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 in May 2013 at HMP Swaleside**

## *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 from sudden adult death syndrome of a man in May 2013, at HMP Swaleside. The man was 46 years old. I offer my condolences to the man's family and friends.

The Ombudsman appointed an investigator and a Clinical Reviewer reviewed the man's clinical care in prison. HMP Swaleside cooperated fully with this investigation.

The man had been in prison since May 2012. He was first at HMP Elmley, where he was prescribed medication for asthma. He had little other interaction with prison healthcare staff at Elmley or at Swaleside, to where he transferred in September. In the days before his death, he had reported that his legs were slightly swollen but had few other symptoms. Blood tests were taken. At approximately 12.20pm on 15 May 2013, the man was found unconscious in his cell and staff immediately attempted to resuscitate him and an emergency ambulance was requested. When paramedics arrived at the prison, they assessed that the man had died.

The clinical reviewer has identified some concerns about the standard of the man's care at Swaleside. In particular, he feels that healthcare staff should have questioned the man more about his symptoms in the days before his death which might have helped indicate whether the man had an abnormal heart rhythm. As a result, the Clinical Reviewer concludes that the man did not receive an equivalent level of care to that he could have expected in the community. When the man was found collapsed the initial emergency response was swift, although it took too long to get ambulance staff to the scene after they arrived at the prison. Resuscitation was attempted, despite clear signs that the man had already died.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **January 2014**

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## SUMMARY

1. The man was sentenced to ten years and seven months in custody for drugs offences on 28 May 2012. He was sent to HMP Elmley and, on arrival, saw a prison doctor who prescribed medication for asthma. On 5 September, the man transferred to HMP Swaleside

2. On 24 December, the man was prescribed antibiotics for a chest infection, was noted to have high blood pressure and was advised to start a smoking cessation course.

3. On 11 May 2013, the man saw a nurse and complained of swollen legs. The nurse recorded that the man had high blood pressure, advised him to rest and referred him to the doctor. On 13 May, the doctor requested further tests after noting that the man's ankles were swollen and his blood pressure was high.

4. On 15 May, at approximately 12.10pm, officers checked the man in his cell and found him unresponsive and not breathing. They immediately started cardiopulmonary resuscitation (CPR) and an emergency ambulance was called. When the paramedics arrived at the prison they confirmed that the man had died.

5. The investigation has identified that healthcare staff did not investigate the man's symptoms sufficiently. The emergency response when the man was found unresponsive in his cell was swift but it was clear that the man had died and that resuscitation was not possible.

## THE INVESTIGATION PROCESS

6. The investigator visited Swaleside on 23 May 2013 and obtained relevant records about the man. Notices were issued to staff and prisoners inviting anyone with information to contact the investigator. Four prisoners came forward. The investigator met the Governor and subsequently interviewed seven members of staff and spoke to the four prisoners who had asked to see him. He gave written feedback about the preliminary findings of the investigation to the Governor on 12 July.

7. A Clinical Reviewer was appointed to review the man's clinical care.

8. The investigator contacted the local Coroner to inform him of the investigation and request a copy of the post-mortem report. The investigation report has been sent to the Coroner.

9. One of the Ombudsman's family liaison officers contacted the man's family to inform them about the investigation and to invite them to identify issues they wished the investigation to consider. His family raised the following concerns:

    - They believed that he had not seen a doctor in the days before his death and also asked whether he had seen a dentist.
    - They asked if the man had been treated for a chest infection.
    - They wanted to know if the man used drugs and whether he had a heart condition.

    These points are addressed in the report. The man's family said that prison staff had been very supportive after his death. The man's mother and legal representative received a copy of the draft report. They did not provide any comments ahead of the report being finalised. The man's ex-partner also received a copy of the draft report. She raised a number of issues/questions, where appropriate, the report has been amended to reflect any factual inaccuracies. The remaining questions/comments have been addressed through separate correspondence to the man's ex-partner.

## HMP SWALESIDE

10. HMP Swaleside forms part of the Isle of Sheppey group of prisons which also includes Elmley and Standford Hill. Swaleside's main function is for life sentenced prisoners but it also holds prisoners serving shorter sentences.

## Her Majesty's Inspectorate of Prisons

11. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Swaleside in July 2011. In relation to healthcare, HMIP concluded that prisoners had good access to primary care health services with a range of services to monitor delivery and a good outpatient department. Inspectors reported that prisoners had to wait too long for dentistry services.

## Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their annual report, for the year to April 2012, the IMB noted that staff at Swaleside had maintained a good standard of care in most areas of the prison. They noted that a GP practice, based on the Isle of Sheppey, had been commissioned to provide a GP service, which was popular with prisoners as this gave them some choice about which doctor they saw. The IMB noted that the dental service was insufficient to meet need.

## Previous deaths at Swaleside

13. The man's death was the first to occur at Swaleside in 2013. There were two deaths in 2012, both of which were self inflicted. There are no similarities between those deaths and the man's death.

## KEY EVENTS

14. On 28 May 2012, the man was sentenced to ten years and seven months in custody for drug offences. He was sent to HMP Elmley. When he arrived, a Nurse carried out a routine initial health screen to identify any immediate physical and mental health needs. The man told the nurse that he had been in custody before and had never used drugs but smoked cigarettes. He suffered from asthma for which he had been prescribed inhalers by his community doctor, but he had not seen his doctor for several months. The man said that he was blind in his right eye, had a family history of heart disease and had no thoughts of self-harm. The Nurse referred the man to see the doctor.

15. On 29 May, the man had a second healthscreen. It was recorded that the man was blind in his right eye because of a cataract, was asthmatic, smoked 20 cigarettes a day, weighed 59.2kg (9st 5lb) and his blood pressure was 140/81 (The normal range for blood pressure is 100/70 to 140/90. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.). A prison doctor, then saw the man. The doctor recorded that he had mild asthma and was a smoker. The doctor prescribed salbutamol (an inhaler used to treat asthma).

16. On 5 September 2012, the man transferred to HMP Swaleside. A Nurse recorded his blood pressure as 139/100, which was slightly raised, and noted that he had been prescribed salbutamol and was blind in his right eye. The nurse offered the man smoking cessation advice.

17. On 3 December, a visiting dentist, saw the man for a routine examination. She recorded that he had tooth decay and needed fillings, and asked for another appointment to be arranged for treatment.

18. On 24 December, the man reported to a Nurse that he had had a cough for the previous six days which had affected his sleep. The man was prescribed amoxicillin (an antibiotic) and honey and lemon lozenges. The Nurse recorded the man's weight as 58.2kg (9st 2lb) and blood pressure as 153/86 which was also high. The man agreed to start smoking cessation sessions which he started on 31 December, when he was prescribed 25mg nicorette patches and 1.5mg niquitin lozenges.

19. Between 2 January and 11 March 2013, the man had eight separate smoking cessation sessions with healthcare staff. By the last session, the man had successfully stopped smoking.

20. On 18 March, the man saw a Nurse as he was concerned that he was not putting on any weight. The Nurse recorded the man's weight as 61.2kg (9st 9lb) which indicated that he had put on 3kg in three months. The man said that he had no other health concerns and felt well.

21. On 15 April, the man had an appointment with the dentist. The dentist recorded that The man attended but then walked out of the clinic before he saw her. The

reason why the man walked out is not known and he did not attend his next appointment on 22 April.

22. On Friday 11 May, the man told a Nurse that his legs were swollen. The Nurse recorded that his legs were slightly swollen, he had psoriasis (a skin condition) and his blood pressure was 152/81 (which was still high). The Nurse prescribed eurax cream for his skin and advised the man not to exercise over the weekend and keep his legs raised as much as possible. She referred the man to be seen by a doctor after the weekend.

23. On Monday 13 May, a doctor examined the man and noted that the man's lower legs were slightly swollen. The man told the doctor that the swelling had improved. The doctor recorded that the man was not short of breath, did not have any chest pains, had psoriasis on the shins and his blood pressure was 145/70 (just slight raised). The doctor requested blood tests and advised the man to keep using the eurax cream and to raise his legs as much as possible.

