A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 31 October 2014, while a prisoner at HMP Thameside

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 sepsis caused by a perforated ulcer, on 31 October 2014 while a prisoner at HMP Thameside. He was 32 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Thameside was undertaken. The prison cooperated fully with the investigation.

On 19 September 2014, the man received a 12-week prison sentence and was sent to HMP Highdown. On 9 October, he was sentenced to a further eight weeks for another offence and taken to Thameside. He was due to be released in November. He was on a methadone maintenance programme to treat his drug problems. From 14 October, he complained of constipation, stomach pain and back pain. Healthcare staff gave him laxatives, indigestion medication and paracetamol.

On 28 October, the man sent a message to healthcare staff, using the prison's electronic communication system, known as CMS, saying he was suffering from internal bleeding. A healthcare assistant responded to say that an appointment had been booked. Two days later, a nurse and a prison officer noticed that he was unwell and a prison doctor diagnosed a perforated ulcer. An emergency ambulance took him to hospital. His condition deteriorated and he died in the early hours of 31 October.

There is no clear record on CMS of what happened, but it appears that an appointment was made for a doctor to see the man on 31 October. However, the nurse who dispensed his methadone on 30 October saw that he looked unwell, so cancelled the appointment and arranged for a doctor to see him that morning.

I am concerned that no one assessed the man quickly after he reported serious medical symptoms. The prison needs to ensure there are appropriate triage arrangements for prisoners reporting medical problems on CMS, which cannot be a substitute for assessing someone in person where this is indicated. The clinical reviewer noted that urgent intervention at an earlier stage might have saved his life and, accordingly, concludes that the standard of care he received at the prison was not equivalent to that he could have expected in the community. I am also concerned that the prison used restraints when taking him to hospital, without proper justification, and that it took too long to inform his family that he was seriously ill.

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 **June 2015**
Prisons and Probation Ombudsman

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SUMMARY

1. On 9 October 2014, the man transferred from HMP Highdown to HMP Thameside. He was serving two concurrent sentences, for having a bladed article in a public place and assault, and was due to be released in November 2014. He had a history of drug misuse and, when he arrived at Thameside, a doctor continued prescriptions for methadone (a heroin substitute used in drug treatment) and diazepam for anxiety. He collected this every morning from a nurse on the wing.

2. On 14 October, a doctor prescribed the man a laxative after he said he was was constipated and not sleeping well. Two days later, another doctor saw him and prescribed a liquid medication for indigestion. On 23 October, a nurse gave him paracetamol for a stomach ache and arranged for him to see a nurse at a clinic on 26 October, for a further review. He did not attend that appointment and no reason was recorded. Nurses gave him more paracetamol on 26 and 27 October. The nurse who gave him the pain relief on 27 October, said he did not observe any symptoms to indicate he had a serious condition.

3. On 28 October, the man used the electronic messaging system in his cell (the Custodial Management System - CMS), and told prison healthcare staff that he had internal bleeding and pain in his stomach and lower back. A healthcare assistant replied that she had booked an appointment for him. There is no note of this in his medical records or on the CMS system, but it seems an appointment was arranged for 31 October.

4. On 30 October, the man appeared unwell, so a nurse cancelled the appointment for the next day and booked him an immediate one. Before he arrived at the prison's healthcare centre, an officer found him unwell on the steps of the wing. Nurses took him to see the doctor, who suspected he had a perforated ulcer and arranged for him to go to hospital by emergency ambulance. At 10.00pm, his condition deteriorated significantly and hospital staff moved him to the intensive care unit. At 2.00am on 31 October, the prison informed his family that he was seriously ill. After several cardiac arrests, he died at 5.30am the next morning.

5. We are concerned that healthcare staff did not respond to the man's request for medical attention on 28 October with sufficient urgency. There does not appear to be an appropriate system for triaging healthcare requests received over CMS and assessing their priority. Healthcare appointments were poorly recorded and it was not clear who made them or for what purpose. We agree with the clinical reviewer that the standard of his healthcare at the prison was not equivalent to that he could have expected to receive in the community. The investigation also found that prison staff used handcuffs to restrain him when he went to hospital the day before he died, without a fully considered risk assessment that took account of his health and its impact on his risk. We consider that the prison should have informed his family of his emergency admission to hospital much sooner. We make four recommendations.

