

**Independent investigation report by
the Prisons and Probation Ombudsman
Nigel Newcomen CBE
into the death of a man,
a resident at Stonnall Road Approved Premises,
in May 2014.**

Our Vision

*To carry out independent investigations to make custody
and community supervision safer and fairer.*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man died of sepsis while a resident at Stonnall Road Approved Premises, Walsall, in May 2014. He was 28 years old. He had been released from HMP Stoke Heath less than a week before. We have therefore examined the care he received at the prison. I offer my condolences to his family and friends.

I agree with the clinical reviewer that the man's overall care at Stoke Heath was equivalent to that he could have expected to receive in the community. Post-mortem tests showed that he had diabetes, which had not been identified. This increased his risk of infection. The clinical reviewer noted this might also have been missed in the community. I am concerned that he did not have a secondary health assessment after he arrived at Stoke Heath and I consider this should include diabetes screening for high-risk groups. I also consider that healthcare staff at the prison should have established whether he had missed a hospital appointment, when he drew this to their attention. He died very shortly after his release from Stoke Heath and I am satisfied that there was nothing staff at the Stonnall Road could have done to prevent his sudden and unexpected death.

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 residents involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2015

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SUMMARY

Events

1. In April 2013, the man was sentenced to 24 months in prison, and was moved to HMP Stoke Heath on 26 July 2013. In 2008, he had been shot in the abdomen. He suffered a fractured pelvic bone and damage to his bowel, which resulted in ongoing chronic pelvic infection and an internal collection of fluid in his pelvis. He was under the care of a consultant at hospital, who monitored and treated his condition regularly.
2. Between May and November 2013, the man attended hospital four times. Doctors considered his condition had improved and the fluid was not collecting any longer, but on 5 November 2013, a consultant referred him for an MRI scan. There is no record of this taking place. The prison was not aware of any further hospital appointments after November. At the end of January, he complained that he should have gone for an appointment on 4 December. There is no record that he had mentioned this at the time, but healthcare staff did not check this with the hospital.
3. In early 2014, a number of healthcare staff at Stoke Heath reviewed the man, after he complained about pain in his leg, and was concerned that his infection had returned. He was referred for blood tests, which indicated no signs of infection. No one did any urine tests.
4. On 25 April 2014, the man was released on licence to Stonnall Road Approved Premises, Walsall. Four days later he went to hospital because he had blurred vision, no appetite, weakness in his joints, photophobia (intolerance of light) and a loss of taste. The hospital admitted him for tests but his condition deteriorated. On the evening on 30 April, the results of urine tests showed he had high glucose and ketone levels, indicating he had severe diabetic illness. Shortly after this, he had a cardiac arrest and died in May.
5. The coroner gave the cause of death as sepsis but considered that that the man might have had underlying diabetes that would have increased the risk of sepsis.

Findings

6. The clinical reviewer concluded that the man's care in prison was equivalent to that he could have expected to receive in the community. However, he was at high risk of diabetes, which increased the risk of infection, and she noted there was no routine diabetes screening for high-risk groups at Stoke Heath. He had no secondary health assessment at Stoke Heath. We are also concerned that no one followed up with the hospital an appointment that he claimed to have missed.

Recommendations

- The Head of Healthcare at HMP Stoke Heath should ensure that all prisoners are offered a secondary health screen within a week of arrival, which should include screening for prisoners at high risk of diabetes, in line with NICE guidelines.
- The Head of Healthcare at HMP Stoke Heath should ensure that a member of healthcare checks with the hospital when a prisoner indicates they have missed a hospital appointment, especially when there has been ongoing complex care.

THE INVESTIGATION PROCESS

7. An investigator issued notices to staff and residents at Stonnall Road Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. NHS England commissioned a clinical reviewer to review the man's clinical care while he was at HMP Stoke Heath.
9. The investigator visited Stonnall Road and Stoke Heath on 21 May 2014. He obtained copies of relevant extracts from the man's prison and medical records. He spoke with four members of staff at Stonnall Road on 21 May.
10. In line with our terms of reference, our investigation into the man's death was suspended for nearly ten months while West Midlands Police carried out enquiries. We are sorry that this led to a delay in issuing this report.
11. Another investigator and the clinical reviewer interviewed three members of staff at Stoke Heath on 5 May 2015.
12. We informed HM Coroner for the Birmingham District of the investigation who gave us the results of the post-mortem examination. An inquest was held on 17 March 2015. In a narrative verdict, the coroner was critical of the hospital for failing to perform a urine dipstick test for diabetes and to assess his early warning scores for a serious condition accurately, when the man presented at the hospital on 29 April 2014. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She considered that he had been denied care at Stoke Heath, including preventing him attending a hospital appointment on 4 December 2014. She believed that Stoke Heath had failed to address his ongoing healthcare needs.
14. The initial report was shared with the Prison Service and the Probation Service. There were two factual inaccuracies and this report has been amended accordingly. An action plan has also been added to the end of the report.
15. The man's mother received a copy of the draft report. The solicitor representing the family wrote to us and pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. The solicitor also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

