Prisons & Probation
Ombudsman
Independent Investigations

Investigation into the death of Mr Kevin Thompson, a prisoner at HMP Lincoln, on 4 September 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned

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.

Mr Kevin Thompson died of heart disease at HMP Lincoln, on 4 September 2015. He was 53 years old. I offer my condolences to Mr Thompson's family and friends.

Mr Thompson was diagnosed with heart disease shortly after he went into prison and had recently received treatment for throat cancer. I am satisfied that he received a standard of healthcare equivalent to that he could have expected in the community and that staff at Lincoln could not have prevented his sudden and unexpected death.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

Contents

Summary ....
The Investigation Process ....
Background Information ....
Key Events ....
Findings ....

Summary

Events

1. In April 2014, Mr Kevin Thompson was remanded to HMP Lincoln. Two months later, he was sentenced to four years in prison for drug offences.

2. On 5 May, Mr Thompson suffered a heart attack and had surgery to insert a stent into his arteries. Hospital doctors also diagnosed chronic heart failure. When Mr Thompson returned to prison, he received medication to help prevent another heart attack and attended cardiac rehabilitation as an outpatient for four months. After September, he reported no further symptoms relating to his heart condition. However, he ignored medical advice to stop smoking, which increased his risk of a further heart attack.

3. On 28 October, Mr Thompson transferred to HMP Humber. In November, after reporting a lump in his throat, a prison doctor referred him to a specialist. He was diagnosed with throat cancer in January 2015.

4. Mr Thompson asked to go back to HMP Lincoln, to be nearer to his family, while he received treatment. He returned there in February. He had surgery in March, followed by radiotherapy and chemotherapy between May and July. From July, Mr Thompson sometimes refused to take some of the medication prescribed for his heart condition and rarely took it in the weeks preceding his death.

5. On the morning of 4 September, a nurse and an officer went to check Mr Thompson, as he had not collected his medication and found him unresponsive in his cell. He was clearly dead, so they did not attempt to resuscitate him. A post-mortem examination found that he had died of heart disease.

Findings

6. The clinical reviewer noted that Mr Thompson was at increased risk of heart failure due to a previous heart attack, his ongoing treatment for throat cancer and his smoking. He concluded that Mr Thompson received a good standard of care at Lincoln, equivalent to that he could have expected in the community. We are satisfied that staff could not have prevented his sudden and unexpected death.

7. The investigation found that the officer who unlocked Mr Thompson on the morning of his death did not make adequate checks on his wellbeing. While it does not appear that this would have altered the outcome for Mr Thompson, early intervention in other circumstances could make a difference. We consider that staff appropriately decided not to attempt resuscitation, as it appears he had been dead for some time.

Recommendation

- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner, and that there are no immediate issues that need attention.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Thompson's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Thompson's clinical care at the prison.

11. The investigator interviewed three members of staff and one prisoner at Lincoln on 26 November.

12. We informed HM Coroner for Central Lincolnshire of the investigation who gave us the results of the post-mortem examination and toxicology report. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Thompson's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She suggested that the investigator speak to a prisoner at HMP Lincoln. She also asked whether Mr Thompson had received appropriate medication and support for his medical condition and if there had been any delays in referring him to hospital.

14. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

15. Mr Thompson's daughter received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Lincoln

16. HMP Lincoln holds up to 738 remand and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, which include a vulnerable prisoners unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Lincoln was in November 2013. Inspectors reported that health services had improved overall since the previous inspection. The health services team delivered a wide range of chronic disease clinics, with reasonable waiting lists. They noted that disabled prisons received good clinical support, but that their social care needs were not adequately met. Although there were no formal prisoner carers, some prisoners received informal help from cellmates and friends. Inspectors recommended that social care plans should be developed for all prisoners with disabilities who require additional help with everyday tasks.

18. Many prisoners complained about the quality of food, but inspectors found that it was varied and nutritious and consultation arrangements had led to improvements.

Independent Monitoring Board

19. 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 January 2015, the IMB reported concerns about the lack of facilities for prisoners with a physical disability or reduced mobility. It also noted that an initiative to reduce the high rate of missed appointments had been successful and healthcare staff now follow up missed appointments to find the reason for non-attendance.

