Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Clarke a prisoner at HMP Pentonville on 13 August 2016

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.

The 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 Kenneth Clarke died in hospital sepsis and multi-organ failure, on 13 August 2016. Mr Clarke was 55 years old. I offer my condolences to his family and friends.

We agree with the clinical reviewer that the care Mr Clarke received from a doctor at HMP Pentonville on 25 July 2016, prior to his emergency admission to hospital, was not equivalent to that he could have expected to receive were he in the community.

We are concerned that the prison planned to restrain Mr Clarke, who suffered from widespread osteoarthritis and poor mobility, with double handcuffs, despite medical advice warning against their use and have not been able to justify that decision. It is of concern that this decision caused Mr Clarke to refuse to attend hospital appointments. We note that officers did not restrain him during his final, emergency admission to hospital.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **March 2017**

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Summary

Events

1. On 17 November 2014, Mr Kenneth Clarke was remanded into custody and sent to HMP Pentonville. On 16 December 2014, he was sentenced to six years in prison for wounding with intent to cause grievous bodily harm. He had a history of heart disease, osteoarthritis and chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), for which he was appropriately treated. Mr Clarke smoked but frequently declined smoking cessation advice.

2. While in custody, prison GPs referred Mr Clarke to an ear, nose and throat specialist and an oncologist, after he suffered from changes to his voice and unexplained hoarseness. After a series of tests, an oncologist diagnosed Mr Clarke with severe dysplasia (abnormal pre-cancerous cells) of the vocal cords. Surgeons also inserted two stents in his left coronary artery in September 2015.

3. In early 2016, Mr Clarke suffered two episodes of breathlessness. Prison GPs treated this with inhalers and recommended that he stop smoking. Mr Clarke also refused to attend two hospital appointments because he did not want to be seen in restraints and osteoarthritis in his wrists made wearing restraints uncomfortable.

4. On 7 June, a prison GP reviewed Mr Clarke, as he was short of breath. The GP diagnosed a chest infection and an exacerbation of COPD so prescribed antibiotics and an inhaler.

5. On 24 July, a nurse saw Mr Clarke, who felt unwell with laboured breathing. The nurse found his vital signs to be largely normal but referred him to the prison GP for review the following day.

6. In the early hours of 25 July, Mr Clarke suffered from respiratory distress so a nurse called an emergency ambulance. Paramedics examined Mr Clarke, diagnosed an anxiety attack and advised that he see a doctor during the morning. Later that morning, a prison GP saw Mr Clarke, found that he was suffering from COPD and prescribed inhalers.

7. Later that afternoon, Mr Clarke collapsed and went into a seizure. A nurse called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) and an emergency ambulance was called. A nurse inserted a nasal airway and gave Mr Clarke oxygen. After his seizure stopped, paramedics took Mr Clarke to hospital.

8. Mr Clarke remained in hospital where doctors diagnosed him with a bacterial infection. Despite intensive medical care, his condition worsened and Mr Clarke died at 2.52am on 13 August.

Findings

9. Mr Clarke suffered with ischaemic heart disease, COPD, osteoarthritis and severe dysplasia of his vocal cords. We agree with the clinical reviewer that

healthcare staff treated these conditions appropriately, though there was no evidence of regular comprehensive medical reviews.

10. However, the clinical reviewer did not consider that the care Mr Clarke received from a prison GP on the morning of 25 July was appropriate, because he should have been sent to hospital or admitted to the prison's inpatient unit. On that basis, we agree with the clinical reviewer that the care Mr Clarke received was not equivalent to that he could have expected to receive in the community.

11. We are not satisfied, without documentation to justify the decision, that the prison should have planned to use double handcuffs for planned hospital appointments, despite medical advice advising against their use. We do not consider that the level of restraint was appropriate in light of his widespread osteoarthritis and poor mobility.

Recommendations

- The Head of Healthcare should ensure that all patients 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 Head of Healthcare should ensure that all clinicians seeing patients adequately review their medical record, assess and appropriately examine the patient, take clinical observations as appropriate and record their assessments, in line with national guidelines.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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

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

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

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

15. We informed HM Coroner for Inner North London District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The investigator wrote to Mr Clarke's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

17. The investigation has assessed the main issues involved in Mr Clarke's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

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

Background Information

HMP Pentonville

19. HMP Pentonville is a local prison that holds over 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.

20. Care UK, in partnership with Enfield and Haringey Mental Health Trust, provides primary healthcare services at the prison 24-hours a day, seven days a week. On-site GP's provide daytime cover Monday to Friday and weekend cover between 1.00pm and 5.00pm. There is a large purpose built healthcare centre which has 22 inpatient beds and a day care facility for patients with mental health problems who are managed on the wings.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Pentonville was in February 2015. Inspectors found that healthcare services were overall, reasonably good. There was an appropriate range of primary care services, with acceptable waiting times, although the management of long-term conditions was inadequate.

