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 on 17 September 2014 at HMP Lewes

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 lung and heart disease on 17 September 2014, at HMP Lewes. He was 49 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. A doctor reviewed the clinical care the man received at Lewes. The prison cooperated fully with the investigation.

The man was remanded to HMP Lewes in 2007 and received an indeterminate sentence for public protection in February 2008. Doctors had diagnosed the man with chronic obstructive pulmonary disease (COPD) many years before. By the time he arrived at Lewes, the disease was severe and became progressively worse. On 17 September, a nurse found the man unresponsive in his cell and he and other staff tried to resuscitate him. Paramedics arrived and took the man to hospital, but he was pronounced dead shortly after.

The clinical reviewer was satisfied that the man's care in prison was equivalent to that he could have expected to receive in the community. It is clear that healthcare staff managed his condition well and I am satisfied that the man was well cared for at Lewes.

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 **February 2015**

CONTENTS

SUMMARY

1. The man was sentenced to an indeterminate sentence for public protection in 2008. He had been at HMP Lewes on remand since 2007 and, apart from a brief transfer to another prison, he remained at Lewes until he died.

2. Doctors had diagnosed the man with chronic obstructive pulmonary disease (COPD – lung disease) many years before he was sent to prison and by the time he arrived at Lewes, his COPD was severe. The man was very underweight and also suffered from a chronic ear condition.

3. The man preferred to remain on a standard prison wing for as long as possible and prison staff gave him a cell adapted for prisoners with disabilities. Nurses visited him each day and prisoner carers helped him with daily living. The man became confined to his bed from 2012.

4. A hospice nurse visited the man from early 2012 to assess whether he needed hospice care and to advise on his end of life treatment. Throughout 2012 and 2013, healthcare staff continued to see him frequently. The man refused to move to the healthcare unit.

5. In January 2014, the prison arranged to transfer the man to HMP Isle of Wight which had better facilities to meet his needs. However, the man did not want to go to another prison and, in February, he agreed to be admitted to the healthcare unit at Lewes instead.

6. In March, after a discussion with a nurse and a doctor, the man decided he wanted resuscitation to be attempted if he had a cardiac or respiratory arrest. On 12 June, doctors said that the man had less than three months to live. The prison submitted an application for compassionate release on 20 August. The Parole Board recommended the application should be approved, but the Secretary of State for Justice rejected it.

7. At 7.36am on 17 September, a nurse found the man slumped and unresponsive on his bed. The nurse and other staff tried to resuscitate the man. They did not use the expected emergency code but asked the control room to call an ambulance. Paramedics arrived and took over the emergency response. They took the man to hospital but he died shortly afterwards.

8. We agree with the clinical reviewer that the man's care in prison was equivalent to that he could have expected to receive in the community. Healthcare staff looked after him well at Lewes and managed his COPD in line with national guidance. His palliative care was delivered in line with national standards

THE INVESTIGATION PROCESS

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

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record.

11. NHS England commissioned a doctor to review the man's clinical care at the prison.

12. We informed HM Coroner for Sussex 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 contacted the man's family to explain the investigation. They did not have any specific issues for the investigation to consider.

14. The man's family received a copy of the draft report but made no further comment. The prison also received the draft and noted two factual inaccuracies, which have been amended.

HMP LEWES

15. HMP Lewes is a local prison which serves the courts of East and West Sussex and holds up to 729 remanded and sentenced adult men and young offenders on remand. The Sussex Partnership NHS Foundation Trust provides healthcare services. There is an inpatient unit with 19 beds.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Lewes was in November 2012. The Inspectorate found that chronic disease management had improved since the time of their previous inspection, with appropriate identification and treatment of the few prisoners with chronic diseases. They found that nurses had a good range of skills and expertise but healthcare staff shortages were a problem.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to 31January 2014, the IMB commented that complaints about healthcare and staffing issues were a concern. They described the healthcare building as old and inadequate, which made it difficult to provide an effective healthcare service.

Previous deaths at HMP Lewes

18. The man was the first prisoner to die from natural causes at Lewes since the start of 2012. There have been two subsequently. We have also investigated four self-inflicted deaths at the prison since 2012. There were no significant similarities with the circumstances of the other deaths.

KEY EVENTS

19. The man was remanded to HMP Lewes on 11 October 2007 for sexual offences. On 15 February 2008, he was sentenced to an indeterminate sentence for public protection with a minimum time to serve of three years and 328 days before he could be considered for release. The man had long standing chronic obstructive pulmonary disease (COPD) which doctors had diagnosed in the community some years earlier.

20. When the man first arrived at Lewes, nurses noted his body mass index (BMI) was 14.5, which was considered to be seriously underweight. (A healthy BMI is considered to be between 18.5 and 25.) Doctors prescribed nutritional supplements.

21. The man also suffered from cholesteatoma (an increasing collection of skin cells in the middle ear which cause destruction of normal tissue) and meant he often suffered pain in his ear. Doctors diagnosed this condition in 1997 and the man had a number of operations to treat it. Because of the effect of this condition on his balance, the man used a wheelchair from 1997.

22. The man refused to be admitted to the prison's healthcare unit and wanted to live on a standard prison wing for as long as possible. His cell was fitted with rails and trained prisoners acted as carers to help with daily tasks. Nurses visited him frequently in his cell and he always declined to move to the healthcare unit when they suggested it. In May 2011, the man stopped work because of his ill health. In 2012, he became confined to bed and needed continuous access to oxygen. However, he continued to smoke cigarettes against medical advice. The man often refused to attend hospital appointments.