Previous deaths at HMP Lincoln

20. Mr Thompson was the first person to die of natural causes at Lincoln since January 2013.

Key Events

21. Mr Kevin Thompson was remanded to HMP Lincoln on 23 April 2014. In June, he was sentenced to four years in prison for drug offences. At an initial health screen, a nurse recorded that Mr Thompson had no medical or mental health concerns and was not receiving any medication.

22. On 5 May, Mr Thompson reported chest pains and healthcare staff sent him to hospital. Hospital doctors diagnosed a heart attack, with clinical signs of chronic heart failure. They inserted a drug-eluting stent (a scaffold placed into a narrowed or diseased artery, which slowly releases a drug to prevent blockage) and referred him for cardiac rehabilitation.

23. Mr Thompson returned to the prison on 7 May, and a nurse gave him a glyceryl trinitrate (GTN) spray, to ease angina pains. The next day, a prison GP prescribed the medication advised by hospital doctors, which Mr Thompson kept in his cell. These included aspirin (to reduce the risk of further heart attacks), atorvastatin (to lower cholesterol), bisoprolol (a beta-blocker to lower blood pressure), ramipril (to treat high blood pressure and congestive heart failure) and ticagrelor (a blood thinner to prevent heart attacks). A nurse checked that he was taking his medication correctly.

24. On 16 May, a cardiac rehabilitation nurse specialist sent a care plan to the prison, advising how to manage Mr Thompson's heart condition. Healthcare staff monitored his condition in accordance with this plan and reviewed it when necessary. They also advised him that smoking was harmful to his health, but he continued to smoke.

25. On 15 September, Mr Thompson attended an appointment with a consultant nurse in cardiology at hospital. Mr Thompson told him that he no longer felt any chest pain. A nurse concluded that his heart condition was stable and discharged him. During the remainder of his time in prison, Mr Thompson did not complain of chest pains, or symptoms associated with heart failure.

26. On 28 October, Mr Thompson transferred to HMP Humber. Doctors continued to prescribe medication for his heart condition.

27. On 14 November, a prison GP examined Mr Thompson as he had a sore throat and a lump on the right side of his neck. The doctor prescribed amoxicillin (an antibiotic) for the sore throat. When the GP reviewed him five days later, he found that the swelling had not reduced. He therefore referred Mr Thompson urgently to an Ear, Nose and Throat specialist at hospital, under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Thompson received an appointment for 3 December.

28. Hospital doctors diagnosed possible throat cancer and performed surgery on 6 January to establish the extent of the malignancy. On 21 January 2015, a consultant clinical oncologist told Mr Thompson that he had cancer of the right tonsil and advised that he would need further surgery, chemotherapy and radiotherapy. Mr Thompson asked the doctor if he could have his follow-up treatment at a hospital nearer to his family.

29. A prison healthcare manager liaised with a nurse at HMP Lincoln to arrange Mr Thompson's transfer and ensure that the prison could manage his health conditions. Mr Thompson moved back to Lincoln on 17 February. Healthcare staff created care plans to manage his clinical needs and reviewed these as necessary.

30. Doctors at the hospital considered how to manage Mr Thompson's cancer treatment along with his heart condition and advised prison staff on his medication.

31. On 27 March, Mr Thompson had neck surgery at hospital. Doctors inserted a special feeding tube into his neck, as his radiotherapy treatment was likely to cause difficulty in swallowing food. Prison healthcare staff fed him daily through the tube. They arranged a special diet of soft foods, fruit and vegetables.

32. Between May and July, Mr Thompson had weekly chemotherapy and radiotherapy treatment at the hospital. Doctors prescribed pain relief to manage his symptoms and the side effects of his treatment. On 10 June, a nurse spoke to Mr Thompson, as staff had found that did not always take his medication as prescribed or clean his feeding tube. She also consulted a GP, who arranged for staff to dispense his medication daily and changed his aspirin medication to liquid form. Nurses visited Mr Thompson in his cell to help feed him.

33. In July, Mr Thompson submitted a formal complaint about the quality of his food. A nurse spoke to him about this and liaised with the kitchen to ensure he received a balanced diet.

34. On 19 July, Mr Thompson stopped taking the medication for his heart condition as he had difficulty swallowing it, but he continued to take his pain relief. Healthcare staff explained to him the importance of taking his medication. Mr Thompson did not take his aspirin on 25 and 28 August, or on 2 and 3 September.