Independent Monitoring Board

22. 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 February 2016, the IMB reported that waiting times for healthcare appointments are on a par with, or better than, waiting times in the community, with an average of one week's wait to see a GP. However, they noted that medical appointments within and outside the prison were frequently cancelled due to a lack of officers to escort prisoners.

Previous deaths at HMP Pentonville

23. Mr Clarke was the second person to die from natural causes at Pentonville since January 2015. There has been one subsequent deaths. We have made a recommendation about the inappropriate use of restraints before.

Key Events

24. On 17 November 2014, Mr Kenneth Clarke was remanded into custody and sent to HMP Pentonville. On 16 December, he was sentenced to six years in prison for wounding with intent to cause grievous bodily harm.

25. Mr Clarke went into prison with a history of heart disease, osteoarthritis and chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). Healthcare staff prescribed Mr Clarke appropriate medication for these conditions, though he did not receive a comprehensive assessment of his long-term conditions and his medication on arrival at the prison. He was a smoker, though he frequently declined smoking cessation advice.

26. In 2015, prison GPs referred Mr Clarke to an ear, nose and throat specialist and an oncologist, after he suffered from changes to his voice and unexplained hoarseness. After a series of tests, an oncologist diagnosed Mr Clarke with severe dysplasia (abnormal, pre-cancerous cells) of the vocal cords. Surgeons also inserted two stents in his left coronary artery in September 2015.

27. On 16 February 2016, a prison GP reviewed Mr Clarke because he felt breathless, which was not helped by using his inhalers. She found that he was no more breathless than usual, though she planned to review him two days time. After this examination, she noted that his air entry was poor, though there was no sign of infection.

28. Five days later, Mr Clarke refused to attend a cardiology clinic appointment at hospital, because his medication would be given late and hospital staff would tell him to stop smoking.

29. On 17 March, Mr Clarke also refused to attend an oncology appointment at hospital, because he felt embarrassed being in restraints and the osteoarthritis in his wrists made wearing them uncomfortable.

30. On 20 April, a prison GP reviewed Mr Clarke, as he was suffering from breathlessness. He gave Mr Clarke his inhalers and he recovered quickly. The GP also performed an electrocardiogram (ECG – a test to check the heart's rhythm and electrical activity) but it found no issues.

31. On 7 June, a prison GP reviewed Mr Clarke, as he had been short of breath over the previous few days. She noted his throat was inflamed so diagnosed a chest infection and a worsening of his COPD. She prescribed antibiotics and another inhaler, and re-referred him to the oncology clinic because the hoarseness of his voice had also worsened. Mr Clarke attended this appointment and hospital specialists referred him for a biopsy of his vocal cords.

Events from 24 July 2016

32. At around 4.00pm on 24 July, Mr Clarke reported that he was feeling unwell, with a persistent cough and laboured breathing. A nurse noted that Mr Clarke's blood pressure and pulse were slightly raised, though his other observations were normal. The nurse referred him to the prison GP for review the next day.

33. At 5.27am on 25 July, an officer asked a nurse to assess Mr Clarke because he was pale, anxious and agitated. He found him in respiratory distress so called for an emergency ambulance and gave him a salbutamol nebuliser to ease his symptoms. Paramedics examined Mr Clarke and diagnosed him with an anxiety attack. They advised that Mr Clarke should be seen by a doctor that morning rather than taking him to hospital.

34. A prison GP reviewed Mr Clarke at 10.07am and found that he had some difficulty in breathing, was agitated and suffering from COPD. She prescribed him with salbutamol, budesonide and ipratropium bromide inhalers.

35. At around 4.25pm, two nurses assessed Mr Clarke, as he was breathless. They found his oxygen saturation level was low (at 92%) and his respiratory rate and pulse were raised. They gave Mr Clarke a salbutamol inhaler and oxygen which raised his blood oxygen level to 100%.

36. One of the nurses asked a prison GP to review Mr Clarke, and she arrived at his cell at 4.45pm. She found that he was struggling to breathe and unable to talk. She found that his respiratory rate had increased in 20 minutes, his blood pressure was high and very little air was entering his lungs. She asked a nurse to give him a salbutamol nebuliser and then left the cell to call an emergency ambulance.

37. Mr Clarke did not tolerate the salbutamol and he collapsed. At 5.08pm, a nurse called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) and the prison control room rang immediately for an emergency ambulance. Mr Clarke then suffered a tonic-clonic seizure (a generalised seizure that affects the entire brain). The nurse manager arrived as Mr Clarke started his seizure, so she inserted a nasal airway into Mr Clarke to give him oxygen.