THE INVESTIGATION PROCESS

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

7. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He and the clinical reviewer interviewed five members of staff at Thameside on 9 December 2014. Another of the Ombudsman's investigators another clinical reviewer interviewed a further member of staff on 12 January 2015.

9. We informed HM Coroner for Southwark of the investigation, who provided the post-mortem report. We have sent the coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation and discuss any issues that she wanted the investigation to consider. The family had the following questions:

    - Should his stomach ulcer have been diagnosed and treated by healthcare staff at the prison sooner?
    - Was he on prescribed methadone and was this managed appropriately?

11. The family received a copy of the draft report. They did not make any comments.

12. The draft report was shared with the prison service. There were no factual accuracies and the action plan has been added to the end of this report.

HMP THAMESIDE

12. HMP Thameside is a local prison serving east London courts, which can hold up to 900 men. It opened on 27 March 2012, and is privately run by Serco. Health services are contracted to Care UK. There is 24-hour nursing provision.

13. All standard cells contain an information technology system, known as the custodial management system (CMS), for communication within the prison. Prisoners use this to book visits, request appointments with healthcare staff, order from the prison shop, choose their meal options, make internal applications, oversee their finances and order telephone credit.

Her Majesty's Inspectorate of Prisons

14. HM Inspectorate of Prisons last inspected Thameside in September 2014. Inspectors found that the standard of health service provided by the prison was equivalent to standards in the community. They highlighted improvements in primary care services, the care of patients with long-term conditions, pharmacy, dentistry and mental health services.

15. Inspectors noted that the healthcare services received about 40 messages each day through CMS and that healthcare professionals responded promptly, offering appointments with a nurse or GP. Prisoners usually waited no more than three or four days to see a GP. Inspectors reported that the prison had developed CMS further, since the time of the previous inspection and levels of prisoner frustration with it had reduced significantly.

Independent Monitoring Board

16. Every prison in England and Wales 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 recent report for the year to June 2014, the IMB found that the provision of healthcare had improved since the prison had opened and there was effective collaboration between healthcare and prison custody staff. It noted that staffing was more stable, booking appointments through CMS worked well and that there had been a fall in the number of applications to the IMB about healthcare concerns.

Previous deaths at Thameside

17. The man was the second person to die at Thameside from natural causes since the prison opened in 2012. There were no significant similarities between the previous death and that of his.

KEY EVENTS

18. On 19 September 2014, the man was sentenced to 12 weeks imprisonment for having a sharply pointed blade in a public place. He was sent to HMP Highdown. He had a history of drug misuse and had been in prison several times. On 9 October, he received a further sentence of 8 weeks for assault, to run concurrently with his original sentence. He was sent to HMP Thameside and was due to be released on 5 November 2014.

19. At a reception health screen at Thameside, a nurse recorded that the man was agitated and immediately referred him to see a prison GP. He tested positive for opiates, benzodiazepines (a psychoactive drug that controls anxiety) and methadone.

20. A prison GP carried out a secondary health assessment. She considered that the man had been undertreated with methadone and needed medication to deal with the physical symptoms of opiate withdrawal. She prescribed methadone, diazepam and hyoscine butylbromide to treat his withdrawal symptoms. He lived on the prison's drug treatment wing and collected his medication every morning and afternoon from the dispensing hatch on the wing.

21. On 14 October, the man told a healthcare assistant that he wanted to see the doctor to review his methadone dose as he was not sleeping well and was constipated. A prison GP prescribed him lactulose, a laxative. The healthcare assistant booked him an appointment to see the drug treatment doctor.

22. On 16 October, a prison GP reviewed the man's methadone prescription and prescribed a two-stage increase in the dose, with a second increase scheduled for 28 October, to ensure his dose was not increased too rapidly. She gave him a bottle of over-the-counter medicine for indigestion. When interviewed, she could not recall why she had given him indigestion medication and she had not recorded the reason in his medical notes.

23. On 23 October, the man did not take his prescribed diazepam and told a nurse that he had a stomach ache. He advised him to make an appointment to see a doctor. Later that that day, he saw him again, and gave him some paracetamol and arranged for him to see a triage nurse to determine whether he needed to see a GP. The next day, a nurse gave him more paracetamol for pain, but recorded no further details. The medical records show that he did not attend the appointment made for him to see a triage nurse on the morning of Saturday 26 October. There is no indication of the reason.

24. Two nurses gave the man more paracetamol on 26 October and twice on 27 October. One nurse told the investigator that the man did not shown any external signs of being in pain on 27 October. He said that, before giving him the paracetamol, he had asked him some questions and found nothing to indicate that he had a more serious condition.

25. On 28 October at 3.20pm and 3.35pm, the man sent two messages to healthcare staff on CMS. In one of these messages, he said that he had internal bleeding. He explained that he had passed a large amount of blood and had stomach and lower back pain. A healthcare assistant responded shortly after receiving the messages, stating that an appointment had been booked for the doctor. There is no record of this appointment in his SystmOne medical record (the electronic medical record kept in prisons) but it appears that an appointment was booked for 31 October.

26. The next morning, a nurse gave the man his dose of methadone at the medication hatch. When interviewed she could not recall anything of note about his presentation to suggest he was unwell. A few minutes later, a nurse recorded that his pulse rate was high but his blood pressure was within normal limits. There is no explanation in the medical notes of any further medical assessment or reasons why these medical observations were taken at the time. (The nurse, who was an agency nurse, was unavailable for interview.)

30 – 31 October

27. At around 9.30am on Thursday 30 October, while a nurse was dispensing the man's methadone at the medication hatch, she noticed that he was pale and uncommunicative. He did not appear to be his normal self. She saw that he had an appointment scheduled to see a doctor the next day, 31 October. However, she considered that the doctor needed to see him sooner. At 9.32am, she cancelled the appointment for 31 October and printed a note to allow him to leave the wing to go straight to the healthcare centre.

28. A few minutes later, an officer noticed the man sitting on the staircase and that he looked unwell, so he helped him up the steps of the wing. The officer sat him down on a chair on the landing, then, at 9.42am, radioed for immediate medical assistance. Within a few minutes, several nurses arrived and assessed him. CCTV footage shows that he was conscious and able to talk to staff. A nurse examined him and found that his pulse rate was high, but he was not short of breath or in distress. At around 10.00am, two nurses took him, by wheelchair, to the prison's healthcare centre.

29. A prison GP immediately assessed the man. He told the doctor that he had been feeling unwell for the past three weeks, including heartburn and stomach pain, and had experienced bleeding when he opened his bowels. The doctor diagnosed a suspected perforated ulcer and referred him to hospital as an emergency. Staff called an ambulance at 10.40am and it arrived at 11.05am.

30. At 11.36am, the ambulance took the man to hospital. Two prison officers escorted him using handcuffs to restrain him, which they replaced with an escort chain when he arrived at hospital. (An escort chain is a long chain with a handcuff at each end, one of which attached to the prisoner and the other to an officer.)

31. Hospital tests, including an endoscopy (a camera inserted inside the man's stomach), showed that he had internal bleeding. His condition deteriorated and, at around 10.00pm, hospital staff admitted him to the intensive care unit. At 12.50am, one of the escort officers recorded in the escort log that his left arm was very swollen. He therefore contacted the manager in charge of the prison that night, who agreed that the escort officers could remove his restraints.

32. At around 1.00am, the man's condition deteriorated significantly and he had a cardiac arrest. Doctors successfully resuscitated him and placed him on a life support machine. They advised the escort officers to contact his next of kin. At around 2.00am, the manager called the man's sister and mother and told them that he was in a critical condition in hospital. His family arrived at the hospital an hour later. He had further cardiac arrests and, on the last occasion, the resuscitation attempts were unsuccessful. At 5.30am on 31 October, a hospital doctor certified his death.

33. The prison issued notices informing staff and prisoners of the man's death and offering support to anyone affected. The prison's Head of Security and Operations and a prison chaplain spoke to the escort officers and offered them support.

34. Later that morning, the prison asked the chaplain to act as the prison's family liaison officer. He telephoned the man's sister and offered condolences and support. He also contacted the man's brother to inform him that his brother had died. The Director wrote to the family to offer his condolences. In line with national guidance, the prison offered a contribution to the cost of the funeral, which was held on 19 November.

