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 October 2013, while in the custody of HMP High Down

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 in October 2013, while in the custody of HMP High Down. The man died from multiple organ failure as a result of septic shock resulting from the spread of a urinary infection. He was 69 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at High Down. The prison cooperated fully with the investigation.

The man was sentenced to eight years in prison in November 2012 and sent to High Down. He was in poor health and had already been diagnosed with several chronic conditions. In January 2013, he became doubly incontinent. Healthcare staff did not believe that there was a medical reason for this but the cause was never fully established. The man had many falls in his cell which were mostly attributed to low blood pressure. Some resulted in head injuries which required hospital treatment and, on one occasion, he broke his wrist.

The man was not always an easy person to manage and the clinical reviewer noted that he presented a significant challenge to the healthcare staff looking after him. However, he considers that the healthcare staff appear to have been too ready to accept that his incontinence was behavioural. While some tests were made, the reasons were not fully investigated and, despite his frequent falls, it is not clear that the possibility of a neurological reason was fully explored. On 7 October, the man was taken to hospital on 7 October after his health deteriorated. He did not respond to treatment and died four days later.

The man had a range of complex conditions which were difficult to manage and I am satisfied that, overall, he received a satisfactory level of care at High Down. However, I do not consider that the use of restraints when the man was taken to hospital was justified by fully considered risk assessment, a matter I have raised with High Down before.

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 **June 2014**

CONTENTS

Summary	5
The investigation process	6
HMP High Down	7
Key Events	8
Issues	12
Recommendations	14
Action Plan	15

SUMMARY

1. The man was sentenced to eight years in prison in November 2012 and sent to HMP High Down. He was in poor health and had been diagnosed with several long term medical conditions for which he was under the care of hospital specialists.

2. In January 2013, staff found the man collapsed on the floor of his cell. He had been suffering from diarrhoea and vomiting. He was admitted to the prison's inpatient unit for observation and returned to his wing a few days later. In the next few months, the man frequently fell in his cell and often went to hospital for treatment for the injuries he had sustained. He moved permanently to the inpatient unit in April 2013. He had a CT scan in May when he injured his head after a fall, but there is no record of the outcome.

3. The man became doubly incontinent and healthcare staff attended to him daily. A prison GP assessed the man and concluded that he did not appear to have a medical condition which could cause incontinence and it was likely to be behavioural. The clinical reviewer believed that healthcare staff accepted this explanation too readily and therefore did not investigate his condition further.

4. On 7 October, the man was admitted to hospital, after his health deteriorated. He did not respond to treatment and died on 11 October. The post-mortem examination concluded that he died from multiple organ failure due to septic shock and urosepsis.

5. An escort chain was used when the man was taken to hospital, although he was assessed as a low risk of escape. He was very ill, but healthcare opinion about how his condition affected his risk was not taken into account. We make two recommendations about investigating unexplained medical symptoms and about appropriate risk assessments for hospital escorts.

THE INVESTIGATION PROCESS

6. The investigator, issued notices to staff and prisoners at HMP High Down informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

7. The investigator obtained copies of the man's prison and prison medical records. She interviewed four members of staff at the prison on 28 November and visited the wing and the inpatient unit where the man had lived. She gave initial feedback to the Deputy Governor and followed this up in writing.

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

9. The investigator informed HM Coroner for Surrey of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted a representative of the man's family to explain the purpose of the investigation. His family did not identify any issues for the investigation to consider.

11. The man's next of kin was informed the draft report was available, but did not wish to receive a copy or make any comment. The prison considered our draft report and recommendations and has accepted these. 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 HIGH DOWN

12. HMP High Down is a local prison near Sutton which holds around 1,100 men. NHS Surrey commissions healthcare services at the prison which are provided by Virgin Care Services. There is a 22 bed inpatient unit.

HM Inspectorate of Prisons

13. The last inspection of High Down was in July 2011. The Inspectorate found that healthcare provision was very good and supported by an impressive level and quality of staff. Prisoners were generally satisfied with their access to healthcare services. However, inspectors noted that there was a need to cater better for prisoners whose needs differed from the population as a whole because of their age, nationality or disability.

Independent Monitoring Board

14. 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 annual report for the year to November 2012, the IMB commented that healthcare was excellent with progressive improvements in all areas, despite budget constraints.

Previous deaths at HMP High Down

15. The man's death was one of three deaths from natural causes at High Down in 2013. We made recommendations about the use of restraints in each of the other investigations.

KEY EVENTS

16. The man was sentenced to eight years imprisonment for sexual offences on 28 November 2012 and taken to HMP High Down the same day.

17. It was noted at a reception health screen that the man's medical history included nephritis (a serious inflammation of the kidneys), and immune thrombocytopenic purpura (ITP - a condition where the blood does not clot properly due to a low platelet count) for which he was under the care of hospital specialists. He also had high blood pressure, gout, raised cholesterol, type 2 diabetes and depression. He was prescribed a range of medication for the conditions.

