PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

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A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in January 2015 at HMP Channings Wood

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 of heart failure, on 13 January 2015, at HMP Channings Wood. He was 56 years old. I offer my condolences to the man's family and friends.

The investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at HMP Channings Wood. The prison cooperated fully with the investigation.

The man had been at Channings Wood since November 2013, after receiving a five-year prison sentence in October 2013. He had a history of serious cardiac problems and was under the care of hospital cardiac consultants, who were investigating whether he was suitable for surgery for a heart valve problem. Nurses saw the man daily and prison GPs reviewed him as necessary.

On the morning of 13 January, an officer found the man collapsed in his cell and called an emergency, which prompted the prison's control room to call an ambulance immediately. Officers and nurses responded quickly and administered emergency treatment until paramedics arrived and took over his care. Shortly afterwards, the paramedics declared that the man had died.

I agree with the clinical reviewer that the standard of healthcare the man received at Channings Wood was equivalent to that he would have expected to receive in the community. Appointments at the hospital cardiac clinic were timely and appropriate, and communication between prison GPs and the cardiac clinic was good. The man was well supported and kept well informed of his treatment and ongoing care. I am satisfied that there was nothing the prison could have done to prevent the man's 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 prisoners involved in my investigation.

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

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SUMMARY

1. The man was sentenced to five years in prison on 15 October 2013 and had been at Channings Wood since 1 November 2013.

2. The man had long-term cardiac problems, including an irregular heartbeat and mitral regurgitation (where blood leaks back into the heart, as the valve does not close properly). He had associated complications, such as shortness of breath and swollen legs. At the time he was sentenced, the man had recently recovered from pneumococcal meningitis and pneumonia. This had caused nerve damage in his legs and he relied on crutches to get about.

3. Nurses saw the man each day and prison GPs reviewed him when necessary. He was under the care of a cardiac consultant and surgeon and waiting for the outcome of investigative tests needed to determine if he was suitable for heart valve surgery.

4. At about 8.10am on 13 January, an officer unlocked the man's cell. At the time, he was sitting at a table watching television. At around 8.30am, the officer found the man collapsed on the floor of his cell. He radioed an emergency medical code and the control room called an ambulance immediately.

5. Officers began cardiopulmonary resuscitation and nurses arrived shortly afterwards with emergency equipment, including a defibrillator. They attached the defibrillator to the man, which administered two shocks before paramedics arrived at 8.43am and took over his emergency care. Paramedics continued treatment but, at 9.07am, pronounced the man dead.

6. We agree with the clinical reviewer that the standard of healthcare the man received at the prison was equivalent to that he might have expected to receive in the community. We make no recommendations.

THE INVESTIGATION PROCESS

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

8. NHS England commissioned a clinical reviewer to review the man's clinical care at Channings Wood.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator and the clinical reviewer interviewed four members of staff at HMP Channings Wood on 10 March 2015. The investigator interviewed three more staff members by telephone.

10. We informed HM Coroner for Torbay and South West Devon District of the investigation, who provided the cause of death. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers spoke to the man's next of kin, about our investigation. The man's partner had a number of questions and points for the investigation to consider and wanted to know:

    - What medication the man was receiving?
    - What care had the man received for his swollen leg?
    - Had the man attended all of his scheduled hospital appointments?
    - What happened when the man collapsed?

12. The man's partner received a copy of the draft report as part of the review period. Despite the findings of this investigation, his partner disagreed strongly that the care provided was comparable to that in the general community. The man's partner had numerous areas of concern and, in her opinion, she felt the prison had been negligent. Her comments have not changed the investigation report. As the Inquest has already taken place, the man's partner will consider pursuing civil action to address her concerns.

13. The draft report was shared with the Prison Service. There were no factual inaccuracies.

HMP CHANNINGS WOOD

14. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds over 700 men. Dorset NHS University Trust provides health services at the prison. There is one permanent GP, and locum GPs run additional clinics. Nurses are on duty everyday and there is an out of hours GP service.

HM Inspectorate of Prisons

15. The most recent inspection of Channings Wood was in September 2012. The Inspectorate noted that healthcare staff were generally helpful and respectful, although many prisoners were unhappy with the support provided. Prisoners had reasonably good access to nurses and a GP, and urgent problems could be dealt with the same day. There were delays for some clinics and chronic disease management was not always systematic.

