

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man on 24 February
2015 while a prisoner at HMP Belmarsh**

Our Vision

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

This is the investigation report into the death of a man, who died of blood poisoning on 24 February 2015, while a prisoner at HMP Belmarsh. He was 41 years old. I offer my condolences to his family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man arrived at Belmarsh on Friday 20 February 2015. He was located on the induction wing, which is also a detoxification unit. Prison nurses and doctors assessed him and he was prescribed methadone and monitored for symptoms of drug withdrawal.

Over the weekend, the man showed his cellmate that he had a painful abscess on his thigh where he had been injecting drugs. There is no evidence that he reported this to prison or healthcare staff.

At 5.30am on Tuesday 24 February, the man pressed his cell bell and said he was having trouble breathing. Nurses assessed him and arranged for him to go to hospital by emergency ambulance. This was the first time that healthcare staff at the prison became aware of the abscess. At the hospital, doctors decided to operate on the abscess. While in the operating theatre, he suffered two heart attacks. He did not recover after the second heart attack.

I am satisfied that the clinical care the man received was equivalent to that he could have expected to receive in the community. He was appropriately treated and monitored for his substance misuse problems. He saw a member of healthcare staff at the prison each day and never mentioned his abscess, even when a nurse discussed safe injecting practice with him. I therefore do not consider that healthcare staff could reasonably have been expected to identify this problem. I am concerned that no one from Belmarsh contacted his family when he was taken to hospital and it took too long to inform them after he died.

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

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SUMMARY

1. On 20 February 2015, the man was sentenced to just less than four months in prison for theft and breaching a community punishment order. He was taken to HMP Belmarsh. Nurses and doctors assessed him and he began a methadone treatment programme for drug dependence. He did not report any other physical or mental health problems to healthcare staff.
2. At a secondary health screen on 21 February, a nurse discussed his health history. The nurse weighed and measured him and checked his blood pressure. The screen did not include any further physical examination and the man did not report any other problems.
3. Over the next two days, healthcare staff monitored the man for drug withdrawal symptoms, at regular intervals. His cellmate said that the man showed him an abscess on his right thigh caused by an infected injection site. He said that the man said it was painful, but there is no evidence that the man told healthcare staff about this.
4. At 5.30am on 24 February, the man rang his cell bell because he was having difficulty breathing. Nurses assessed him. His oxygen levels were low at 67% and he had low blood pressure (80/66). An on-call doctor, advised them to call an ambulance, and he was taken to hospital as an emergency.
5. In hospital, the man had blood tests and doctors were concerned about the abscess on his thigh. He was taken for an operation on the abscess, but before the operation, he had a heart attack. Hospital staff stabilised him, and operated on the abscess. After the operation the man had another heart attack and died at 7.05pm. At 10.40pm, a prison family liaison officer informed his family of his death.
6. The clinical reviewer was satisfied that the clinical care the man received at Belmarsh was equivalent to that he could have expected to receive in the community. We are concerned that no one contacted his family when he was admitted to hospital as an emergency, which might have allowed them the opportunity to see him before he died. It also took too long to inform them of his death. We make one recommendation about this.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
8. She obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator interviewed four members of staff and two prisoners at Belmarsh.
9. NHS England commissioned a doctor to review the man's clinical care at the prison.
10. We informed HM Coroner for Inner South London District of the investigation, who provided the cause of death. We have sent the coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's mother, his nominated next of kin, on 31 March, to explain the investigation. His family asked for information on the searches and assessments he would have had when he arrived at the prison, and if anyone had noted his abscess. They wanted to know what care he had received in prison and whether the prison could have done more to prevent his death. They also wanted to know why no one contacted them as soon as he was taken to hospital and why it had taken three hours to inform them of his death.
12. The man's family received a copy of the draft report. They did not raise any further issues, or comment on the factual accuracy of the report. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP BELMARSH

13. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds over 900 men. Care UK provided healthcare services at the prison at the time the man was there. There is 24-hour healthcare cover and healthcare facilities on each of the houseblocks, as well as in reception, and the first night centre.

HM Inspectorate of Prisons

14. The most recent inspection of Belmarsh was in February 2015. Inspectors assessed that health services were generally satisfactory and improving. Health screening on arrival was very thorough. There was 24 hour nursing cover on the induction spur and that drug misuse nurses and doctors had relevant training.

Independent Monitoring Board

15. 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 report for the year to June 2014, the IMB noted that the treatment rooms on the houseblocks had been refurbished.

Previous deaths at HMP Belmarsh

16. The man was the third prisoner to die of natural causes since January 2013. There were no significant similarities with the circumstances of the other deaths.

