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 at HMP Swaleside in December 2013

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 in December 2013, at HMP Swaleside. He was 47 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the clinical care the man received at HMP Swaleside. The prison cooperated fully with the investigation.

The man was sentenced to 18 years in prison in October 2009 and was transferred from HMP Elmley to Swaleside. He had no significant medical history, but was overweight, had high blood pressure and cholesterol and smoked cigarettes. One day in December 2013, he did not turn up at his place of work in the prison. A prison officer went to his cell, found him unresponsive and called for emergency help. Healthcare staff responded, but it was evident that he had been dead for some time.

While the man's death was sudden and unexpected and could not have been foreseen, the clinical reviewer was concerned that he had a number of factors that increased his cardiovascular risk which were not appropriately assessed. I am also concerned that there was a failure to check his wellbeing when his cell was unlocked on the day he died.

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**

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SUMMARY

1. The man was sentenced to 18 years in prison on 1 October 2009 and transferred to HMP Swaleside on 23 October from HMP Elmley where he had been remanded. On reception, he had no significant medical history apart from mild asthma. However, it was noted that he smoked cigarettes and was clinically obese.

2. The man's blood pressure was monitored for four months at the start of his time in prison. The reason is not recorded, but most of the readings were high. Despite this, there is no evidence of any further referral or investigation.

3. In April 2010, the man was prescribed anti-inflammatory medication for an old knee injury. He remained on this medication until his death. He suffered periodically with infected gums for which he received appropriate dental care and antibiotics.

4. In May 2010 and November 2011, blood tests showed the man's cholesterol level was significantly raised. There is no record that this was followed up or acted upon.

5. Throughout 2012 and 2013, the man had little interaction with healthcare staff, apart from repeat prescriptions for ibuprofen (and omeprazole to help reduce stomach acid, a possible side-effect of prolonged use of ibuprofen). His medication was not reviewed as frequently as guidance suggests.

6. On Thursday 19 December 2013, the man did not turn up for work as expected, at 2.00pm. An officer went to his cell at approximately 2.45pm and found him in bed and unresponsive. Healthcare staff assessed that he had been dead for some time and so did not attempt resuscitation. The prison doctor confirmed his death shortly afterwards.

7. The man was a smoker, clinically obese and had been identified as having high blood pressure and high levels of cholesterol. He was prescribed regular anti-inflammatory medication which also increased the risk of him developing a heart attack or stroke. While recognising that it sudden could have occurred if he were in the community, the clinical reviewer considered that his healthcare fell below the standard expected, as Swaleside did not take a sufficiently active approach to assessing his vascular risk.

8. We are concerned that prison officers did not check the man's welfare when they unlocked his cell or when they went into it cell on the day he died. Although this would not have affected the outcome for him, in other circumstances, it could save a life. We make three recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners responded.

10. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.

11. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He visited Swaleside on 2 January 2014, and interviewed three members of staff and three prisoners at the prison on 28 February.

12. We informed HM Coroner for Mid-Kent and Medway of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers spoke to the man's sister to explain the purpose of the investigation. She did not have any specific matters for the investigation to consider.

14. The man's family received a copy of the draft report. They pointed out some factual inaccuracies in the clinical review report, which have been amended. They remain very concerned about the lack of care they believe he received. The prison considered our draft report and recommendations, which they have accepted. 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 SWALESIDE

15. HMP Swaleside forms part of the Isle of Sheppey group of prisons which also includes Elmley and Standford Hill. Swaleside's main function is to hold life-sentenced prisoners, but it also holds some prisoners serving shorter sentences. The prison can hold up to 1,112 men. Healthcare is provided by IC 24 Integrated Care. There is a GP run practice and inpatient unit.

Her Majesty's Inspectorate of Prisons

16. The most recent inspection of Swaleside was in July 2011. The inspectorate found prisoners had access to primary care health services with a range of services to monitor delivery and a good outpatient department.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) made up 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 April 2013, the IMB noted a new healthcare provider was still settling in and the reliance on agency staff was beginning to decline as more permanent staff were appointed. There had been no specialised clinics in the last year, but plans were in place for specialist nurses from the community to run these. There was a successful GP practice which was popular with prisoners.

Previous deaths at Swaleside

18. The man is the third prisoner to die from natural causes at Swaleside since the start of 2012. We have previously identified the need to follow up symptoms indicating an increased risk of heart disease, and obtaining a response from prisoners at unlock.

KEY EVENTS

19. The man was remanded into custody on 23 October 2008 and was sent to HMP Elmley. An initial health screen recorded that he had no current medical issues and was not taking medication. He had a history of mild asthma, smoked cigarettes and was clinically obese.

20. Records show that the man's blood pressure was monitored from 24 October 2008 to 10 February 2009, but it is not clear why. The majority of his observations were above the recommended levels and the last recorded reading was high at 171/80. (The clinical reviewer says that normal blood pressure for someone of his age would be 140/80 and below.) There was no evidence of further investigation or a medical referral to help lower his blood pressure.

21. On 1 October 2009, the man was sentenced to 18 years in prison and was transferred to Swaleside on 23 October. Healthcare staff noted he was clinically obese, had a history of mild asthma and smoked about 10 cigarettes a day. Records show that he was advised about stopping smoking a number of times.

22. The man settled into the prison regime. Staff noted that he was quiet and spent most of his time in and around his cell. He was employed in the prison's packaging workshop and attended regularly.

23. In April 2010, the man was prescribed ibuprofen (anti-inflammatory medication) for pain in his knee caused by an old rugby injury.

24. On 5 May 2010, a prison GP noted that the man had high cholesterol and requested a follow up appointment. This was also to review his pain relief medication. On 28 June, the doctor saw him and noted he had been using ibuprofen (an anti inflammatory) for two months. He prescribed omeprazole to reduce any stomach irritation caused by the ibuprofen. There does not appear to have been any follow up of the high cholesterol.

25. From July 2010 until November 2011, the man had little interaction with healthcare staff, apart from receiving regular prescriptions for ibuprofen and omeprazole.

26. A prison GP saw the man on 8 November 2011 about the knee pain. He diagnosed a tendon irritation. Blood and urine samples were taken to make sure there were no other underlying reasons. The results of the blood tests showed his kidney and liver function and blood sugar were normal, but he had raised cholesterol. The GP noted that he should make a further GP appointment about this, which he did not do.

27. From November 2011 to March 2012, the man continued to be prescribed ibuprofen and omeprazole. On 29 March, a doctor reviewed his medication, and renewed the prescriptions. Apart from

dental treatment, he had little interaction with healthcare staff from April to December. He continued to receive regular prescriptions of ibuprofen and omeprazole. On 4 December 2012, the doctor reviewed his medication and again re-prescribed the ibuprofen and omeprazole.

28. There is nothing significant in the man's healthcare records for most of 2013, apart from incidents of dental pain which were treated with antibiotics and repeat prescriptions of ibuprofen and omeprazole.

Events leading up to the incident

29. Just after 7.10am, an officer carried out a roll check on the man's wing. She looked through the observation flap of his cell door and told us that she was almost certain she had seen him working at his desk. (He was studying for an Open University exam.)

30. At 8.20am, cells were unlocked for association. A prisoner told us that he and the man nodded to each other just after unlock. Cells were locked again at 8.50am and unlocked at 9.00am for prisoners to go to work and education. The man worked in the packing workshop and was expected to go to work that morning.

31. The officer was checking cells that morning and reached the man's cell sometime between 10.00 and 10.30am. She said that he lying on his bed on his front, as he usually slept. She assumed he had not gone to work that day after being up late studying for exams and had not been expected to go to work that morning. He appeared to be asleep and she did not attempt to wake him.

32. The cells were opened for prisoners to collect their lunch between 11.30 and 11.45am. Another prisoner told us that he had spoken to the man over the lunch period.

33. At 12.10pm, an officer started to lock cells after the lunch period. He closed the man's cell door and saw him apparently sleeping, his lower half was covered in a sheet and the cell lights were off. He then moved on to the next cell.

34. An officer began unlocking cells at about 2.00pm. At around 2.45pm, the workshops contacted the wing to ask why the man had not turned up for work that day. The officer went to his cell and saw him lying in his bed with the blankets pulled halfway up his back. His head was face down in his pillow and he looked as if he were asleep. The officer asked him why he had not gone to work but he did not reply. He placed his hand on his shoulder and found that he was cold. He then noticed that he was not breathing and that there was blood mottling on his right arm. The officer said he was sure he had died.

35. The officer radioed a medical emergency code blue (which indicates incidents such as when a prisoner is unconscious or has breathing

difficulties). A nurse and a healthcare assistant arrived within a few of minutes. The nurse noted the man's position and that the sheet beneath him was wet. She examined him and found he was not breathing, had no pulse and was cold. She noted his skin was mottled and rigor mortis was present in his legs. As these were clear signs that he had died, she did not attempt resuscitation. A prison GP attended and at 3.23pm confirmed death.

Liaison with the man's family

36. The man had listed his solicitor as his next of kin. The Governor contacted the man's solicitor, who gave her the contact details of his father.

37. A prison family liaison officer rang the man's father later that day and informed him of his son's death. The man's sister later contacted the family liaison officer. His mother had been informed of his death and she gave her the prison her contact details. As his mother lived some distance from Swaleside, the prison arranged for a family liaison officer from a prison nearby to visit her.