Post-mortem

35. A post-mortem examination, found that the cause of death was sepsis (infection of the whole body) with disseminated intravascular coagulation (blood clotting) and acute pancreatic and gastric ulceration.

ISSUES

Clinical care

36. The man's medical records show that he had complained of stomach and back pains since 23 October and nurses had given him paracetamol. On Tuesday 28 October, he sent two messages to healthcare staff using CMS requesting medical attention, shortly before and just after 3.30pm. In one of these messages he wrote:

> "internal bleeding I haven't been to the toilet in over 2 weeks and I went this morning the pain just to push out was so severe I had to look at it there was blood everywhere black colour very dark blood I get stomach pain every morning and night."

37. A healthcare assistant responded to both messages within 40 minutes, indicating that an appointment had been booked. There is no record of the time of the appointment, but another nurse subsequently explained that when the man collected his methadone on 30 October, he appeared unwell. She noticed that an appointment had been scheduled for 31 October, so she cancelled it and arranged for him to be seen immediately. There is no record to show where the nurse saw that he had a GP appointment on 31 October or what the appointment was for, but we assume that this was the appointment the healthcare assistant had made.

37. When interviewed, the healthcare assistant said that she was unaware of any written policies about the use of the CMS. We have found this to be the case and it is concerning that there is no clear guidance for healthcare staff about how to assess and prioritise requests received on CMS. CMS undoubtedly has some benefits for prisoners, but we do not consider that an electronic communication system can be a substitute for effective personal intervention when a prisoner needs an urgent healthcare intervention.

38. The healthcare assistant explained that she used her discretion when assessing the urgency of a response and asked a nurse or a GP for advice when she was not sure about the seriousness and priority required. She had no triage protocols to follow. She deals with a high number of CMS requests each day and could not remember what she did specifically in relation to the man's request. However, she said that if a prisoner had stated that they were bleeding, she would tell a nurse or doctor. In his case, there is no record of this or that a nurse or doctor took any action in response.

39. The man complained of a serious medical condition (internal bleeding), which should have led to an urgent or immediate assessment, but this did not happen. Healthcare staff did not assess these symptoms until nurses took him to the healthcare centre two days later, on the morning of 30 October. The clinical reviewer noted that, from his arrival at Thameside until the morning of 28 October, the clinical care he received, including drug treatment, was satisfactory. However, he concluded that, overall, his care was not equivalent to that he could have expected in the community, as the response

to his request for medical attention on 28 October was unsatisfactory. The clinical reviewer noted that, if he been assessed and admitted to hospital on 28 October, it is possible that his death could have been prevented.

40. We agree with the clinical reviewer's assessment and consider there should be a clear and safe process for the use of CMS for healthcare matters, to ensure effective triage by trained staff. We are also concerned that there is no clear, auditable record of healthcare appointments and consider that healthcare staff should use SystmOne to record all appointments and the reasons for them. We make the following recommendations:

The Director and the Head of Healthcare should produce written policy and guidance on the operation of the Custodial Management System for healthcare matters. This should include safe and effective protocols for prioritising patients to ensure that those with potentially serious conditions are assessed urgently.

The Head of Healthcare should ensure that healthcare staff use SystmOne to record all important information about a prisoner's health, including requesting and recording appointments.

Restraints, security and escorts

41. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

42. On 30 October, the man went to hospital by emergency ambulance. The risk assessment indicated that he presented a low risk of escape, but it contained several flaws. His most recent conviction related to an attack on a hospital employee, but the risk assessment indicated that he was not a known risk to hospital staff. The GP who assessed him before he referred him to hospital told the investigator that he needed a wheelchair to move because of his health condition (a suspected perforated ulcer). However, the medical information section of the risk assessment contains no information about whether his condition impacted on his risk of escape, as the court judgement requires. The authorising manager did not complete the section of the document titled 'Justification for Decisions Made'.

43. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken

into account and balanced against the security risks. The man was serving a relatively short prison sentence, from which he was due to be released in less than a week. He had a suspected perforated ulcer, a painful condition that meant his mobility was extremely limited and he needed a wheelchair. He remained restrained for some time after his condition became critical and he was admitted to the intensive care unit. We consider there should have been an immediate review at that stage. We are not satisfied that the use of restraints was justified by fully considered risk assessments that took into account his risk and condition at the time, in line with the 2007 High Court judgement.