KEY EVENTS

17. On Friday 20 February 2015, the man was sentenced to nearly four months in prison for theft and breaching a community punishment order. He was sent to HMP Belmarsh. When he arrived he had a rub down search, and then a strip search. The strip search is for security purposes and not a healthcare check.
18. At initial health screens to assess immediate needs on arrival, he told nurses that he was dependent on drugs and alcohol and said he had been sick at the police station. The initial health screen does not include a routine physical examination and he did not report any pain in his thigh. He claimed he used £40-£50 worth of heroin each day, by subcutaneous (under the skin) injection, known as 'skin popping'. He said he smoked £30 worth of crack cocaine daily and used 20mg of diazepam (a benzodiazepine). He also said he drank between 10-15 bottles of lager a day.
19. A doctor reviewed the man in reception and noted that he felt ill and had told the nurse he had been sick at the police station. He recorded that the man's pulse and blood pressure were both within normal range. The doctor referred him to the prison's Integrated Drug and Treatment Service (IDTS) and began methadone treatment. (Methadone is a heroin substitute used to treat opioid dependence.) As the man showed few serious signs of opiate withdrawal, the doctor prescribed 10mls of methadone, a low dose, to be reviewed after the weekend. He disclosed no other health issues and staff allocated him to a cell on the induction wing, which he shared with two other prisoners.
20. The next day, a nurse saw the man for a secondary health assessment. This is expected to be equivalent to a primary care assessment when registering with a new practice in the community. It allows healthcare staff to gather further medical information, check how the prisoner is settling and give advice about health promotion. The nurse noted that the man said he felt fine. He weighed 58kg and was six foot tall, had a low body mass index and normal blood pressure. The nurse told the investigator that he had asked the man if he had any other health concerns and he did not mention any problems with the injection site on his thigh or elsewhere. There was therefore no reason to carry out any further physical examination. Over the next two days, nurses monitored him regularly for symptoms of drug and alcohol withdrawal.
21. One of the man's cellmates told the investigator that over the weekend, the man had asked him to check the injection site on his thigh because it was so sore he could not sit on it. His cellmate said it was a large red mark, which looked like a bruise, from his hip to the top of his thigh and appeared inflamed. He said that he told the man that he had seen worse infected injection sites and that he probably needed antibiotics. However, we found no evidence that the man reported any concerns about this to staff.
22. On Monday 23 February, the man told a nurse that he had taken illicitly obtained subutex (a drug used to treat opiate dependence) over the weekend, because his methadone dose was insufficient. He said he suffered from locked muscles. His blood pressure was within normal range (110/82). The nurse told the investigator that they discussed safe injecting practices. The man said that he had been 'skin-popping'. When the nurse assessed him, in response to a standard question, he said he had no itching, pins and needles

or burning sensations. The nurse told the investigator that the man had visible scars on his forearms from injections and she had asked him if he had any swelling or redness on his body and he had said he had none. Because he had taken subutex, the nurse referred him to a doctor in line with the IDTS protocol. She told the investigator that the man was mostly concerned with having his methadone dose increased.

23. Later that day, a doctor reviewed the man, who said he felt unwell with general aches and pains. The doctor noted he look slightly unwell and had mild withdrawal symptoms. He increased the methadone dose to 10mls twice daily. There is no record that the man mentioned his sore thigh to the doctor.
24. At 5.30am on 24 February, an officer responded to the man ringing his cell bell. The man told him that he was finding it difficult to breathe and felt as if he was going to pass out. The officer radioed the emergency response nurse and two nurses and a custodial manager all went to the man's cell. He told a nurse that he had breathing difficulties, which had begun the night before. The staff took him to a wing treatment room.
25. Two nurses took the man's observations. He had low oxygen levels (67%), his chest was swollen and his blood pressure was low at 80/66. At about 5.45am, a nurse phoned the on call doctor and explained the situation. The doctor advised them to administer oxygen and call an emergency ambulance and said that he would come to the prison. An ambulance was requested at 5.59am. Paramedics arrived at 6.11am and the doctor arrived shortly afterwards. It was during this emergency response that healthcare staff first became aware that the man had an abscess on his right thigh.
26. Paramedics took him to hospital. Two officers accompanied him and used an escort chain to restrain him. (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.) At hospital, he had blood tests and doctors told the escort officers that the results were worrying.
27. The man continued to feel unwell and have difficulty breathing. One of the escort officers was concerned that the man's condition was deteriorating quickly and hospital staff intended to move him to the intensive care unit. He therefore called the prison at 3.56pm and got permission to remove the restraints. Once the escort chain was removed, doctors took him to theatre to operate on the infected injection site.
28. At 4.15pm, hospital staff told the escort officers that the man had had a heart attack before the surgery could take place and doctors and nurses were treating him. Doctors operated on him later that evening. Just after the operation, he had another heart attack and did not recover. He was pronounced dead at 7.05pm.

