Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Sulc a prisoner at HMP Ashfield on 22 December 2016

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

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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 Robert Sulc died in hospital on 22 December 2016 of acute heart failure, while a prisoner at HMP Ashfield. He was 64 years old. I offer my condolences to Mr Sulc's family and friends.

During his time in prison, Mr Sulc developed multiple health conditions, including high blood pressure, chronic kidney disease, diabetes and suspected heart failure. Prison staff monitored these conditions closely and made appropriate and timely referrals to hospital specialists when necessary.

I am satisfied that the clinical care Mr Sulc received was equivalent to that which he could have expected in the community.

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 **August 2017**

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Summary

Events

1. On 12 June 2014, Mr Robert Sulc, a Slovakian national, was remanded into custody for sexual offences and sent to HMP Bristol. During an initial health screen Mr Sulc was diagnosed with high blood pressure. Two weeks later, on 27 June, Mr Sulc complained of chest pain. He was admitted to hospital where doctors diagnosed acute coronary syndrome (an umbrella term for situations where the blood supplied to the heart muscle is suddenly blocked) with possible left ventricular hypertrophy (thickening of the heart muscle).

2. On 24 July, Mr Sulc was sentenced to eight years in prison. He was transferred to HMP Ashfield on 5 September.

3. Mr Sulc complained of further chest pain on 10 September. A prison doctor diagnosed costochondritis (chest wall pain). After review by a hospital cardiologist his chest pain was not thought to be cardiac related but due to gastro-oesophageal disease. Mr Sulc had a further cardiology review on 23 July 2015. A scan of his heart identified no concerns.

4. On 15 February 2016, Mr Sulc was diagnosed with chronic kidney disease and macrocytic anaemia (a type of anaemia where the red blood cells are larger than normal but have low levels of haemoglobin which is needed to carry oxygen around the body). Mr Sulc had a blood transfusion on 21 March and was given a steroid to treat his blood disorder. Mr Sulc's blood pressure and blood sugars were reviewed weekly.

5. Mr Sulc was taken to hospital on 21 May after becoming breathless. A chest x-ray and ECG of his heart showed nothing of concern. Mr Sulc's hospital consultant thought his symptoms were caused by his steroid use and reduced his dosage before discharge.

6. Mr Sulc was sent to the Accident and Emergency Department on 11 November when he complained of shortness of breath and chest pain. A chest x-ray showed bilateral haziness in his lungs. Mr Sulc was referred to the heart failure clinic for further assessment. A CT coronary angiogram completed on 1 December diagnosed possible atheroma disease (thickening of the artery walls around the heart).

7. On 18 December, an officer found Mr Sulc sitting on his bed, out of breath. He was taken to hospital by ambulance. Mr Sulc was discharged from hospital the following day with suspected inflammatory lung disease. The prison GP was concerned that Mr Sulc remained very ill and, after discussion with the consultant, he was readmitted to hospital on 20 December. Mr Sulc died two days later, on 22 December 2016.

Findings

8. While in prison, Mr Sulc developed complex and multiple health conditions. Prison healthcare staff monitored his conditions regularly and made appropriate and timely referrals to local specialist teams at the hospital. We found that the clinical care Mr Sulc received was at all times equivalent to that which he could have expected in the community.

9. We make no recommendations.

The Investigation Process

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

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

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

13. One of the Ombudsman's family liaison officers contacted Mr Sulc's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Sulc's daughter asked a number of questions about the healthcare her father received. She also asked why the family were not contacted when her father was taken to hospital on 20 December, two days before he died.

14. Mr Sulc's wife and daughter received a copy of the initial report. They did not make any comments.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Ashfield

16. Until June 2013, HMP Ashfield was a Young Offenders' Institution. In July 2013, it reopened as a specialist medium secure adult male prison for sex offenders. It accommodates approximately 400 men and is managed by Serco.