35. Just after 8.00am on 4 September, an officer unlocked Mr Thompson's cell. At interview, she told the investigator that he appeared to be asleep, so she decided not to disturb him. Shortly afterwards, a prisoner went to the cell and he too thought Mr Thompson was asleep. At around 8.30am, she locked Mr Thompson's cell at the end of morning association.

36. At around 9.00am, a nurse and an officer went to check on Mr Thompson, as he had not collected his medication. They went into his cell, but he did not respond when the nurse spoke to him. She checked, but could find no pulse, and noted that he was cold, stiff, and showed signs of blood pooling (which indicates he might have been dead for some time). A Senior Officer went to the cell and radioed the control room to call an ambulance. Staff did not attempt to resuscitate Mr Thompson, as he was clearly dead. Paramedics arrived at the scene at 9.12am and recorded his death at 9.28am.

Contact with Mr Thompson's family

37. At around 9.30am, a member of staff broke the news to another prisoner and the partner of Mr Thompson's daughter. The Governor gave him permission to call Mr Thompson's daughter, his listed next of kin, to inform her of his death. Mr Thompson's daughter called the prison chaplain, who offered his condolences and arranged for someone from the prison to visit her.

38. The prison appointed a prison manager and an officer as family liaison officers. Later that morning, they visited Mr Thompson's daughter at her home and offered their support. The prison manager arranged for Mr Thompson's daughter to visit the prison and to see her partner.

39. Mr Thompson's funeral was on 25 September. The prison contributed towards the costs, in line with national policy.

Support for prisoners and staff

40. After Mr Thompson's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

41. The prison posted notices informing other prisoners of Mr Thompson's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Thompson's death.

Post-mortem report

42. The post-mortem concluded that Mr Thompson died of ischaemic heart disease and there was evidence of acute cardiac failure. While his treated throat cancer was not the immediate cause of death, it contributed to the outcome.

Findings

Clinical Care

43. The clinical reviewer considers that, although Mr Thompson's death was unforeseeable, it was not surprising considering his poor health, the significant cardiac muscle damage from his heart attack in May 2014 and his continued smoking, which had increased his risk of a further heart attack. As he had recently completed cancer therapy, he was also physically weak, with a more vulnerable immune system.

44. In June 2015, a doctor had arranged for healthcare staff to dispense Mr Thompson's medication daily, after a nurse had raised concerns that he was not taking it as prescribed. He had also changed his aspirin to a soluble form, so that it was easier to swallow.

45. In the weeks leading up to his death, Mr Thompson rarely took his atorvastatin and ramipril medication, which had been prescribed for long-term management of his heart condition. However, the clinical reviewer said this was unlikely to have contributed to his death. Mr Thompson had also refused to take his daily aspirin four times in the two weeks before he died. As aspirin is prescribed to prevent heart attacks, the clinical reviewer considered this might have had an effect in the short term, but it was not possible to determine the extent of this.

46. The investigation found that healthcare staff created care plans and managed Mr Thompson's conditions appropriately, with relevant medication. There is no evidence of any delay in sending Mr Thompson to hospital when he suffered a heart attack in May 2014. The clinical reviewer concluded that Mr Thompson's care in prison was equivalent to that he could have expected to receive in the community. We agree with the clinical reviewer's assessment of the standard of Mr Thompson's care and are satisfied that he received appropriate support.

Unlock procedures

47. When staff found Mr Thompson, there were several physical signs that he had been dead for some time. An officer said she had called to Mr Thompson when she opened his cell, but he did not respond, and she believed he was sleeping. She knew that he had cancer and thought he was probably tired because of this. Another prisoner went to Mr Thompson's cell shortly after this and drew the same conclusion.

48. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. 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". Prison Service Instruction 75/2011 states, "there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock…

Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".

49. We are concerned that when the officer unlocked Mr Thompson's cell on the morning of his death, she assumed he was sleeping without making adequate checks to make sure this was the case. While it is unlikely that this would have changed the outcome, it meant that staff missed an opportunity to check his wellbeing and this could have resulted in other prisoners finding him dead. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner, and that there are no immediate issues that need attention.

Prisons & Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141