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 recent annual report for the year to August 2014, the IMB noted that there have been improvements in the delivery of healthcare services, but it was still not of an acceptable consistency. Some clinics, including for chronic disease management, were still not being run. Recruitment for healthcare staff was ongoing.

Previous deaths at Channings Wood

17. The man was the sixth prisoner to die from natural causes at Channings Wood since the start of 2013. There were no significant similarities with the circumstances of the previous cases. We draw the Governor's attention to previous recommendations about risk assessments for hospital escorts, as it appears that the man was restrained for some hospital appointments in 2014, when it was not clear this was necessary.

KEY EVENTS

18. On 15 October 2013, the man was sent to HMP Exeter after being sentenced to five years imprisonment for sexual offences. He moved to HMP Channings Wood on 1 November.

19. The man had cardiac problems, including an irregular heartbeat and mitral valve regurgitation (where blood leaks back into the heart because the valve does not close properly). The man's heart condition caused fluid retention, mainly in his legs. He also had blurred vision and peripheral nerve damage in his legs caused by previous meningitis. This had left him with limited mobility and he was reliant on crutches to get about.

20. The man had been referred for a heart valve operation before he was sentenced to prison and his follow-up appointments with his cardiac consultant, at Royal Devon and Exeter Hospital were re-arranged to ensure continuity of care. The man was prescribed warfarin to thin the blood, furosemide to reduce water retention (a common side effect of heart disease), ramipril for high blood pressure, omeprazole to treat acid reflux, sotalol for irregular heartbeat and digoxin to treat heart rhythm disorders and heart failure.

21. The consultant referred the man to a cardiac surgeon at the South West Cardiothoracic Centre, Plymouth. On 20 January 2014, a doctor referred the man for investigative tests, including a CT scan, blood tests and an ultrasound to see if he was fit enough for heart valve surgery.

22. The man had a blood test on 10 March, which showed he was anaemic and doctors prescribed an iron supplement, which resolved the anaemia. A colonoscopy later that month showed the likely cause of his anaemia was diverticular disease (a common bowel condition) and he was treated with a three-month course of iron supplement. He had an ultrasound scan, which showed he had a fatty liver. A CT scan indicated evidence of a previous stroke and signs of brain deterioration.

23. The fluid retention in the man's legs worsened and, on 6 May, a prison GP, increased his dose of furosemide to treat it. His blood pressure was within the normal range.

24. On 17 June, the man complained of chest pain and shortness of breath. A doctor examined the man and noted that he was breathless, sweating and his blood pressure was high. The doctor gave the man aspirin, glyceryl trinitrate spray (GTN – to relieve chest pain) and oxygen. The doctor arranged an emergency ambulance to take him to Royal Exeter and Devon Hospital, where doctors admitted him to the cardiac unit. The hospital discharged the man the next day. The discharge summary noted that he had not had a heart attack, but an exacerbation of the symptoms of heart disease.

25. On 19 June, another prison GP, reviewed the man. The man did not have any chest pain but was still short of breath and his blood pressure was still high. The GP noted that the hospital had stopped his sotalol and furosemide and he prescribed bumetanide (an alternative drug to treat water retention), as the hospital had advised.

26. On 11 September, the man attended a follow-up appointment with a doctor, who told him that it was very unlikely that he would be suitable for surgery on his heart valve. However he needed further tests to confirm this, including a repeat CT scan, an ultrasound, an echocardiogram (an ultrasound scan of the heart) and a heart catheter (where a thin plastic tube is inserted into the heart chambers to assess the pulmonary pressures).

27. On 16 October, at an appointment at the Royal Devon and Exeter Hospital, the doctor noted that the man was becoming increasingly breathless and had occasional sharp chest pain. An echocardiogram showed his heart condition had deteriorated. The doctor referred the man for treatment for dental disease. (Dental disease can be a reason to withhold cardiac surgery due to the complications it can cause.) The doctor prescribed bumetanide and an ACE inhibitor (a blood pressure drug).

