Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Benjamin Chimbalagna a prisoner at HMP Channings Wood on 19 December 2015

A report by the Prisons and Probation Ombudsman
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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*

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 Benjamin Chimbalagna died on 19 December 2015 of a heart attack following a stroke, while a prisoner at HMP Channings Wood. He was 43 years old. I offer my condolences to Mr Chimbalagna's family and friends.

Mr Chimbalagna had high blood pressure and diabetes but frequently did not take the medication he was prescribed to control these conditions, which increased his risk of stroke and cardiac disease. While he had the mental capacity to take decisions about his care and the right to refuse to treatment, the clinical reviewer considers that prison healthcare staff should have done more to encourage his compliance and monitor his conditions. I am not satisfied that the use of restraints when Mr Chimbalagna was taken to hospital after suffering a stroke was justified by fully considered risk assessments.

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 **June 2016**

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Summary

Events

1. On 7 August 2013, Mr Benjamin Chimbalagna was sentenced to six years in prison. He had been at HMP Channings Wood since November 2013.

2. When he first arrived in prison, a nurse noted that he had long-standing diagnoses of schizophrenia, hypertension (high blood pressure) and type 2 diabetes. Mr Chimbalagna was prescribed medication for these conditions but often did not take his medication for hypertension and diabetes.

3. In September, a prison GP referred Mr Chimbalagna to a diabetes specialist. He had not received an appointment before he moved to Channings Wood in November 2013, and this was never followed up.

4. Throughout 2014 and 2015, Mr Chimbalagna's compliance with his medication for hypertension and diabetes continued to be poor. In April 2015, a prison GP suggested giving him his medication daily to see if this helped, but there is no record that this was done.

5. In November 2015, a prison GP referred Mr Chimbalagna to a diabetes nurse, but the prison did not have a specialist diabetes nurse and no one referred him to a relevant hospital or community diabetes specialist instead.

6. On the night of 10 December, Mr Chimbalagna was unwell. A doctor who happened to be in the prison at the time, examined him and suspected that he had suffered a stroke. He was admitted to hospital and doctors confirmed he had had stroke.

7. Mr Chimbalagna remained in hospital and officers used an escort chain to restrain him. On the afternoon of 19 December, he suffered a cardiac arrest. Officers removed the chain and hospital staff tried to resuscitate him but were unsuccessful and Mr Chimbalagna died.

Findings

8. We are satisfied that Mr Chimbalagna received appropriate care for his mental health in prison. However, the management of his diabetes and hypertension was not equivalent to community standards. Mr Chimbalagna often did not take his medication, and had the right and the capacity to refuse treatment, but there was little evidence of active plans to encourage him to comply. There were no clear care plans to ensure consistent and good management of his long-term conditions in line with National Institute for Health and Care Excellence (NICE) guidelines.

9. There was insufficient healthcare input into risk assessments to justify the use of restraints in hospital and we are concerned that a prison manager refused a request to remove the restraints for a test in hospital without a record of the reasons.

Recommendations

- The Head of Healthcare should ensure that all prisoners with long-term health conditions have clear personalised care plans, with stated aims, planned interventions and monitoring and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The Governor and 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.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

11. The investigator visited Channings Wood on 29 January. He obtained copies of relevant extracts from Mr Chimbalagna's prison and medical records.

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

13. The investigator and clinical reviewer interviewed three members of staff at Channings Wood on 29 January. The clinical reviewer interviewed another member of staff by telephone on 7 February.

14. We informed HM Coroner for Devon and Cornwall of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. Mr Chimbalagna's family were informed the initial report was available, but did not wish to receive a copy or make any comment.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Channings Wood

17. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds over 700 men. Dorset NHS University Trust provides health services at the prison. There is one permanent GP, with locum GPs running additional clinics. Nurses are on duty everyday and there is an out of hours GP service.

HM Inspectorate of Prisons

18. The most recent inspection of Channings Wood was in September 2012. The Inspectorate noted that healthcare staff were generally helpful and respectful, although many prisoners were unhappy with the support provided. Prisoners had reasonably good access to nurses and a GP, and urgent problems could be dealt with the same day. There were delays for some clinics and chronic disease management was not always systematic.

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 August 2015, the IMB reported that although staff were still working under pressure, morale had improved with the appointment of a permanent healthcare manager. Recruitment for other permanent healthcare staff was ongoing. The IMB was concerned about the paper based prescription system and that there were long queues at the dispensary.

Previous deaths at HMP Channings Wood

20. Mr Chimbalagna was the third prisoner to die from natural causes at Channings Wood since the start of 2015. We have raised the issue of the inadequately justified use of restraints before.