24. Several prisoners told the investigator after the man's death that during this weekend (10-13 May) he had shown them his swollen ankles. A prisoner said that the man's ankles were wider than his calves. He also said that on 9 May, the man was so short of breath that he did not go to work. The prisoner said that the man's health "was not good at all". Another prisoner said that the man had told him that he had chest pain.

25. On 14 May, the visiting optician saw the man, for a routine examination. The optician noted that the man was blind in his right eye and had some loss of vision in the left eye. He referred the man to the ophthalmic consultant at Moorfields Hospital, London. The optician also noted in the man's medical record that he had observed a very pronounced pulse in the man's neck and that he had a family history of heart disease.

26. On Wednesday 15 May, the man was seen during the early morning roll checks in his bed apparently asleep. There was a quarterly full staff meeting at 9.30am that morning and all prisoners remained locked in their cells. Prisoners were unlocked for lunch at 11.40am, and were locked back up at around 12,00pm. At approximately 12.20pm, an Officer took a letter to the man. He said he slid the letter under the door and knocked on it before going to deliver a letter on the landing above. When he knocked on that prisoner's cell, the prisoner responded and the Officer realised that the man had not done so. He returned to the man's cell, and looked through the observation flap. He saw the man on the bed and could not get a response. He asked a Senior Officer (SO) if he could go into the cell to check to the man.

27. When he went into the cell, the Officer found the man in bed but cold and unresponsive. He asked the SO to call for emergency assistance and immediately started cardiopulmonary resuscitation (CPR). An emergency ambulance was called at approximately 12.22pm. Healthcare staff, including a prison doctor responded immediately. Two of the nurses involved in CPR,told the investigator that the man was stiff when they attempted CPR. A defibrillator was used but it advised to continue CPR and not to administer a shock.

28. Paramedics arrived at the prison at 12.39pm and reached the man at 12.48pm. The paramedics noted that rigor mortis was clearly evident and immediately pronounced that the man had died. The prison doctor had not told the nurses to stop CPR or pronounce that the man had died.

**Contact with the man's family**

29. At 2.30pm, on 15 May, two prison family liaison officers left Swaleside to break the news of the man's death to his mother, who lived in Gloucestershire. The officers arrived at her home at 6.10pm, broke the news to her and offered support. The prison maintained contact with the man's family to provide ongoing support and offered financial assistance towards the funeral expenses in line with national guidance.

**Support for staff and prisoners**

30. A debrief was held on the afternoon of the man's death for staff involved in the emergency incident to discuss what had happened and to offer support. They were offered the services of the prison's care team.

31. Officers and members of the chaplaincy were available to support prisoners affected by the incident. Prisoners subject to suicide and self-harm monitoring measures had their cases reviewed in case they had been adversely affected by the man's death.

## ISSUES

### Clinical Care

32. The clinical reviewer, noted that the symptoms the man's fellow prisoners described him having when they were interviewed were consistent with heart failure, a condition where the heart does not beat strongly enough. This causes fluid to gather in the lungs and ankles, shortness of breath, especially on exertion, ankle swelling, and visible pulsations in the veins of the neck. The post-mortem examination ruled out most of the possible causes of heart failure, but did not rule out abnormal heart rhythm.

33. According to the clinical reviewer abnormal heart rhythms are often intermittent and might not be present when medical staff examine a prisoner. He notes that the man's symptoms seemed to be bad on 10 May (as noted by his fellow prisoners), improved on 11 and 13 May (when he saw a nurse and doctor respectively), and probably worse again on 14 May when the optician noted the pulsations in the vein. The symptoms then worsened, leading to the oedema (fluid) in the lungs found at the post-mortem examination.

34. The Clinical Reviewer noted that the treatment of abnormal heart rhythms can be very successful, but only if the symptoms have been noticed. In his opinion, although his symptoms might not have been apparent at the time, The Nurse and prison doctor did not question the man sufficiently about his symptoms so were not able to assess him properly or diagnose or rule out any abnormality in his heart rhythm. As a result, the Clinical Reviewer has concluded that the standard of care provided to the man was not equivalent to that he might have received in the community. The Clinical Reviewer has recommended that the Nurse and prison doctor discuss the findings of his report with their supervisors, to identify training issues or other appropriate action.