BACKGROUND INFORMATION

Stonnall Road Approved Premises

16. Stonnall Road is an approved premises in Walsall (formerly known as a probation and bail hostel) managed by the National Probation Service - Midlands Division. It can accommodate up to 12 residents. All residents must be over the age of 18, and are required to live there as conditions of their licence, bail or a court imposed Community Order. Residents of approved premises are responsible for managing their own healthcare needs and can register with a nearby medical practice.

Previous deaths at Stonnall Road

17. The man was the first resident to die at Stonnall Road.

HMP & YOI Stoke Heath

18. HMP & YOI Stoke Heath is a local prison, which predominantly takes prisoners from North West England and Wales. It holds over 750 men over 18. Shropshire Community Health NHS Trust provides health services. It provides 24-hour nursing access, but there is no inpatient facility.

Her Majesty's Inspectorate of Prisons

19. The report of the most recent inspection of HMP Stoke Heath in May 2015 has yet to be published. At the previous inspection in March 2012, inspectors reported that prisoners received good health care from appropriately trained professionals. There was an excellent range of clinical services, at least comparable to those in the community. NHS appointments were managed well and there were few cancellations due to lack of escorts.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2014, the IMB noted that a number of prisoners had made complaints about healthcare services but had not received a response. The IMB reported that the local Health Board had inspected health services during the year and had been impressed about many aspects of services. The introduction of a prisoner pass had ensured better attendance at appointments. There had been no significant problems with getting prisoners to nearby hospitals for appointments but the IMB noted that the changing population meant there were higher demands for medical services.

Previous deaths at HMP & YOI Stoke Heath

21. The man was the first prisoner to die from natural causes at Stoke Heath since 2010.

KEY EVENTS

22. On 26 April 2013, the man was sentenced to 24 months in prison for wounding or inflicting grievous bodily harm and was sent to HMP Birmingham.
23. In August 2008, the man had been shot in the abdomen. He had suffered a fractured ilium (a pelvic bone) and damage to his bowel. This injury had resulted in an ongoing chronic pelvic infection and an internal collection of fluid in his pelvis. The hospital treated this with antibiotics and CT guided aspiration (the insertion of a needle into the body in order to remove fluid). A consultant at the hospital continued to monitor his condition.
24. A nurse noted the man's condition when he first arrived at Birmingham. He was prescribed ciprofloxacin (an antibiotic) for an infection. Doctors at the hospital saw him three times between May and July 2013 and referred him for various tests, including a CT scan and a C-reactive protein test (CRP – a test that searches for a particular protein that is released at the start of an infection). The CT scan showed that there was no recurrence of the fluid collection in his pelvis and the CRP test was normal. He told doctors that the pain in his pelvis had significantly improved.
25. On 26 July 2013, the man moved to Stoke Heath. At his reception health screen, he said that he had an outstanding appointment at hospital, but the date of the appointment was not recorded. He was referred to the GP, but a prison GP recorded that he had not attended three appointments with her in August. She decided not to rebook the appointment unless he specifically requested one. No one asked why he had not attended the appointments.
26. On 30 October, the GP saw the man because his pelvic injury had been causing him problems with his prison job. She referred him for blood tests but decided that there would be no benefit in referring him to a local hospital, as he was due to be released in six months and it was unlikely he would get appointment before then. She noted his complex care was better managed at the hospital.
27. On 5 November, a consultant orthopaedic surgeon at the hospital saw the man and noted he had some pain in the right iliac area. He referred him for an MRI scan.
28. An appointment letter from the hospital arranged for the man to attend an MRI scan on 2 December. He did not attend this appointment.
29. On 4 December, at the man's request, a GP asked the Offender Management Unit (OMU) at Stoke Heath whether he would be able to transfer to a prison closer to Birmingham, which would make it easier for him to attend appointments at the hospital. She said the journey to the hospital was difficult due to his condition and it was not clinically appropriate to refer him to a local hospital because he was suffering from an ongoing, complex problem. OMU staff told him that HMP Birmingham was not taking additional prisoners at the time, but this could be considered later. The OMU staff noted that he had

also asked to transfer to HMP Littlehey to complete an offender behaviour programme. He preferred to transfer to Littlehey and moved there on 31 December.