17. Healthcare is provided by an amalgamation of Hanham Health, Bristol Community Health and Avon and Wiltshire Partnership Mental Health Trust. The healthcare unit provides on-site chronic disease management including diabetes, respiratory and cardiovascular disease screening.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Ashfield was in 2015. Inspectors found that health services were effective and responsive, long-term conditions were identified and care was good. The inspection report noted the appointment system for internal and external referrals was very good and comparable to the best community GP practices.

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 June 2016, the IMB reported that the prisoners were overwhelmingly positive about the quality of care they receive from nurses, GPs and others. They noted that a nurse triage facility ensured that prisoners received prompt assessments of their needs and prisoners benefited from 15 minute appointments, of a longer duration than in the community.

Previous deaths at HMP Ashfield

20. Mr Sulc was the third person to die of natural causes at Ashfield since the prison changed its function in 2013, the second to die from a heart condition.

Key Events

2014

21. On 12 June 2014, Mr Robert Sulc was remanded into custody for sexual offences and sent to HMP Bristol. During an initial health screen Mr Sulc was diagnosed with high blood pressure and was prescribed ramipril, a medication used to help reduce blood pressure.

22. Two weeks later, on 27 June, Mr Sulc complained of chest pain. He was admitted to hospital, where doctors diagnosed acute coronary syndrome with possible left ventricular hypertrophy (thickening of the muscle of the left ventricle of the heart, which is often a symptom of uncontrolled high blood pressure or cardiovascular disease). Mr Sulc was prescribed atorvastatin to reduce the risk of heart attack and a hypertension care plan was created.

23. On 24 July, Mr Sulc was sentenced to eight years in prison. He was transferred to HMP Ashfield on 5 September. During an initial health screen he told healthcare staff that he did not want to stop smoking.

24. Mr Sulc complained of further chest pain on 10 September. A prison GP diagnosed costochondritis (chest wall pain) and sent a referral to the cardiology department at hospital. A scan of Mr Sulc's heart on 24 September showed nothing of concern. His chest pain was not thought to be cardiac related but due to gastro-oesophageal disease. Omeprazole, an antacid was prescribed.

2015

25. On 6 January 2015, Mr Sulc complained of having a dry cough over the previous three months. A prison GP made a rapid access chest clinic referral that day. Mr Sulc later had a chest x-ray, which was clear.

26. Mr Sulc reported left arm weakness and a headache on 10 March. He did not have any other symptoms at this time. A CT scan at hospital did not show any signs of a stroke but in light of his risk factors (his high blood pressure) a hospital doctor prescribed Clopidogrel, a medication to lower the risk of heart disease and stroke. Hospital doctors thought Mr Sulc's symptoms may be migraine related.

27. While in Ashfield Prison Mr Sulc had frequent mental health assessments, one after a threat of self harm on 3 March. He was diagnosed with depression and given sertraline, an antidepressant.

28. Mr Sulc had a cardiology review at hospital on 23 July. A scan of his heart identified no concerns.

2016

29. After an abnormal blood test result on 15 February 2016, Mr Sulc was diagnosed with chronic kidney disease and macrocytic anaemia (a blood disorder where the red blood cells are larger than normal but have low levels of haemoglobin which is needed to carry oxygen throughout the body). A prison GP sent a referral to the Nephrology and Haematology department at the hospital.

30. Mr Sulc saw a haematologist at hospital on 15 March. He was diagnosed with autoimmune haemolytic anaemia (a blood disorder where the body's immune system mistakenly destroys its own red blood cells carrying oxygen around the body) and spherocytosis (symptoms can include anaemia, jaundice and an enlarged spleen). Mr Sulc was also found to have a chest infection, possibly linked to his haemolysis. Antibiotics were prescribed.

31. Mr Sulc had a blood transfusion on 21 March, and was given prednisilone, a steroid to treat his blood disorder. Mr Sulc's haematologist asked the prison GP to monitor Mr Sulc's blood pressure and blood sugars weekly. (Side effects of high dose continued steroid use include diabetes, high blood pressure, fluid retention and bone thinning.)

32. On 28 April, Mr Sulc saw a prison GP when he complained of swollen legs. He was well in himself and had no other symptoms. Mr Sulc saw her two weeks later, on 16 May. She prescribed furosemide to reduce fluid retention in his legs. Mr Sulc developed further side effects to the steroids on 16 May when his face started to swell. He was diagnosed with cushingoid syndrome. (Cushingoid syndrome often develops as a side effect of long term high dose steroid use. One symptom is the face develops a rounded appearance due to fat deposits on the sides of the face.)

33. Mr Sulc was taken to hospital on 21 May after becoming breathless. He told prison nurse that he was unable to walk from his bed to the dining table outside his cell. A chest x-ray and ECG of his heart showed nothing of concern and Mr Sulc was discharged back to the prison the following day. Mr Sulc's consultant haematologist thought his symptoms were caused by his steroid use and reduced his dosage before discharge.

34. Mr Sulc's health deteriorated further on 16 June when, as a result of a routine blood test, he was found to have hypokalaemia (low serum potassium levels). Normal potassium levels range between 3.5 – 5.0 mmol but Mr Sulc's level was very low at 1.8mmol. (Hypokalaemia can increase a person's risk of developing an abnormal heart rhythm and cardiac arrest.) Mr Sulc was admitted to hospital for oral replacement serum K treatment. He was discharged back to the prison the following day.

35. Between March and October 2016, Mr Sulc's blood sugar reading ranged from 5 – 14mmols depending on the time of day. (Blood sugar levels should range between 4-7mmols.) A healthcare assistant took Mr Sulc's blood sugar reading at 2pm on 12 October, when it was 24.7mmols. Mr Sulc was monitored by healthcare staff and at 5pm his blood sugar reading had reduced to 14.7mmols. A nurse spoke to Mr Sulc about his risk of developing diabetes due to his steroid use and dietary advice was given.

36. Mr Sulc saw a prison GP on 18 October, when his blood sugar level was raised at 22mmols. He was diagnosed with diabetes and prescribed gliclazide, an antidiabetic medication. Mr Sulc's blood sugar levels were monitored and his gliclazide medication was varied in line with blood sugar readings.

37. On 11 November, Mr Sulc complained of shortness of breath and chest pain. A chest x-ray showed bilateral haziness in his lungs. After review, a hospital

consultant asked the prison GP to refer Mr Sulc for an outpatient echocardiogram (ECG) and to the heart failure team for further assessment and definitive diagnosis and treatment options. A prison GP sent this referral on 15 November.

38. A CT coronary angiogram completed on 1 December diagnosed possible atheroma disease (thickening of the artery walls around the heart) but further tests were required to confirm this. (Atheroma is the narrowing of the arteries, restricting the flow of blood to the heart muscle.)

39. On 18 December, an officer found Mr Sulc sitting on his bed out of breath. He had fallen over and had pain in his right lower leg. He was unable to speak in full sentences. He was alert but pale and sweating. Mr Sulc did not have chest pain but due to his complex and multiple health issues he was taken to the accident and emergency department by ambulance. He was not restrained during his escort to hospital.

40. Mr Sulc was discharged from hospital at 5.10pm the following day with suspected inflammatory lung disease. A hospital doctor asked the prison GP to refer Mr Sulc to the outpatient respiratory clinic for consideration of long term oxygen therapy. A prison nurse made Mr Sulc an appointment to see the prison GP the next day.

41. A prison GP reviewed Mr Sulc the following morning at 11.29am on 20 December. He was unhappy that Mr Sulc had been discharged from hospital. Co-ordinating Mr Sulc’s care with numerous specialists (renal, cardiology and haematology) had become challenging and he needed a prison with 24 hour healthcare cover. Mr Sulc remained unwell and the GP telephoned a hospital consultant at the hospital, requesting that he be readmitted. The GP requested a non-emergency ambulance for Mr Sulc. Mr Sulc returned to the wing and the GP told healthcare staff that he did not require continuous monitoring while he waited for his transfer to hospital. Mr Sulc left the prison at 12.51pm that afternoon and was re-admitted to hospital. Mr Sulc was not restrained during his escort to hospital.