28. A prison GP, reviewed the man on 29 October. She explained to him that the advised tests had been booked. The GP re-started the prescription of sotalol. On 3 November, the man told the GP again that his symptoms were getting worse. She noted his worsening shortness of breath but recorded that he had forthcoming cardiac outpatient appointment. In November, the man had an echocardiogram, which showed severe mitral valve regurgitation and an ultrasound of his liver, which did not show anything new.

29. The man continued to be short of breath and a prison GP, increased the medications used to treat his heart condition on 11 December. His condition did not change significantly during December or the beginning of January 2015. His blood pressure remained within normal limits and his chest was clear. He still suffered from swollen legs that were treated with medication and doctors advised him to keep his legs up. Prison GPs reviewed the man as necessary and nurses saw him each day on his wing.

13 January 2015

30. At around 7.30am, on 13 January, a Supervising Officer (SO) did a morning roll check of the man's wing and had no concerns about any of the prisoners at the time. At around 8.10am, the officer unlocked the man's cell. The officer said he did not speak to the man, but he was sitting at the table in his cell watching television at the time. He had made his bed and he was fully dressed. The officer had no concerns about him and carried on unlocking the rest of the wing.

31. At about 8.25am, the officer went around the cells again and checked that prisoners had gone to work or to collect their medication. When he got to the man's cell, he was unable to open the door properly as something was blocking it. The officer could see the man's feet and it looked as though he was lying face down on the floor. The man did not respond to him, so the officer immediately radioed a code blue to signify a life threatening medical emergency. The prison called an ambulance straight away, at 8.30am.

32. The officer managed to get into the cell and saw that the man was collapsed face down on the floor. He had his outside coat, hat and shoes on, which suggested that he had been about to go outside to the healthcare centre to collect his medication. His crutches were still under his arms. The officer could still get no response from the man and turned him on his back. His eyes were

wide open and his skin was a normal colour and warm to touch. Another officer arrived at the cell at around 8.32am and both officers started cardiopulmonary resuscitation.

33. The nurse arrived and asked the officers to bring the man onto the landing where there was more space for emergency treatment. The emergency nurse responder arrived shortly afterwards with an emergency bag and brought a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The staff continued cardiopulmonary resuscitation and attached the defibrillator, which administered two shocks to the man. At 8.43am, paramedics arrived and took over his emergency care.

34. The paramedics administered emergency drugs and continued with the resuscitation attempt. However, at 9.07am, the paramedics pronounced the man dead.

Liaison with the man's next of kin

35. The prison's family liaison officer, and the Governor went to the man's partner's home at 11.30am and broke the news that he had died. They took his partner to the man's father's house and explained the family liaison process to them and offered condolences and support. The prison contributed towards funeral costs, in line with national guidelines.

Support for prisoners and staff

36. A Governor's notice informed staff and prisoners of the man's death. A prison manager debriefed the staff involved in the emergency response and the care team offered them support. Two members of staff believed that managers should have offered more support, which the governor will wish to note.

37. A prison manager spoke to all residents on the man's wing and offered them support. Staff checked those considered at risk of suicide or self-harm in case they had been adversely affected by the man's death.

Cause of death

38. The coroner gave the cause of death as heart failure. The man's heart had become enlarged due to overcompensation because of long-term mitral regurgitation.

ISSUES

Clinical care

39. The man arrived in prison with a history of cardiac problems, including an irregular heartbeat and mitral valve regurgitation. He took many medications, which were appropriate and regularly reviewed. Shortly before coming to prison, he had suffered meningitis, which had caused blurred vision and peripheral nerve damage. Cardiac consultants reviewed the man in their clinics and referred him for investigative tests to see if he was eligible for surgery to his heart valve. The tests were ongoing at the time of his death.

40. The clinical reviewer considered that the clinical care the man received at Channings Wood was equivalent to that he would have expected to receive in the community. The man's appointments at the cardiac clinic were timely and appropriate and he attended them all. Communication between prison GPs and nursing staff and secondary services, such as the cardiac clinic was good, providing good continuity of care. The man was kept well informed of his conditions and his ongoing treatments and appointments. He was well supported and seen daily by nursing staff on his wing and by prison GPs when necessary. He received appropriate care and medication for all of his conditions, including his swollen legs. The emergency response when he collapsed was quick and professional. There was nothing prison staff could have done to prevent his death and we are satisfied that the man received an appropriate standard of care at Channings Wood.