30. On 16 January 2014, the man returned to Stoke Heath, as he had not wanted to continue with the offender behaviour programme at Littlehey. He told the nurse at his reception health screen that his weight was fluctuating due to his pelvic infection. The nurse referred him to the GP.
31. On 21 January, a prison GP recorded that the man had not attended his appointment with her. No one checked the reasons why.
32. On 22 January, the man made a written complaint to the NHS Trust that prison staff had not taken him to an outpatient appointment at hospital on 4 December and that the prison would not transfer him to Birmingham. He said that since his last appointment at the hospital, he had been suffering from pain in his right leg and his stomach, and had lost weight. Stoke Heath did not have any record of the appointment. A prison GP responded to his complaint. She did not refer to the appointment he said he had missed on 4 December, but said she had asked the prison to transfer him to Birmingham and he had had a response.
33. On 13 February, the prison GP examined the man, who said that he had been experiencing pain in his right leg since January. She did not find any tenderness in his abdomen or iliac crest. She arranged a blood test, which did not find any evidence of infection.
34. On 26 February, a nurse saw the man because he was worried he had an infection in his pelvis. She noted she would refer him for a GP appointment but there was no record that an appointment was booked.
35. On 11 April, a prison GP examined the man, who was concerned he was losing weight. She noted that he had lost five kilograms, but was in the normal range for his height. She turned down his request for food supplements, as she did not consider his weight loss was abnormal. He had thrush on his penis and she prescribed clotrimazole (an antifungal medication).
36. On 25 April, the man was released on licence from Stoke Heath to Stonnall Road Approved Premises (AP).
37. A few days later the man went to the hospital because he had blurred vision, no appetite, weakness in his joints, photophobia and a loss of taste. The hospital admitted him and carried out tests. The next day a urinalysis showed he had high glucose and ketones, indicating severe diabetic illness. At 9.00pm, he had a cardiac arrest and doctors moved him to the critical care unit. He died three hours later, just after midnight.

Contact with the man's family

38. After his release from Stoke Heath, the man had spent time with his girlfriend, mother and brother. His family were at the hospital with him when he died.
39. On 1 May, the man's mother telephoned a probation supervisor to inform her that he had died. Later that day, a senior probation officer contacted the man's mother to offer her condolences and support. She arranged for the family to visit Stonnall Road and to collect his property.
40. The Probation Service contributed to the costs of the funeral in line with national guidance.

Support for prisoners and staff

41. After the man's death, the senior probation officer met staff and residents at Stonnall Road and offered them the opportunity to talk to her or a confidential support service.
42. At a resident's meeting on 19 May, the deputy manager and a probation supervisor offered further support to residents who in case they had been adversely affected by the man's death.

Post-mortem report

43. A post-mortem examination found that the man had died from sepsis due to complications from the gunshot wound to his pelvis. Post-mortem tests indicated that he had had diabetes for at least two months before his death. The pathologist also discussed the relevance of diabetes, which might have increased the risk of sepsis.

FINDINGS

Clinical Care

44. The gunshot wound that the man suffered in 2008 caused a chronic pelvic infection and an internal collection of fluid in his pelvis. The condition was not expected to shorten his life and he received regular secondary treatment at the hospital. For the majority of 2013, his inflammatory markers were normal and fluid was not collecting in his pelvis.
45. Although the clinical reviewer identified some areas for improvement, she found that, overall, healthcare staff at the prison were responsive and caring and gave a high standard of care; equivalent to that the man could have expected to receive in the community. She noted some areas of good practice, including the doctor's support for his request for a prison transfer, that his health concerns were addressed quickly when he was worried about a bone infection in his pelvis and that the doctor arranged blood tests urgently and gave him the normal results quickly to reassure him.