Key Events

21. On 7 August 2013, Mr Benjamin Chimbalagna was sentenced to six years in prison for a sexual offence and arrived at HMP Dorchester that day.

22. At an initial health screen, a nurse noted that Mr Chimbalagna had a history of hypertension, type 2 diabetes and schizophrenia. He had been prescribed medication for these conditions but said he only took medication to help control his schizophrenia. He declined any medication for hypertension and diabetes. The next day, a prison GP saw Mr Chimbalagna and he said he would take medication for hypertension but not for diabetes, as he did not consider he needed it.

23. On 29 August, Mr Chimbalagna told the GP that he would think about resuming his diabetic medication. The GP advised him about diet and exercise.

24. Over the next few months, Mr Chimbalagna's compliance with his medication for hypertension and diabetes was poor. A prison GP referred Mr Chimbalagna to a specialist diabetic clinic on 5 September. Mr Chimbalagna continued not to take his medication, but another prison GP reviewed him on 27 September and concluded that he had the mental capacity to make decisions about his care and treatment.

25. On 1 November, Mr Chimbalagna was transferred to HMP Exeter as Dorchester was closing and, on 18 November, he was moved to HMP Channings Wood. He had not received a diabetic appointment before leaving Dorchester, and no one followed up the prison GP's referral.

26. Throughout 2014 and 2015, Mr Chimbalagna's compliance with taking his medication for hypertension and diabetes continued to be very poor. He needed eye injections to treat swelling caused by diabetes, but a number of appointments at hospital were cancelled as his blood pressure was too high. Despite this, there were no clear care plans aimed at reducing his blood pressure.

27. On 27 April 2015, a prison GP noted that she was not convinced that Mr Chimbalagna had been taking his medication and suggested trying daily collection of his medication to see if this would help. However, no one acted on this suggestion. Records show he continued to collect weekly supplies of medication and often did not take the medication for hypertension and diabetes.

28. On 20 November, a prison GP reviewed Mr Chimbalagna and took an HbA1c test, which identifies average blood sugar levels for diabetic patients over a period of 2-3 months. The result was a reading above 120 mmol/l, which was high. The GP recommended that a specialist diabetic nurse should review Mr Chimbalagna. The prison had no diabetic specialist nurse and no one referred him to an external specialist.

29. At approximately 10.45pm on 10 December, wing staff informed a prison manager that Mr Chimbalagna was not well. The manager was with an out of hours GP who was at the prison to assess another prisoner, and they both went straight to see Mr Chimbalagna. Mr Chimbalagna was slurring his words and was drooping on one side of his body and the GP suspected that he had suffered

a stroke. The manager radioed the prison's communication room and asked for an emergency ambulance which arrived at 11.15pm. Mr Chimbalagna was admitted to hospital and hospital doctors confirmed he had suffered a stroke. Officers restrained Mr Chimbalagna by handcuffs on the way to hospital and used an escort chain after he arrived.

30. Mr Chimbalagna remained in hospital. On the afternoon of 19 December, he had a cardiac arrest and hospital staff could not resuscitate him. At 3.17pm, a doctor recorded that Mr Chimbalagna had died.

Contact with Mr Chimbalagna's family

31. At 7.00am on 11 December, the prison manager contacted Mr Chimbalagna's nephew, who he had named as his next of kin, to let him know that Mr Chimbalagna was in hospital. On 12 December, the prison arranged for members of Mr Chimbalagna's family to visit him in hospital during normal visiting hours.

32. On 19 December, Mr Chimbalagna's sister had been visiting him. At 3.20pm, she was with the hospital chaplain when a nurse told her that Mr Chimbalagna had died. A custodial manager met Mr Chimbalagna's sister at 4.15pm to offer his condolences and support. At 6.20pm, the duty governor went to the hospital and added his condolences.

33. Mr Chimbalagna's sister acted as the family's main point of contact with the prison. A Supervising Officer was the prison's family liaison officer and kept in contact with Mr Chimbalagna's sister, and helped with arrangements to repatriate his body to Malawi, his home country. The prison paid the repatriation costs, in line with national policy.

Support for prisoners and staff

34. After Mr Chimbalagna's death, a senior prison manager and the care team offered support to staff who had been affected by his death.

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

Post-mortem report

36. A post-mortem examination found that Mr Chimbalagna had died of ischaemic and hypertensive heart disease (a restriction of blood to the heart as a result of high blood pressure) with a background of cerebral infarction (a stroke).

Findings

Clinical care

37. Mr Chimbalagna arrived in prison already diagnosed with schizophrenia, hypertension and type 2 diabetes. His mental health remained stable during his time in prison and his compliance with medication for his mental health was good. The clinical reviewer considered that the mental health care Mr Chimbalagna received was delivered professionally, was of a good standard and equivalent to that he could have expected to receive in the community.