44. Ultimately, it is the Director's responsibility to ensure that the process is managed properly. However, the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities, and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Director and the Head of Healthcare 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.

Liaison with the man's family

45. Prison Service Instruction (PSI) 64/2011, Safer Custody, requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill. Prison Rule 22(1) states:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

46. At 10.30am on 30 October, a prison GP diagnosed the man with a suspected perforated ulcer and he was taken to hospital by emergency ambulance. His condition later deteriorated. At 2.00am on 31 October, the acting manager of the prison telephoned the man's family to inform them that he was in hospital, seriously ill. His family did not reach the hospital until shortly after 3.00am, by which time his condition was very critical.

47. We are concerned that the prison did not inform the man's family immediately when he was taken to hospital by emergency ambulance or, at the very least, when his condition deteriorated and he was admitted to the intensive care unit at 10.00pm that night. We see too many cases where prisoners' families are not told that they have been admitted to hospital and do not have the opportunity to see seriously ill prisoners before they die. It is therefore important that prisons follow the requirement of Prison Rules to inform

families “at once” when a prisoner become seriously ill. We make the following recommendation:

The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed promptly so that, where possible, they are able to visit them in hospital without delay.

RECOMMENDATIONS

1. The Director and the Head of Healthcare should produce written policy and guidance on the operation of the Custodial Management System for healthcare matters. This should include safe and effective protocols for prioritising patients to ensure that those with potentially serious conditions are assessed urgently.

2. The Head of Healthcare should ensure that healthcare staff use SystmOne to record all important information about a prisoner's health, including requesting and recording appointments.

3. The Director and the Head of Healthcare 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.

4. The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed promptly so that, where possible, they are able to visit them in hospital without delay.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Director and the Head of Healthcare should produce written policy and guidance on the operation of the Custodial Management System for healthcare matters. This should include safe and effective protocols for prioritising patients to ensure that those with potentially serious conditions are assessed urgently.	Accepted	The Healthcare 'General / Query' option on the Custodial Management System will be removed. In its place, the prison will introduce a Healthcare Helpline for prisoners, which will be available seven days a week between the hours of 07:30 and 08:15 each morning. Prisoners will be able to speak to a member of the healthcare team during these times, for initial assessment and triage of their medical condition. Following this assessment they may be referred onto the appropriate medical practitioner if applicable. Outside the Helpline times (07:30 and 08:15), prisoners can request healthcare assistance by using the in-cell call system or by speaking to a member of wing staff. The Healthcare Applications for 'Request an Appointment' and for 'Request a Medication Review' will remain in place. The Director and the Head of Healthcare will produce written policy and guidance on this process. A Prisoners' Notice will also be issued to advise of this change.	11 May 2015 Healthcare Manager / IT Manager

2	The Head of Healthcare should ensure that healthcare staff use SystmOne to record all important information about a prisoner's health, including requesting and recording appointments.	Accepted	Internal appointments, which are pre-booked on the Custodial Management System, will be input into the Healthcare Appointment Ledger on SystmOne. In addition to this, a proof check will also be performed to ensure that the Custodial Management System and SystmOne appointment reconcile.	30 April 2015 Healthcare Manager
3	The Director and the Head of Healthcare 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	Risk Assessment training will be developed and delivered to all staff undertaking risk assessments for prisoners taken to hospital so that they understand the legal position, and that any assessment fully take into account the health of a prisoner and is based on the actual risk the prisoner presents at the time.	25 May 2015 Healthcare Manager / Security Manager
4	The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed promptly so that, where possible, they are able to visit them in hospital without delay.	Accepted	In the event of a prisoner being identified as having serious or life threatening illness before leaving the prison, the Duty Manager/Orderly Officer will follow the Local Security Strategy (LSS). During the escort of the prisoner to hospital, any deterioration will be reported by escorting staff to the Orderly Officer who will determine whether to activate contact with next of kin. The LSS will then be updated to include due consideration of contacting the next of kin where the prisoner has a serious/life threatening illness as affirmed by hospital staff.	30 April 2015 Security Manager