23. A nurse, from St Peter and St James Hospice, first saw the man on 14 March 2012 and discussed his symptoms and improvements that could make him more comfortable. In May, a multidisciplinary meeting at the prison reviewed the man's care and agreed to meet every three to four weeks to review his condition.

24. On 14 January 2013, the man was taken to hospital for assessment as nurses were concerned that he was not responding properly to his oxygen therapy. Two officers escorted him but they did not use restraints. The man returned to the prison the next day. The hospital thought he had been over- using the oxygen in his cell and nurses supervised him using it to ensure that he set it at the correct level.

25. On 16 October 2013, staff from the healthcare unit at HMP Isle of Wight visited the man to discuss his suitability to move there, but he did not want to move. In January 2014, a modern matron noted that the man's needs could not be met adequately on the wing. However, the man refused to be admitted to the healthcare unit. Staff arranged for him to move to the Isle of Wight, but the man then agreed to move to the healthcare unit at Lewes. He moved on 27 February and had a single cell with a hospital bed.

26. The hospice nurse visited the man frequently and, on 10 March, they discussed whether he wanted staff to attempt to resuscitate him if he had a

cardiac or respiratory arrest. The man said that he did not want to make a decision at the time. On 13 March, the man told a prison doctor that he wanted to be resuscitated if it was ever necessary. The doctor recorded this decision.

27. From August, security staff agreed that the man's cell door should be left open at all times so that nurses had easy access.

28. East Sussex County Council assessed the man's social care needs to determine the type of support he would require if he were to be released from prison. On 20 August, they agreed to fund a place and identified a suitable nursing home. The prison submitted an application for compassionate release immediately they received this confirmation. (Four previous applications had been turned down either because the man's prognosis was not clear or because he did not have an appropriate release address).

29. On 12 September, the Parole Board recommended release on compassionate grounds and the recommendation was forwarded to the Secretary of State for Justice.

30. On 15 September, staff told the man that the Parole Board had given their approval for him to be transferred to a nursing home. The man was reported to be pleased about this news and expected to move in the next few days. However, on 16 September, staff told the man that the Secretary of State had reviewed his case and had decided not to approve his release as he considered he still posed a risk to the public.

Events on 17 September

31. At 5.44am on 17 September, a nurse went to see the man in his cell because he said he was feeling very weak and unwell. The nurse gave him lorazepam (a relaxant that is useful to relieve feeling short of breath) and sevredol (morphine) as prescribed.

32. At 7.36am, a nurse found the man slumped on his bed. He was not breathing and did not have a pulse. The nurse called staff for help, attached a defibrillator (which analyses heart rhythm and delivers electric shocks to restart the heart). The defibrillator did not find any shockable heart rhythm and the nurse began to try to resuscitate him. Two nurses and an officer arrived and helped with the cardiopulmonary resuscitation. At 7.37am, one of the nurses asked the control room to call an ambulance. No one radioed a code blue medical emergency which is the usual requirement when a prisoner is unconscious or not breathing.

33. An Operational Support Grade (OSG) in the control room called an ambulance. As she did not have full information about the emergency, the ambulance service initially set a target response time of 30 minutes. At 7.41am, the OSG informed the ambulance service that the man was not breathing and they upgraded the target response time to eight minutes. The ambulance arrived at the prison at 7.51am. Paramedics took over the man's care and took him to hospital at 8.25am. He was not restrained. The man arrived at the Royal Sussex Hospital at 8.43am and hospital doctors pronounced him dead at 8.55am.

Support for staff and prisoners

34. The Governor issued notices informing staff and prisoners of the man's death and offered support for those who needed it. A senior manager debriefed the staff involved in the emergency response and offered appropriate support. Staff checked prisoners considered at risk of suicide and self-harm in case they had been adversely affected by the news of the man's death. The prison held a memorial service for the man on 25 September.

Informing the man's family

35. The man had not nominated a next of kin. A probation officer acted as the family liaison officer. He ensured the man's daughters were notified of his death and arranged for them to visit Lewes. The funeral was on 2 October and, in line with national guidance, the prison contributed to the costs.

Cause of death

36. The Coroner gave the cause of death as chronic obstructive pulmonary disease and ischaemic heart disease.

ISSUES

Clinical Care

37. The clinical reviewer concluded that the man received a good standard of care at the prison which was equivalent to the care he could have expected to receive in the community. The man's treatment was in line with the National Institute for Health and Care Excellence (NICE) guidelines on the management of COPD and healthcare staff reviewed him regularly.

38. The clinical reviewer considered that healthcare staff referred the man to secondary services promptly when necessary and ensured there was follow up, although the man sometimes refused to attend appointments. The man's palliative care was in line with Macmillan Adopted Prison Standards. The clinical reviewer commended the healthcare staff and prisoner carers who looked after the man for their persistence, despite his lack of compliance with treatment.

39. The hospice nurse and doctor discussed and recorded the man's preferences about resuscitation and this was respected. Although unsuccessful, they made appropriate resuscitation efforts when he was found unresponsive in his cell.

Emergency response

40. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains a mandatory instruction that prisons should have a local protocol which gives guidance on efficiently communicating the nature of a medical emergency (a code blue emergency call should be used for respiratory issues or if a prisoner is unconscious), ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance.

41. Although we would normally expect staff to follow the required procedures, in this case the emergency was in the healthcare unit so nurses were immediately on hand to administer emergency treatment. A nurse asked the control room to call an ambulance immediately and this was done. After some initial need to clarify the nature of the emergency with the ambulance service, an ambulance arrived quickly. It is preferable to use the agreed emergency medical codes wherever an emergency occurs in a prison so that all staff use standard emergency procedures that they are familiar with. However, in this case we are satisfied that the response was as quick, if not quicker, than if a code blue had been called, and make no recommendation.