Contact with the man's family

29. An escort officer told the investigator that while he was in hospital, he had asked the man whether he wanted someone to let his family know. He had asked them to inform his mother. The officer said he had informed the prison of this but could not recall who he had spoken to, or at what time. There is no

evidence that anyone from the prison attempted to contact the man's mother when he was first taken to hospital or after he was admitted.

30. A Reverend, a prison family liaison officer, was not on duty when the man died, but someone from the prison left a message on his phone, which he got at 9.19pm, asking him to inform the man's family of his death. At 10.42pm, he and another chaplain, went to his mother's home and told her and his father that the man had died. His brother and sister joined their parents. The chaplains offered condolences and support. The prison contributed towards the cost of the funeral, in line with national guidelines.

Support for prisoners and staff

31. A governor's notice informed staff and prisoners of the man's death, and how to access help if they needed it. The staff we spoke to, who had been involved in his care, said that they had felt supported.
32. An officer told the man's cell mates in person that he had died and offered them support.

Post-mortem

33. The man died of septicæmia caused by necrotizing fasciitis, a bacterial infection of the deep soft tissue.
34. The clinical reviewer noted that necrotizing fasciitis is bacterial infection of the deep soft tissues which can be caused by deep penetrating injuries, such as injecting drug use. He noted that skin and soft tissue infections are very common in injecting drug users and the practice of subcutaneous injection, 'skin popping', is an additional major risk factor.

ISSUES

Clinical care

35. The clinical reviewer concluded that the clinical care the man received at Belmarsh was equivalent to that he could have expected to receive in the community. He was satisfied that the methadone maintenance regime was in line with IDTS policies and that staff monitored the man and took his physical observations in line with the prescribed frequency. When he became unwell on 23 February, his treatment and urgent referral to hospital was timely.

Identifying the man's infection

36. The police custody record, which went with the man to prison, showed that he had reported a 'burning' in his thigh, but there is no record that he identified this as an issue with any of a number of healthcare staff he came into contact with at the prison. The information was vague in his general police custody record and not in specific healthcare information. We do not consider that healthcare staff at the prison could reasonably have been expected to identify this. If his thigh had continued to be a problem, we would have expected the man to have raised this with healthcare staff. There is no evidence that healthcare staff were aware of the abscess or that he, or his cellmate, who he showed the abscess to over the weekend, reported it to anyone.
37. A doctor said that on 20 February he asked the man if he had any other health concerns in addition to drug withdrawal, but he said he did not. A nurse told us that when she saw him on 23 February she asked him directly if he had any concerning lumps or bumps, and he did not report any injury, pain or swelling anywhere. She recorded in his medical record at the time that she had asked him about 'tactile disturbances' which would cover these questions. She also recorded that they had discussed safe injecting practices. This would have been the opportunity for the man to mention his abscess, but he did not do so.
38. The first time the man reported his abscess to healthcare staff was on the morning of 24 February, during the emergency response. We are satisfied that healthcare staff could not reasonably have been expected to identify this earlier. It was the man's responsibility to inform staff if he was worried about his sore thigh. Healthcare staff saw and monitored him frequently during his time at the prison and he had many opportunities to report any health concerns.

Family liaison

39. Prison Rule 22 states that if a prisoner dies or becomes seriously ill then the governor should 'at once' inform a prisoner's spouse or next of kin and also any other person who the prisoner may reasonably have asked should be informed. The prison had an address for the man's mother, which was less than two miles from the prison, but not a phone number. However, no one attempted to inform his mother when he was taken to hospital seriously ill on the morning of 24 February. The man asked an officer if his mother could be told he was in hospital. He passed this message to the prison, but there is no

evidence that anyone from the prison tried to contact the man's mother then either.

40. The man was pronounced dead at 7.05pm but his family was not informed of his death until three and a half hours later. This is unacceptably long, particularly as they lived so close by. We consider it was inappropriate to leave a message for an off duty family liaison officer. If there was no other family liaison officer available at the time, a manager from the prison should have gone as soon as possible to inform the man's mother of his death. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that a prisoner's family is notified as soon as possible when a prisoner becomes seriously ill or dies.

RECOMMENDATION

The Governor should ensure, in line with Prison Rule 22, that a prisoner's family is notified as soon as possible when a prisoner becomes seriously ill or dies.

