

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Michael Brown a prisoner at HMP Swaleside on 18 May 2017

**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*



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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Brown died on 18 May 2017 of a heart attack at HMP Swaleside. Mr Brown was 68 years old. We offer our condolences to those who knew him.

Mr Brown's death was sudden and unexpected. We are satisfied that the care provided to Mr Brown at Swaleside was equivalent to that which he could have expected to receive 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.

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**October 2017**

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# Summary

## Events

1. Mr Michael Brown was remanded in custody in February 2016. He was moved to HMP Swaleside in November 2016 following his conviction for sexual offences.
2. When Mr Brown arrived at Swaleside, a nurse noted that he did not have any significant medical conditions. He suffered from heartburn and indigestion and prison GPs prescribed appropriate medication. Mr Brown declined help to stop smoking.
3. At 2pm on 18 June 2017, a prison officer found Mr Brown unresponsive on his cell floor and immediately called a medical emergency code. Healthcare staff and paramedics performed cardiopulmonary resuscitation (CPR) but were unable to resuscitate Mr Brown. At 3.08pm, paramedics recorded that Mr Brown had died.

## Findings

4. The clinical reviewer considered that prison nurses at Swaleside had completed an appropriate cardiovascular risk assessment. Nurses offered Mr Brown help to stop smoking, but he declined. Mr Brown's death from a heart attack was sudden and unexpected.
5. We agree with the clinical reviewer that the care provided to Mr Brown was equivalent to that which he could have expected to receive in the community. We make no recommendations.

## The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator visited Swaleside on 24 May 2017. She obtained copies of relevant extracts from Mr Brown's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison.
9. 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.
10. The investigator wrote to Mr Brown's ex-wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP Swaleside

12. HMP Swaleside, HMP Elmley and HMP Standford Hill form a group of prisons on the Isle of Sheppey. Swaleside houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17 bed inpatient unit. Minster Medical Group provides GP cover from 9.00am to 5.00pm on Monday to Friday, while Medoc provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

## HM Inspectorate of Prisons

13. The most recent inspection of HMP Swaleside was in April 2016. Inspectors reported that only 15 per cent of prisoners were satisfied with healthcare provision. While prisoners had access to an appropriate range of primary care services and visiting specialists, they reported that not all long-term conditions clinics ran regularly because staffing was inconsistent.

## Independent Monitoring Board

14. 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 30 April 2016, the IMB reported that the healthcare unit was well equipped and clean. The prison's senior management team were concerned that NHS England had failed to ensure the provision of staff hatches on residential wings to help prevent the illegal use of tradeable medication. The IMB found it difficult to get regular information from the primary healthcare provider about complaints from prisoners.

## Previous deaths at HMP Swaleside

15. Mr Brown was the third prisoner to die from natural causes at Swaleside since January 2015. There has been one death since. There were no significant similarities between these deaths and Mr Brown's.

## Key Events

16. On 2 February 2016, Mr Michael Brown was remanded in custody for sexual offences and sent to HMP High Down. On 14 June he was sentenced to 17 years in prison and was moved to HMP Swaleside on 25 November.
17. At an initial health screen at Swaleside, a nurse noted that Mr Brown did not have any significant medical conditions. His blood pressure and cholesterol level were within normal ranges. The nurse recorded Mr Brown's weight as 59kgs (9st 4lbs). Mr Brown was a heavy smoker and declined help to stop. Prison GPs prescribed medication to relieve the symptoms of heartburn and indigestion.
18. Mr Brown had limited contact with healthcare staff. Nurses gave him his prescribed medication, which he kept in his possession.
19. On 12 May 2017, Mr Brown did not attend an older person's clinic appointment but gave no reason. A nurse assessed Mr Brown the same day and recorded his weight as 62kgs (9st 11lbs). Mr Brown declined a referral to the weight management clinic and the physical exercise programme. She noted that Mr Brown again declined help to stop smoking.

### