at 5.40pm on Sunday, 22 June. His cause of death was given as pneumonia, severe brain injury and a heart attack, while also suffering from a build up of deposits in his arteries. The hospital did not inform the prison that he had died and they did not learn of his death until 24 June, when the Coroner contacted them.

34. The prison informed their family liaison officer that the man had died. The family liaison officer contacted the man's family the next day and offered condolences and support. The prison paid funeral expenses, in line with national guidelines.

ISSUES

Clinical care

35. The circumstances of the man's death are unusual. The prison had released him on temporary licence for a heart bypass operation in November 2013. He never returned to the prison and died seven months later from complications arising from his heart condition and the operation. The clinical reviewer found that the care the man received in prison was equivalent to the care that he could have expected in the community.

36. The clinical reviewer made some recommendations about initial health reviews and chronic disease management. As these were not directly related to the circumstances of the man's death, we do not repeat them in this report but the Head of Healthcare will need to address them. However, the investigation also identified some areas for improvement in prison procedures.

Hospital appointments

37. The man was able to attend all, apart from one, of his hospital appointments. However, he missed a hospital appointment on 14 October, because of an apparent administrative delay. He told a nurse that he did not receive the letter from wing staff with details of the appointment, until 15 October. We found that the letter had been scanned into his healthcare records on 11 October. The reason for the delay in the man receiving the letter is not recorded and it does not appear that anyone from the healthcare team checked this. The hospital rearranged the appointment for 28 October, two weeks later than originally planned. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that prisoners diagnosed with serious illnesses do not miss scheduled hospital appointments.

Communication with hospital

38. Communication between the hospital and prison was frequent at first, but once the man had been in hospital for four months it became rarer. The clinical reviewer noted that he would not have expected healthcare staff in the prison to phone for more frequent updates because they run a primary care service. He considered the contact was a courtesy and that it was appropriate in the circumstances.

39. However, the man remained a serving prisoner during his time in hospital. The prison continued to owe him a duty of care and we would have expected the prison to have kept in reasonable touch with the hospital about his conditions. It is surprising that the hospital did not keep the prison informed of major events such as his heart attack on 26 November and eventually his death. Although the prison continued to extend his release on temporary licence, there appears to have been few management visits to the hospital and the only recorded one is that of a prison manager on 3 December. It is possible that a lack of obvious prison presence and contact meant the hospital forgot to inform the prison and, unsurprisingly, saw their main

responsibility as keeping his family informed. We make the following recommendation:

The Governor and Head of Healthcare should ensure that when a prisoner is admitted to hospital for long-term treatment, there is regular and clear communication between the prison and hospital.

Early Release on Compassionate Grounds

40. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. 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 early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

41. In January 2014, it became apparent the man would never be able to return to prison because of his health. A doctor was tasked to get the hospital consultant's report on the man's condition, so an application for early release could be made. She received the report detailing his health, progress and needs in February and the Head of Healthcare sent it to prison managers. On 15 May (but scanned into the medical records on 5 June), a doctor from King's College Hospital wrote to the Governor of Brixton and requested the man be given early release with the view to him moving to a nursing home.

42. A prison manager told the investigator that she remembered the Head of Residence had been asked to complete the application before May. She could not remember it being as early as February, when the Head of Healthcare said he had forwarded the consultant's report. The prison manager said that the Head of Residence moved posts in May, but it is not clear why the application did not progress. Shortly before the man died, someone recognised that nothing had been done and the prison manager asked a custodial manager to oversee the application. On Sunday 22 June, she sent the completed application to the prison manager who said she gave it to the Governor, to complete the final section before the application was sent to the Public Protection Casework Section. The man died that day before the application could be dealt with.

43. We do not know whether an application for the man's early release on compassionate grounds would have been successful, particularly as he had no definite prognosis. However, the prison should have dealt with the application more quickly and there is no explanation for the delay. We make the following recommendation:

The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with quickly.

Family Liaison

44. We understand that the man's family were aware of his condition and visited him in the hospital. However, although he had been seriously ill in hospital for some months, there is no record that the prison had any communication with his family before his death.

45. On 3 December, a prison manager noted that she would ask a family liaison officer to speak to the man's family, but there is no evidence that this happened. The family liaison officer did not recall being asked, but said he had visited the man once in hospital, on an unplanned visit. He did not remember when that was. He said that as the man had not been expected to die at the time, his family only had questions for hospital doctors, rather than for the prison. The family liaison officer contacted his family after his death.

46. Prison Service Instruction (PSI) 64/2011, states that:

> Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill. It is good practice for a log of the contact with the family to be maintained.

The man was seriously ill from 26 November 2013 but the prison did not appoint a family liaison officer until 25 June, three days after he had died. We make the following recommendation:

The Governor should ensure, in line with PSI 64/2011, that a member of staff is given responsibility for engaging with families of seriously ill prisoners.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should ensure that prisoners diagnosed with serious illnesses do not miss scheduled hospital appointments.

2. The Governor and Head of Healthcare should ensure that when a prisoner is admitted to hospital for long-term treatment, there is regular and clear communication between the prison and hospital.

3. The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with quickly.

4. The Governor should ensure, in line with PSI 64/2011, that a member of staff is given responsibility for engaging with families of seriously ill prisoners.

ACTION PLAN: The man – HMP Brixton

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor and the Head of Healthcare should ensure that prisoners diagnosed with serious illnesses do not miss scheduled hospital appointments.	Accepted	The prison and healthcare department has now devised a strategy to protect appointments for those prisoners with serious medical conditions. This now includes prioritising and using a system to alert detailing staff and the orderly officer to the escort. *Telemedicine* is now used to provide consultation within the prison to appropriate professionals in hospital settings.	Completed Healthcare Manager/ Head of Operations
2	The Governor and Head of Healthcare should ensure that when a prisoner is admitted to hospital for long-term treatment, there is regular and clear communication between the prison and hospital.	Accepted	When a prisoner is identified as having a terminal illness, a case management team will be appointed consisting of a member of healthcare to communicate with the hospital due to medical in confidence information, a member of the Offender Management Unit (OMU) and the Family Liaison Officer (FLO). This will be chaired by the Deputy Governor who will have overall responsibility for the management of the team.	30 November 2014 Deputy Governor
3	The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with quickly.	Accepted	The Deputy Governor will be the nominated person responsible for coordinating applications for early release. However, as per response for recommendation 2 and in order to gather all relevant information a case management team will be appointed consisting of a member of healthcare to communicate with the hospital due to medical in confidence information, a member of OMU and the FLO. This will be chaired by the Deputy Governor who will have overall responsibility for the management of the team.	30 November 2014 Deputy Governor
4	The Governor should ensure, in line with PSI 64/2011, that a member of	Accepted	As recommendation 2 and 3, the FLO will be part of the case management team responsible for managing those with terminal illnesses; and will also be responsible for	30 November 2014

	staff is given responsibility for engaging with families of seriously ill prisoners.		liaising with the families of seriously ill prisoners.	Deputy Governor