38. At 5.20pm, paramedics arrived at Mr Clarke's cell and gave him diazepam to stop the seizure. They stabilised Mr Clarke before taking him to hospital at 6.55pm. Due to his poor physical condition, officers did not restrain Mr Clarke.

39. Mr Clarke remained in hospital, where his condition worsened, and doctors diagnosed him with a bacterial infection. Despite mechanical ventilation, renal dialysis and cardiovascular support, Mr Clarke's condition continued to decline and he died at 2.52am on 13 August.

Contact with Mr Clarke's family

40. Following Mr Clarke's emergency admission to hospital, the prison attempted to contact Mr Clarke's cousin, his named next of kin, but could not do so because the contact details were not valid. After checking Mr Clarke's prison records, they found alternative contact details and, the following day, a family liaison officer told his next of kin about the deterioration in Mr Clarke's health.

41. The officer remained in contact with Mr Clarke's next of kin and arranged hospital visits on 29 July and 12 August. As Mr Clarke's death was imminent, his next of kin agreed to be contacted by telephone when he actually died.

42. On the morning of Mr Clarke's death, the officer telephoned his next of kin, who was preparing to visit him in hospital, and informed him of his death. He then travelled to the next of kin's home to offer his condolences and ongoing support.

43. Mr Clarke's funeral took place on 14 October, which the prison paid for, in line with national instructions.

Support for prisoners and staff

44. After Mr Clarke's death, a senior prison manager debriefed the escorting officer who was present when Mr Clarke died, to ensure he had the opportunity to discuss any issues arising, and to offer care team support.

45. The prison posted notices informing staff and prisoners of Mr Clarke's death and offering support. All prisoners assessed as at risk of suicide or self-harm were reviewed in case they had been adversely affected by Mr Clarke's death.

Post-mortem report

46. A post-mortem examination took place on 21 August and established that Mr Clarke died of multi-organ failure and sepsis. Mr Clarke's COPD and ischaemic heart disease were significant contributors to his death.

Findings

Clinical care

47. Mr Clarke suffered from ischaemic heart disease, COPD, osteoarthritis and severe dysplasia of his vocal cords. We agree with the clinical reviewer that these conditions were cared for appropriately, though there was no evidence of regular, comprehensive reviews, which would have included a medication review, and would have been good practice.

48. While healthcare staff had previously treated Mr Clarke appropriately, the clinical reviewer was not satisfied with a prison GP's interaction with Mr Clarke on the morning of 25 July. He felt that the GP's consultation was unacceptable, considering Mr Clarke's medical history, as the GP did not examine his vital signs or his chest. The clinical reviewer felt that the GP should have ordered follow-up reviews and admission to the prison's inpatient unit. As these actions were not taken, healthcare staff could not explain the cause of Mr Clarke's respiratory distress.

49. Overall, we agree with the clinical reviewer that the events of 25 July meant that the standard of care Mr Clarke received at Pentonville was not equivalent to that he could have expected to receive in the community. We make the following recommendations:

    The Head of Healthcare should ensure that all patients 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 Head of Healthcare should ensure that all clinicians seeing patients adequately review their medical record, assess and appropriately examine the patient, take clinical observations as appropriate and record their assessments, in line with national guidelines.

Restraints, security and escorts

50. 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.

51. Mr Clarke had a history of osteoarthritis, which caused him to suffer with poor mobility. He also used a walking stick and medical supports for his wrists and ankles.

52. On 12 August 2015, a prison GP warned, in Mr Clarke's medical record, that if Mr Clarke were double cuffed (when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs) his mobility would be compromised. In spite of this warning, Mr Clarke had been told that he would be restrained with double handcuffs at an appointment at hospital on 10 September, so he refused to attend it.

53. Mr Clarke also refused to attend an oncology appointment at another hospital on 17 March 2016 because the osteoarthritis in his wrists made wearing restraints uncomfortable. There was no evidence that prison staff discussed this with Mr Clarke or attempted to come up with alternatives arrangements to ensure that he could attend this appointment.

54. Double cuffs are usually used for moving category A or category B prisoners in good health. However, Mr Clarke was a category C prisoner with a number of long term health conditions that affected his mobility and his ability to escape unaided. We have asked Pentonville for the risk assessments created for both of these hospital appointments to see if there is any evidence to justify the proposed use of restraints. They have not provided them. Therefore, we cannot see how the decision to use double cuffs could be justified, particularly in light of the medical advice from a prison GP. We are concerned that the prison's failure to discuss the issue of restraints with Mr Clarke meant that he missed a further hospital appointment. We have raised the issue of the unjustified use of restraints with the prison before. 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 on the use of restraints 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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