35. The man had very limited contact with healthcare staff during his time at Swaleside but was successful in stopping smoking with their support. Although the man's symptoms seem to have improved when the nurse saw him on 11 May and the doctor saw him on 13 May, they did not question him in detail about the symptoms he had experienced. Healthcare staff need to have the appropriate skills and knowledge to be able to assess a patient, interpret their symptoms and understand when these might indicate a serious underlying problem. We therefore make the following recommendation:

    **The Head of Healthcare should ensure that staff fully question and investigate with prisoners symptoms which might indicate an underlying serious disease.**

### Emergency response

36. When the man was found unresponsive the Officer immediately started CPR, which healthcare staff continued even though it was clear that rigor mortis had set in. The Clinical Reviewer noted that the decision to stop CPR should only

be taken by someone such as a paramedic or doctor who is suitably qualified to decide that CPR is futile.

37. The doctor attended the emergency very quickly, but he did not intervene to stop the CPR attempt. Although he realised that rigor mortis was present he said he had never been in such a situation before so he thought it best for CPR to continue. It was clear to the paramedics who attended that rigor mortis had set in and that CPR was futile. The doctor does not seem to have appreciated this, about which the Clinical Reviewer is critical.

38. After interviewing the doctor on 20 July, the investigator and the Clinical Reviewer spoke to the Governor of Swaleside. The Clinical Reviewer told him that in his professional opinion, the doctor's actions and knowledge appeared well below the level expected of a competent general medical practitioner and he recommended that an investigation should be undertaken into The doctor's competence. The Governor suspended the doctor the next day.

39. While we understand the wish to attempt and continue resuscitation until death has been formally confirmed, it is surprising that healthcare staff decided to carry out CPR in these circumstances when it appears to have been evident that the man could not be revived. The European Resuscitation Council Guidelines for Resuscitation 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". We make the following recommendation:

    **The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate.**

40. According to Ambulance Service records, the ambulance arrived at Swaleside at 12.38pm. However, it took another ten minutes for paramedics to reach the man's cell. We believe that this is too long. The investigator walked the route from the gate to the man's cell and estimated that this took eight minutes. He noted that there were six internal gates for an ambulance to negotiate, but as this was during the day, there should have been staff available to ensure that these were open. National guidance, entitled 'Responding to Medical Emergencies', was issued to all prison staff in October 2012. This guidance states that "it is essential … that access to both the prison and the individual prisoner is not delayed". This guidance is also now reflected in Prison Service Instruction (PSI) 03/2013 about medical emergency response codes which came into force over two months before the man's death. The PSI requires prisons to have local protocols to "prevent any unnecessary delay in escorting ambulances to the patient".

41. This delay did not affect the outcome for the man. However, in other circumstances, such a delay might make a difference between life and death. We therefore make the following recommendation :

    **The Governor should ensure that there are no delays in ambulance staff reaching prisoners in an emergency.**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff fully question and investigate with prisoners symptoms which might indicate an underlying serious disease.

2. The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate.

3. The Governor should ensure that there are no delays in ambulance staff reaching prisoners in an emergency.

**ACTION PLAN**

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
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| 1. | The Head of Healthcare should ensure that staff fully question and investigate with prisoners symptoms which might indicate an underlying serious disease. | Accepted | All registered general nurses now have a mandatory requirement to undertake a period of competency assessment on their triage assessment abilities by the head of professional development. This will be underpinned with mandatory training in minor injuries and illness training. This will form part of their professional development record and will be subject to on-going assessment and clinical supervision. | Completed and ongoing<br><br>Healthcare Manager | |
| 2. | The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate. | Accepted | Resuscitation guidelines to be published to incorporate clear guidance on when not to resuscitate. | 31 December 2013<br><br>Healthcare Manager | |
| 3. | The Governor should ensure that there are no delays in ambulance staff reaching prisoners in an emergency. | Accepted | There is a procedure in place to ensure that any ambulance will be escorted on arrival to the location as a matter of emergency. | Completed and ongoing<br><br>Duty Governor | |