42. While in hospital, Mr Sulc was instructed by hospital staff to sit up in bed with an oxygen mask on due to his low oxygen levels. He was not always compliant with this instruction and prison staff called a nurse to assist. Hospital staff continued to monitor Mr Sulc and prison documentation shows that, on 21 December, a hospital doctor told Mr Sulc that he would be in hospital for the next few days to enable them to carry out more tests.

43. At 1.40am on 22 December, Mr Sulc complained of chest pain. He was connected to an ECG machine to monitor his heart. At 3.15am, Mr Sulc walked to the toilet. At 3.30am, a nurse came to take his blood pressure. He was sitting up in bed and without warning fell back. When the nurse tried to help him up, she realised he was not breathing. Resuscitation was attempted but was unsuccessful. Mr Sulc’s death was confirmed at 3.55am.

Contact with Mr Sulc's family

44. A prison family liaison officer and an Operational Support Grade (OSG) visited Mr Sulc's wife and daughter at 8.55am on 22 December to inform them of Mr Sulc's death. The OSG, who spoke Slovakian, attended in case an interpreter was required.

45. Mr Sulc's funeral was held in Slovakia. The prison contributed towards the cost of repatriation and funeral in line with national policy.

Support for prisoners and staff

46. After Mr Sulc's death, the Director came to the hospital to speak to the officers who were with Mr Sulc when he died to ensure they had the opportunity to discuss any issues arising, and to offer support.

47. The prison posted notices informing other prisoners of Mr Sulc'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 Sulc's death.

Post-mortem report

48. A post mortem showed that Mr Sulc died of acute heart failure as a result of hypertensive heart disease and pulmonary fibrosis.

Findings

Clinical Care

49. Mr Robert Sulc was remanded into the custody of HMP Bristol in June 2014. He was diagnosed with high blood pressure and started on medication by the prison GP. His blood pressure was appropriately monitored and his medication was adjusted as necessary. He was transferred to HMP Ashfield in July 2014.

50. While in prison, Mr Sulc developed complex and multiple health conditions. These were appropriately diagnosed after referral to local specialist teams at the hospital including, Haematology, Nephrology and Cardiology. The referrals to hospital clinics and monitoring of his conditions were appropriate and timely.

51. In November 2016, Mr Sulc was admitted to hospital with shortness of breath and chest pain. A chest x-ray showed bilateral haziness in his lungs. He was referred to the hospital's heart failure clinic for further assessment and definitive diagnosis and treatment options. Prison healthcare staff again continued to monitor Mr Sulc to detect any deterioration in his condition.

52. On 18 December, an officer found Mr Sulc sitting on his bed, out of breath. He was taken to hospital by ambulance. Mr Sulc was discharged from hospital the following day, 19 December, with suspected inflammatory lung disease.

53. The prison GP was concerned that Mr Sulc remained very ill and after discussion with the consultant he was readmitted to hospital on 20 December. Mr Sulc died two days later, on 22 December 2016.

54. The post mortem report lists acute cardiac failure as cause of death. Although this diagnosis had been suspected by the prison GP and his hospital consultant in November 2016, he died before definitive tests and diagnosis could be made. The clinical care Mr Sulc received was at all times equivalent to that which he could have expected in the community.

Family Liaison

55. A prison family liaison officer and an OSG visited Mr Sulc's wife and daughter on 22 December to inform them of Mr Sulc's death. A second meeting took place on 12 January 2017 to enable the family to discuss any concerns they had.

56. When contacted by one of the Ombudsman's family liaison officers, Mr Sulc's daughter asked why the family was not contacted when her father was taken to hospital on 20 December. The investigator has been told that at the time of Mr Sulc's admission to hospital his condition was not deemed to be life threatening and therefore contact was not made. We are satisfied that healthcare staff did not consider that Mr Sulc was critically ill at that time and therefore prison staff were not required to inform his family. We nevertheless understand the family's distress at not being aware of Mr Sulc's hospital admission until after his death two days later.

57. We make no recommendations.

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