

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colwyn Baker a prisoner at HMP Elmley on 31 December 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 Colwyn Baker died in hospital on 31 December 2016 of liver and pancreas disease, while a prisoner at HMP Elmley. Mr Baker was 73 years old. I offer my condolences to Mr Baker's family and friends.

Mr Baker had a history of diabetes, hypertension, heart disease and depression when he arrived at Elmley in 2015. He later developed heart failure, chronic kidney disease and anaemia. We could not establish a clear link connecting Mr Baker's known medical conditions and his cause of death.

Although the clinical reviewer identified some areas for improvement in Mr Baker's care at Elmley, these did not affect his death and, overall, she was satisfied that his care was equivalent to that he would have expected to receive in the community. I consider that Mr Baker received a satisfactory standard of medical care at Elmley.

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 2017

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Summary

Events

1. On 27 February 2015, Mr Colwyn Baker was remanded in custody charged with sexual offences and was taken to HMP Elmley. Mr Baker had type 2 diabetes, hypertension, a heart murmur, mobility issues and a history of depression. He was prescribed appropriate medication and medical staff introduced a number of care plans to help manage his various conditions.
2. Mr Baker arrived at Elmley from court with a suicide and self harm warning and staff opened an ACCT (Assessment, Care in Custody and Teamwork - the Prison and Probation Service care-planning system used to support prisoners at risk of suicide or self-harm). He was located in a cell in the healthcare inpatient unit and initially staff kept him under constant watch. He later moved to a cell on a standard wing and the ACCT was closed.
3. On 27 May 2015, Mr Baker was convicted and sentenced to 20 years in prison. He remained at Elmley where, despite regular input and treatment from prison healthcare staff and hospital specialists, his health gradually deteriorated. He developed heart failure, chronic kidney disease and associated anaemia.
4. During the night of 25 December, Mr Baker developed breathing difficulties and became increasingly agitated. A nurse gave him oxygen and checked him every half hour. Just after 7.00am, the nurse decided that Mr Baker needed to go to hospital and called an emergency ambulance.
5. Mr Baker was sent to hospital and, two days later, a senior manager authorised his temporary release on a special purpose licence. Staff made arrangements to move Mr Baker from hospital to a local hospice but he died before this could happen, shortly after midnight on 31 December.
6. Mr Baker died from cirrhosis of the liver (long term liver damage) with chronic pancreatitis (where the pancreas is permanently damaged from inflammation). He had not previously displayed any of the symptoms normally associated with either disease.

Findings

7. We did not establish a clear link connecting Mr Baker's known medical conditions and his cause of death.
8. The clinical reviewer considered that the care Mr Baker received at Elmley was equivalent to that he could have expected to receive in the community.
9. Mr Baker did not have a named clinical lead responsible for the overall management of his care and the management of his diabetes was, in some areas, below that recommended in NICE (National Institute for Health and Care Excellence) guidelines. However, the clinical reviewer did not consider that these issues affected the outcome for Mr Baker and that, overall, his care was satisfactory.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Baker's prison and medical records. On 21 February, he took a statement from a member of healthcare staff.
12. NHS England commissioned a clinical reviewer to review Mr Baker's clinical care at the prison.
13. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. Mr Baker listed a firm of solicitors as his next of kin to manage his affairs once he died. The solicitors are aware of the investigation.
15. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Elmley

16. HMP Elmley is a local prison on the Isle of Sheppey, and serves the courts in Kent. It holds more than 1,250 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides 24 hour primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided good care for prisoners with the most acute needs, though general access to healthcare services remained a problem. They also found that prisoners sometimes missed routine external hospital appointments because of competing prison priorities for escort staff.

Independent Monitoring Board

18. 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 October 2015, the IMB reported that long-term chronic diseases were monitored by well trained healthcare staff. However, they were concerned about the number of prisoners who did not attend healthcare appointments.

Previous deaths at HMP Elmley

19. Mr Baker was ninth prisoner to die from natural causes at Elmley since January 2015. There are no similarities between this and the previous deaths.