18. On 5 December, a nurse saw the man and noted he appeared confused and smelt of urine. She admitted him to the prison's inpatient unit for observation and for blood and liver function tests. The results showed that his kidneys and liver were not functioning normally. A prison GP referred the man to the renal department at a hospital. The man went back to his wing on 10 December.

19. On 1 January 2013, wing staff found the man lying on the floor of his cell. He was suffering from diarrhoea and vomiting. He was admitted to the inpatient unit again and returned to his wing on 10 January. Healthcare staff regularly monitored the man and treated his conditions. He had recurrent diarrhoea and incontinence and needed daily help with his personal hygiene.

20. On 20 January, the man fell in his cell and hit his head. Records show that he seemed confused and responded to commands but did not speak. He initially had a fixed left pupil, which can be a sign of brain injury, but this soon returned to normal. The same day, the inpatient nurse manager noted that the man did not seem to have diarrhoea or be incontinent when he was in the inpatient unit. She believed his incontinence was more likely to be behavioural than caused by physical factors.

21. On 26 January, the man had a fall but did not injure himself. On 30 January, the man fell in his cell again after suffering a hypoglycaemic episode (low blood sugar). There was a strong smell of urine. The man was admitted to the inpatient unit and tests indicated that he had a urinary infection. A prison GP saw him later that day, but there is no record that he was treated for the infection.

22. During February and March, the man fell in his cell five more times. Sometimes he was treated for cuts to his head. On 7 February, the man refused to attend an appointment with a renal specialist. He saw a haematologist on 20 March. On 26 March, he was admitted to hospital after a fall and was diagnosed with autonomic neuropathy as a result of his diabetes. This led to drops in blood pressure which in turn caused him to fall.

23. On 10 April, the man was fitted with a 24 hour cardiac monitor at Epsom Hospital. The results indicated that no treatment or intervention was required.

24. On 18 April, the man was taken to hospital again after another fall. He had stitches for a head injury. He also had a chest X-ray, which was clear. When he returned to the prison later that day, he was admitted to the inpatient unit. A nurse noted that he looked gaunt and frail and had lost 20kg since November 2012. Records show that staff reviewed the man's nutrition frequently and encouraged him to eat and offered him extra food.

25. Over the next two weeks, the man had three more falls and went to hospital on 28 April to treat a head injury. He came back to the prison the same day.

26. On 1 May, a multidisciplinary meeting discussed the man's complex medical and social needs and agreed that he should remain in the inpatient unit as staff could not manage him effectively on the wing. The next day a nurse found the man on the floor of his cell. She carried out a falls assessment and identified the man as high risk, requiring staff assistance at all times.

27. The man's medical records show that he continued to be doubly incontinent and did not always tell staff when he had soiled himself. Healthcare staff tried various methods to assist with this condition.

28. On 12 May, the nurse manager noted that the man was lying in his bed fully clothed and soaked in urine. This was despite having incontinence pants and a convene (a tube which fits over the penis). A prison GP reviewed the man on 13 May and found nothing abnormal. He also noted that urine tests had been normal. The man appeared to have removed his incontinence aids and the GP suggested he should be screened for dementia. A subsequent assessment showed that the man scored 27/30 on a mini mental state examination, for assessing possible dementia. This indicated only minor cognitive impairment.

29. On 21 May, the man had another fall and went to Epsom Hospital for treatment to a cut to his scalp. He had a CT scan which was normal and no further treatment was required. He returned to High Down the next day.

30. On 1 June, the man was taken to the Acute Medical Unit at St Helier Hospital because he had not passed urine for approximately 24 hours. Urine was removed from his bladder by a catheter and he was given intravenous fluids. He returned to the prison the next day. Throughout June, July and August, the man remained doubly incontinent and healthcare staff helped him with his personal hygiene and encouraged him to eat and mobilise. He had two more falls, one of which caused a wrist fracture which was treated at Epsom Hospital. On 25 July, a stool specimen was tested for infection, but no evidence of infection was found.

31. On 16 September, staff found that the man had fallen on the floor of his cell and cut his head. He was taken to hospital and was discovered to have a urinary tract infection for which he was treated with intravenous antibiotics. He returned to High Down on 26 September.

32. The GP examined the man on 4 October. He noted that the man had been assessed by healthcare staff at the prison and hospital and judged to have mental capacity. The GP recorded that the man was able to use the cell bell to call staff for help when he needed to use the toilet, but was choosing not to do so. He said there was no underlying disease of the man's colorectal or urogenital areas and concluded that there might be a voluntary behavioural element to his incontinence. The man continued to refuse help from healthcare staff to use the toilet.

33. On the evening of 7 October, the man was unable to swallow his medication and appeared to be choking. The nurse attended to him. She noted he had low blood pressure and gave him oxygen. Staff called an ambulance and he was admitted to Epsom Hospital.