Diabetes screening

46. The night before the man died, hospital staff carried out urinalysis, which showed high glucose and ketones, which indicated severe diabetic illness. The post-mortem report referred to a hospital test, which showed that he had diabetes, which would have been present for the preceding two months. Having diabetes puts a patient at increased risk of infections such as chest and skin infections and recurrent thrush. It also increases the risk to the patient when they have an infection. If the patient's immune system is severely compromised, this could lead to sepsis.
47. The clinical reviewer considered that there had been some missed opportunities to diagnose diabetes during the man's time at Stoke Heath. She noted that it would be logistically difficult to take a urine sample at the initial reception health screen, as Stoke Heath does not have the facilities in the reception area. However, there is no record that he was offered a secondary health screen. Prison Service Order 2050, Continuity of Healthcare for Prisoners, says, "Following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community". This could take place in the healthcare unit, which does have facilities, such as a sluice and private toilet.
48. When the GP saw the man on 11 April, he reported symptoms including weight loss and recurrent thrush. With hindsight, the clinical reviewer considered that the significance of the weight loss and recurrent thrush together, could have led to more questions about the risk of diabetes. However, because the two symptoms were looked at in isolation this did not happen. This was a further missed opportunity possibly to identify diabetes.

49. The National Institute for Health and Care Excellence (NICE) published guidance aimed at preventing type 2 diabetes in July 2012. The guidance said that GPs and other health professionals should implement a two-stage strategy to identify people at high risk of type 2 diabetes. The two-stage strategy involved offering a risk assessment and, where necessary, a blood test. According to NICE, high-risk groups include people aged between 25 and 39 from African-Caribbean, black African and other black minority groups. The man was of African-Caribbean heritage and would have been at higher risk of diabetes. We make the following recommendation:

The Head of Healthcare at HMP Stoke Heath should ensure that all prisoners are offered a secondary health screen within a week of arrival, which should include screening for prisoners at high risk of diabetes, in line with NICE guidelines.

Hospital appointments

50. The man was under the care of a hospital after a gunshot wound in 2008. Between May and November 2013, he had four appointments to review his condition and there is no evidence that he missed any of these.
51. In January 2014, the man complained that he had missed an appointment at the hospital on 4 December. Information supplied by the solicitor representing his mother showed that he was asked to attend an MRI scan on 2 December. The clinical services manager at Stoke Heath reviewed the prison's appointment log and told us there were no further appointments booked for him at the hospital after November 2013. Hospital treatment is outside the remit of the investigation and it is possible that an administrative error at the hospital resulted in missed appointments rather than on the part of the prison. However, we are concerned that, at his last appointment on 5 November, the consultant referred him for an MRI scan. This was noted in his discharge letter, but the prison did not follow this up.
52. In her reply to the man's complaint, the GP concentrated on his complaint about not moving prisons and did not refer to his alleged missed appointment on 4 December. He had been under the care of a consultant at the hospital since 2008, had been attending regular appointments and had not been discharged from the hospital's care. We therefore consider it would have been prudent to check with the hospital whether he had missed or had outstanding appointments. We make the following recommendation:

The Head of Healthcare at HMP Stoke Heath should ensure that a member of healthcare checks with the hospital when a prisoner indicates they have missed a hospital appointment, especially when there has been ongoing complex care.

The man's location

53. The man complained that the journey from Stoke Heath to the hospital had caused him discomfort (the journey is usually a little over an hour). A GP asked the prison's Offender Management Unit (OMU) if it was possible to move him to a prison closer to the hospital. This was not possible at the time, although the OMU were willing to look at it again later. They pointed out that it was only possible to pursue one transfer request and he had asked to go to HMP Littlehey. He chose to continue with that request. Littlehey is slightly further away from the hospital than Stoke Heath.
54. We are satisfied that the man was appropriately located at Stoke Heath and that appropriate consideration was given to his request to move.

Liaison with the man's family

55. The man's mother had previously worked at Stonnall Road and was with him when he died. She informed the centre manager of his death. After this, we are satisfied that the manager offered appropriate support to his family.

ACTION PLAN

Recommendation	Accepted / not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
<p>1. The Head of Healthcare at HMP Stoke Heath should ensure that all prisoners are offered a secondary health screen within a week of arrival, which should include screening for prisoners at high risk of diabetes, in line with NICE guidelines.</p>	Accepted	<p>Current reception health screens (first and second) ask about history of diabetes, but this is insufficient. New template for screening of patients at risk of diabetes to be added to both reception screens.</p> <p>This is a West Midlands template and therefore proposal put forward to System1 user group West Midlands to have additional screening tool added.</p>	31/10/2015	
<p>2. The Head of Healthcare at HMP Stoke Heath should ensure that a member of healthcare checks with the hospital when a prisoner indicates they have missed a hospital appointment, especially when there has been ongoing complex care.</p>	Accepted	<p>This has already been completed by the administration team. To ensure that this is embedded into daily practice, information posters and guidance to be displayed within reception and GP areas.</p>	30/09/2015	