38. However, Mr Chimbalagna consistently refused medication for hypertension and diabetes, which was problematic for his care. The clinical reviewer was satisfied the prison clinicians appropriately assessed Mr Chimbalagna and considered he had mental capacity to make such decisions but he was concerned about aspects of the management of his hypertension and diabetes.

Diabetes management

39. The clinical reviewer considered that Mr Chimbalagna's diabetes care was not equivalent to that he could have expected in the community. His non-compliance with diabetic medication caused considerable problems with high blood sugar levels and the clinical reviewer was not satisfied that the overall response of GPs was sufficient to address this.

40. Diabetes is a constant state which clinicians should aim to help the patient control. The four recorded HbA1c tests showed high blood sugar levels but there was little in the records to show that most GPs considered any proactive treatment or active encouragement to take his medication. There were no clear care plans to ensure effective monitoring and review of his diabetes.

41. In September 2013, a GP at Dorchester referred Mr Chimbalagna to a diabetic specialist. Two months later he moved briefly to Exeter and then to Channings Wood. No one followed up the referral and Mr Chimbalagna never saw a specialist. In November 2015, a GP at Channings Wood asked for a diabetic nurse to review Mr Chimbalagna after a high HbA1c test. There was no specialist nurse at the prison, but no one referred him to a community specialist or hospital diabetic nurse instead. (The clinical reviewer noted that this partly because of poor communication systems between healthcare staff and had made a recommendation about this, which the Head of Healthcare will need to address.) The clinical reviewer considered that GPs should have referred Mr Chimbalagna to hospital diabetic services when it was evident that GP treatment was not working.

Hypertension management

42. The clinical reviewer was also concerned about the care and management of Mr Chimbalagna's hypertension, which he considered was not equivalent to community care. With very few exceptions, Mr Chimbalagna's blood pressure remained in the very severe range throughout his time in prison. As with the management of his diabetes, he considered that GPs should have been more proactive in treating his hypertension and should have referred him to a hospital

specialist when his blood pressure remained high. Mr Chimbalagna's poor compliance with his medication clearly contributed to this, but apart from a few occasions, there was no evidence of any sustained attempts at encouraging him to take his medication and no clear care plans to ensure effective monitoring and review of his hypertension.

43. The clinical reviewer noted that poorly controlled diabetes and poorly controlled hypertension are both substantial risk factors for the development of heart disease and strokes. The primary responsibility for this lay with Mr Chimbalagna because of his refusal to take medication as prescribed. However the clinical reviewer considered that the high level of risk presented by this poor control was not sufficiently recognised by most of the GPs responsible for his care. National Institute for Health and Care Excellence (NICE) guidelines for managing type 2 diabetes and hypertension were generally not followed. We make the following recommendations:

The Head of Healthcare should ensure that all prisoners with long-term health conditions have clear personalised care plans, with stated aims, planned interventions and monitoring and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidelines.

Restraints, security and escorts

44. 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 a 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 judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

45. On 10 December 2015, a prison manager completed the risk assessment for Mr Chimbalagna's emergency admission to hospital after his suspected stroke. The risk assessment stated that his risk to the public and of escape was normal. He decided that officers should restrain Mr Chimbalagna by handcuffs on the journey to hospital and use an escort chain at the hospital. (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.) There was no healthcare input into the risk assessment although a GP was present at the time. He said that officers could not remove the restraints for treatment, without the duty governor's permission.

46. On 11 December, an updated risk assessment simply indicated that healthcare staff did not have any medical objections to the continued use of restraints. There was no comment from healthcare staff about his condition and whether this affected his ability to escape.

47. On 17 December, a hospital behavioural therapist asked officers to remove the escort chain to allow cognitive testing. The records show that a prison manager

refused the request but no reasons were given. When asked, he said he could not recall this decision.

48. Mr Chimbalagna continued to be restrained by an escort chain in hospital until 1.40pm on 19 December, when he had a cardiac arrest and the crash team were called. Mr Chimbalagna was pronounced dead under two hours later.

49. We are concerned that the risk assessment when Mr Chimbalagna went to hospital did not comment on his condition following his suspected stroke or how this affected his risk of escape, as the 2007 High Court judgment requires. We accept that this was an emergency admission, but subsequently, there was no meaningful healthcare input into the risk assessment in line with guidance issued by the Prison Service after the High Court judgement. It is also concerning that a prison manager refused a hospital request for restraints to be removed with no record to explain the decision or any record that he discussed this with clinical staff, as Prison Service guidance requires. We make the following recommendation:

The Governor and 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.

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