34. Before the man was taken to hospital, a security risk assessment was completed. The head of security authorised that two officers should escort him and that he should be restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Healthcare staff did not complete the medical section of the assessment to say how his condition impacted on his risk. The next morning the escorting officers were concerned about the man's condition and, at 7.15am, a custodial manager agreed that the man's restraints should be removed.

35. The man did not respond to treatment in hospital. On 9 October, the hospital's palliative care team reviewed him and placed him on an end of life pathway. The man died at 12.10am on 11 October.

36. Prisoners and staff were informed of the man's death later that day and a service was held in the prison chapel. Appropriate support was offered to other prisoners.

37. The man did not have any contact with his family while he was in prison and he had given no next of kin contact details. On 9 October, when the man was placed on the end of life pathway, the prison family liaison officer, the Reverend contacted the man's probation officer and solicitor but they were unable to assist with any family details. After the man's death, the Reverend established that he had a half brother and a cousin living in Scotland. She informed them of the man's death but they did not wish to have any further involvement. The prison arranged and paid for the man's funeral which took place on 11 November 2013.

Post-mortem

38. The pathologist who conducted the post-mortem examination noted that the man had a number of conditions. These included severe hypotension (low blood pressure), gross urosepsis (an infection of the urinary tract that has spread to the bloodstream), prostatic hypertrophy (enlarged prostate), colitis consistent with clostridial disease (a bacterial infection of the colon), old strokes, old myocardial infarct (heart attack) and terminal bronchopneumonia.

39. The cause of the man's death was identified as multiple organ failure, septic shock and urosepis.

ISSUES

Clinical care

40. The clinical reviewer noted that the man was in poor health when he first arrived at High Down and had a number of chronic conditions. During his time in prison he had many falls and sustained injuries which were appropriately treated in hospital. The clinical reviewer considers that most of the man's falls were as a result of low blood pressure caused by complications with his diabetes. However, he is concerned that some of the man's falls and diarrhoea could have been the result of transient ischaemic attacks or 'mini strokes' (caused by a temporary disruption in the blood supply to part of the brain) and clostridium colitis (identified at post-mortem). The clinical reviewer also notes that despite the man's frequent falls, subsequent head injuries and hospital admissions, there is no record that he had a brain scan.

41. The man was doubly incontinent for much of his time in prison. These symptoms were unexplained and the clinical reviewer considered that healthcare staff too easily concluded that there was no medical reason for the man's symptoms and that they were mainly behavioural.

42. The clinical reviewer noted that the man's medical conditions and his behaviour were a significant challenge to the staff looking after him and that his overall standard of nursing care was good. However, he believes that more should have been done to investigate further whether there were any other physical causes for his incontinence and to explain the reasons for his falls. He considers that further referrals to appropriate specialist should have been considered and that the staff should not have attributed medically unexplained symptoms to behavioural causes only. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners who are suffering from medically unexplained symptoms have multidisciplinary reviews and are referred to an appropriate specialist when appropriate.

Restraints, security and escorts

43. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process.

44. In October 2013 (and again in January 2014), we made recommendations to High Down that the level of restraints used for escorts took should take into account the medical condition of the prisoner at the time. The prison has since revised its local security strategy to require appropriate assessments. The new document had an implementation date of December 2013 so was not in force at the time of the man's death.

40. Although the revised policy was not in place at the time when the man was taken to hospital, the guidance in the court judgement and Prison Service national guidance should have been followed. No medical opinion was obtained about how the man's health impacted on his risk and restraints were used even though he was frail and very ill and had been assessed as a low risk of escape. We note that an appropriate decision was made to remove the escort chain on 8 October, the day after his admission to hospital, in recognition that he was no longer a risk. We welcome the introduction of new local security guidance but our experience has been that all staff involved in such risk assessments need to be briefed fully about the legal position. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners who are suffering from medically unexplained symptoms have multidisciplinary reviews and are referred to an appropriate specialist when appropriate.

2. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners who are suffering from medically unexplained symptoms have multidisciplinary reviews and are referred to an appropriate specialist when appropriate.	Accepted	HMP High Down fully accepts the need to work in a multidisciplinary way and will ensure that when prisoners suffer from medically unexplained symptoms in the future multidisciplinary reviews will take place to discuss treatment options. The final decision for referrals to hospital or secondary care will continue to be made by GPs.	Complete Head of Healthcare	
2.	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The Local Security Strategy at HMP High Down has been revised to ensure that appropriate risk assessments take place when prisoners are taken to hospital, and medical opinion will now always be considered when determining an individual's actual risk at the time of assessment. The Head of Security has briefed all staff undertaking risk assessments about the legal position and the revised Local Security Strategy, and notices will be issued to staff in the future to remind them of their responsibilities when completing assessments.	Complete Head of Security	