38. The funeral was held on 17 January 2014. The prison offered financial assistance in line with national guidance.

Support for staff and prisoners

39. The staff involved with finding the man were appropriately debriefed and supported. A Governor's notice informed all staff and prisoners of his death and reminded them of the support available. All prisoners subject to suicide prevention monitoring were reviewed and offered additional support, in case they had been affected by his death. A memorial service was held at the prison on 30 December.

Post-mortem

40. The post-mortem concluded that the cause of death was due to ischaemic cardiomegaly (an enlarged heart).

ISSUES

Clinical care

41. The clinical reviewer concluded the man's sudden death could not have been foreseen or prevented. However, he considers the standard of healthcare he received fell below that he could have expected in the community. He states that his medical history revealed potential causes of his heart condition including obesity, high cholesterol and high blood pressure. None of which were well followed up.

42. There is no record that the man was given any advice about managing his weight, for example through a healthy diet and regular physical activity.

43. The man's blood pressure was monitored for a four month period in 2008/09 (before he was transferred to Swaleside) and was recorded as consistently high. The clinical reviewer considers that this should have prompted treatment with medication to lower his blood pressure and continued regular monitoring (in line with National Institute of Clinical Excellence (NICE) guidelines), which should have continued at Swaleside. Other than the initial monitoring, there is no record of any further action.

44. In May 2010 and November 2011, blood tests revealed that the man had very high cholesterol. The clinical reviewer states that such high levels would need further assessment to establish an underlying cardiovascular risk score. On both occasions, there is nothing in the record to indicate this was followed up or discussed with him.

45. The National Institute for Clinical Excellence (NICE) best practice guidelines advise screening all patients who are at risk of heart disease. If the patient has an increased risk, they should be monitored regularly. As Swaleside had information that the man had high blood pressure and high levels of cholesterol, they should have begun screening for heart disease through regular GP reviews, including advice on weight and lifestyle. We make the following recommendation:

    The Head of Healthcare should introduce routine reviews of cardiovascular risk for prisoners with known risk factors, and ensure that such prisoners receive appropriate treatment and advice.

46. The man was continually prescribed ibuprofen tablets and omeprazole (the latter to help reduce the side effect of stomach irritation that ibuprofen can cause). Another side affect of such medication is the rare risk of cardiovascular problems. The clinical reviewer considers that medication reviews did not happen often enough and it was not always clear whether these involved him so that the risks of taking the

medication could have been discussed and considered. We make the following recommendation:

The Head of Healthcare should ensure that there are regular reviews of long term medication which involve the prisoner.

Unlock procedures

47. For their own safety, officers are expected to make contact with a prisoner through the observation hatch before opening a locked cell door. When unlocking a cell they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

48. We have been unable to establish who unlocked the man's cell in the morning and what checks were made at that time. An officer said that when she carried out accommodation checks sometime after 10.00am, she saw him lying face down on his bed. She said he appeared to be asleep and she did not want to disturb him. We considered whether he might have been dead at that time, but could not establish this as she did not attempt to rouse him. However, a prisoner told us that he had spoken to him at lunchtime unlock some time between 11.30am and 12.00pm. (Another prisoner said that he had not collected his lunch that day.) Unless he was mistaken, he must have died not long after that. At 2.45pm, when he was found dead, rigor mortis was present. Rigor mortis begins about three to four hours after death, so if an officer had checked him when he unlocked his cell at 2.00pm his death would have been discovered earlier.

49. We were told that there was no expectation that officers unlocking cells after lunch would check on the welfare of prisoners. Officers just open each cell and move on. We consider that it is important that officers obtain a response from prisoners when unlocking or entering a cell at any time. While it clear this would not have prevented the man's death, on another occasion it could help save a life. We make the following recommendation:

The Governor should ensure that when a cell door is unlocked, and when an officer enters a cell, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

RECOMMENDATIONS

1. The Head of Healthcare should introduce routine reviews of cardiovascular risk for prisoners with known risk factors, and ensure that such prisoners receive appropriate treatment and advice.

2. The Head of Healthcare should ensure that there are regular reviews of long term medication which involve the prisoner.

3. The Governor should ensure that when a cell door is unlocked, and when an officer enters a cell, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and **function responsible**
1	The Head of Healthcare should introduce routine reviews of cardiovascular risk for prisoners with known risk factors, and ensure that such prisoners receive appropriate treatment and advice.	Accepted	A cardiovascular review clinic will be introduced which will be led by GPs and used to monitor individuals at risk of heart decease.	June 2014 Head of Healthcare
2.	The Head of Healthcare should ensure that there are regular reviews of long term medication which involve the prisoner.	Accepted	A weekly clinic will be introduced to review the issuing of medication.	June 2014 Head of Healthcare
3.	The Governor should ensure that when a cell door is unlocked, and when an officer enters a cell, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	The Governor will issue a notice to staff advising them of the importance of getting a response from prisoners when they unlock cell doors.	May 2014 Governor