Key Events

20. On 27 February 2015, Mr Colwyn Baker was remanded in custody charged with sexual offences. He was sent to HMP Elmley. Mr Baker had type 2 diabetes, hypertension, a heart murmur and mobility issues (having had two hip replacement operations). He walked with the aid of a stick. The prison requested his community medical records and got these within the week.
21. Mr Baker had a history of depression, which a psychiatrist had recently re-diagnosed as Asperger's (a lifelong developmental disability that affects how people perceive the world and interact with others). His medication consisted of pregabalin (for chronic pain), venlafaxine (for depression), metformin (for diabetes), lisinopril and hydrochlorothiazide (to lower blood pressure), simvastatin (to reduce cholesterol), amlodipine (to lower blood pressure) and warfarin (a blood thinner to reduce the risk of a stroke).
22. Mr Baker arrived at Elmley from court with a suicide and self harm warning. He told a mental health nurse, at his initial health assessment, that he had previously made a number of attempts to commit suicide by taking an overdose of prescribed medication.
23. Staff opened an ACCT (Assessment, Care in Custody and Teamwork - the Prison and Probation Service care-planning system used to support prisoners at risk of suicide or self-harm) and kept Mr Baker on constant watch. After a second mental health assessment healthcare staff admitted Mr Baker to the prison inpatient unit. He remained on constant watch.
24. A prison GP reviewed Mr Baker the next morning and described him as 'settled'. Mr Baker told the doctor that he had no thoughts of self harm. He referred him to the mental health team due to his previous history and suicide attempts.
25. Members of the healthcare team saw Mr Baker over the next few days and implemented various care plans, which included plans to monitor heart disease, hypertension, diabetes and his mobility. Mr Baker took warfarin (an anticoagulant used to stop blood from clotting) and was regularly monitored and tested to make sure he took the correct dose. He had regular and ongoing input from the mental health team.
26. Mr Baker went out to court daily for his trial. On 5 March, he came off constant watch but remained subject to continued ACCT monitoring. On 19 April, Mr Baker moved from the inpatient unit to a cell on a standard wing and, on 23 May, the ACCT was closed. However, on 27 May, staff opened a second ACCT after Mr Baker's conviction and 20 year sentence. Staff closed the ACCT the next day as they were satisfied that he no longer presented a risk of suicide or self harm.
27. Throughout his time at Elmley, despite significant input from prison healthcare staff and hospital specialists, Mr Baker's health gradually deteriorated. In addition to his known conditions he developed heart failure, chronic kidney disease and anaemia. He continued to live on a standard wing until 16 July 2016, when healthcare staff admitted him to the inpatient unit for a period of assessment. He moved back to his cell on 2 August, but returned to the inpatient

unit on 18 October, as his condition deteriorated. He had massive oedema (swelling caused by fluid retention) in both legs which made walking difficult.

28. Mr Baker took medications which effectively maintained his mental health. A mental health nurse frequently reviewed him and from 8 November onwards Mr Baker had his mental capacity assessed on a weekly basis to ensure he remained capable of making decisions about his healthcare.
29. Mr Baker took metformin doses as part of a diabetic care plan and monitored his own blood sugar levels. Mr Baker was obese and staff gave regular advice about eating a healthy diet.
30. Mr Baker had an irregular heart beat, high blood pressure and elevated cholesterol which healthcare staff monitored and controlled. He also saw a specialist cardiologist, who diagnosed stable angina. Mr Baker experienced episodes of light headedness and occasional loss of consciousness which, despite admission to hospital, remained unexplained.
31. A prison GP saw Mr Baker on 15 June to discuss the results of blood tests which showed raised alkaline phosphate (a possible indicator of liver disease or bone disorders). A corresponding liver function test showed slight abnormalities and the GP arranged an abdominal ultrasound scan (a scan that uses high frequency sound waves to create images inside the body) to assess liver function. The scan did not show any obvious abnormality. He prescribed iron tablets to supplement his diet.
32. Further investigations for anaemia, including an ultrasound scan in hospital, showed no gastrointestinal or liver concerns. On 31 August, a letter from the hospital colorectal department indicated that Mr Baker's anaemia was linked to kidney disease. They suggested prescribing him erythropoietin (used to treat anaemia related kidney disease). A locum GP referred Mr Baker to a haematology specialist for further advice.
33. Mr Baker saw the specialist on 12 September, who arranged various tests including more blood tests. The results, received in early November, showed some concerns but the cause of Mr Baker's anaemia remained unclear. He had a haematology review planned for January 2017.

Events of 25 - 31 December 2016

35. On the evening of 25 December, Mr Baker did not attend the medication hatch to collect his medication. At about 9.00pm, a nurse went to see him in his cell and Mr Baker told him he was struggling to walk. The nurse examined him and described him as wheezy. His vital signs were within the normal range.
36. The nurse gave Mr Baker his medication in his cell and arranged for the door to be kept unlocked. He continued to monitor Mr Baker and, shortly after 11.00pm, gave him oxygen as his blood saturation levels were low and he had difficulty breathing. Mr Baker improved and his condition stabilised. The nurse was satisfied that he could be managed in prison and did not need to go to hospital. He monitored him every half hour from that time onwards.

37. Mr Baker remained stable but restless throughout the night. At around 6.00am he began to have breathing difficulties and his heart and respiratory rate increased. The nurse gave him oxygen but when Mr Baker's condition did not improve he decided he needed hospitalisation and called a Code Blue over the radio to signify a medical emergency. The control room called an ambulance and the night manager attended.
38. The nurse continued to give Mr Baker oxygen until the ambulance arrived. He remained conscious and said he was not in any pain. After examining him, the ambulance crew took Mr Baker to hospital. Two prison officers accompanied him and a Custodial Manager (CM) authorised the use of an escort chain (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). Staff removed the escort chain at the hospital shortly after midday.
39. On 28 December, the prison began the process to consider Mr Baker for compassionate release on medical grounds. At 2.00pm, a senior prison manager authorised Mr Baker's temporary release on a special purpose licence. A prison officer remained at hospital with Mr Baker for support.
40. On 30 December, members of the hospital palliative care team found a place for Mr Baker at a local hospice. They planned to transfer him the next day. Unfortunately, despite intensive treatment, Mr Baker died shortly after midnight on 31 December, before his move to the hospice and before the prison could complete the compassionate release application.

Contact with Mr Baker's family

41. On 26 December, the prison appointed a Senior Officer (SO) as the family liaison officer. Mr Baker had no family named as next of kin and had instead nominated a firm of solicitors in Edinburgh to manage his affairs. A prison chaplain visited Mr Baker in hospital on 26 December, and he confirmed that these were his instructions.
42. On 27 December, the SO telephoned the solicitors but had to leave a message as they were closed over the Christmas and New Year period. He contacted them again when they re-opened on 3 January.
43. Mr Baker's funeral was organised for 4 April 2017. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

44. The prison posted notices informing other prisoners and staff of Mr Baker's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Baker's death.
45. Prisoner listeners (prisoners trained by Samaritans to offer emotional support) were available to offer peer support.

Cause of death

46. Mr Baker died from died from cirrhosis of the liver (long term liver damage) with chronic pancreatitis (where the pancreas is permanently damaged from inflammation).

Findings

Clinical care

47. The clinical reviewer was unable to establish a clear link connecting Mr Baker's known medical conditions and his cause of death. Overall, she was satisfied that the medical care Mr Baker received at Elmley was equivalent to that he could have expected to receive in the community.
48. Cirrhosis is a condition characterised by the replacement of normal liver tissue by scar tissue. Symptoms are usually only experienced when the condition becomes so severe that it causes liver failure. It usually develops over a matter of years and common causes include excess alcohol intake, chronic hepatitis and chronic fatty infiltration of the liver.
49. Liver function tests in June 2016 identified small irregularities, but even then did not indicate a problem with liver cell function. Ultrasound scans (that use high frequency sound waves to create images inside the body), the last being in early December 2016, did not show any significant abnormality and no sign of cirrhosis.
50. Chronic pancreatitis is an inflammation of the pancreas over a prolonged period of time. It is most commonly caused by excess alcohol intake, obstruction of the pancreatic ducts (for example by stones or tumour) or autoimmune conditions (where the immune system attacks healthy cell by mistake). There are almost always associated symptoms, most commonly central abdominal pain. It can also cause vomiting, bulky offensive stools and weight loss. Mr Baker's ultrasound scans and blood tests did not identify chronic pancreatitis.
51. Mr Baker did not display or report any of the symptoms associated with cirrhosis or pancreatitis and the clinical reviewer suspected that the complexity of his existing health problems made these much harder to identify.
52. On 12 September 2016, Mr Baker saw a haematology consultant regarding anaemia. The consultant arranged more tests but the results, received in November, were inconclusive and the cause of Mr Baker's anaemia remained unclear. The clinical reviewer considered that Mr Baker would have benefitted from an urgent haematology review at that time, rather than waiting for his planned review in January 2017. However, there is no confirmed link between this and Mr Baker's death and no indication that earlier intervention would have changed the final outcome for him.
53. During 2016, Mr Baker underwent several referrals to investigate the cause of his declining health. A number of different GPs were involved in his care but he did not have a named clinician with overall responsibility. Though the management of his heart failure was good, there were some omissions from NICE guidelines regarding the management of his diabetes. In her review the clinical reviewer has made recommendations for improvement. We do not repeat these in this report, but the Head of Healthcare will need to address them.
54. When Mr Baker became acutely unwell the combination of heart, liver and kidney failure, together with his diabetes and overall frailty made his prognosis very poor.

The clinical reviewer does not consider that there was anything that the healthcare staff at Elmley could have done differently for him at that time and we agree that overall Mr Baker received satisfactory care.

Security and Restraints

55. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
56. In 2016, Mr Baker went to hospital twelve times. On each occasion, staff completed a person escort record (PER) form and an escort risk assessment document. In general, these were thorough and the decisions well documented. On nine occasions, Mr Baker went to hospital on an escort chain (escort staff had permission to remove it if necessary for medical treatment). For the other three hospital visits staff did not restrain him.
57. When Mr Baker went out to hospital on 26 December 2016, a PER form was completed and on it a nurse listed Mr Baker's medical conditions. He did not object to the use of restraints. A CM did a risk assessment but did not have time to complete all of the paperwork.
58. The CM authorised two prison officers to escort Mr Baker to hospital and to restrain him using an escort chain. She explained that when prisoners are admitted to hospital the need to use restraints is reassessed as soon as possible. Shortly after midday, another CM reviewed the continued need for restraints at the hospital and authorised the removal of the escort chain.
59. Although the decision to authorise the use of restraints was not recorded in full, we are satisfied that the use of an escort chain was appropriate when Mr Baker was taken to hospital. The CM prioritised getting Mr Baker to hospital and understood the need to consider Mr Baker's health as it was at that time, and that a review on restraints was needed as soon as possible. We are pleased that staff reviewed the continued need to use restraints after Mr Baker's hospital admission and authorised their removal.

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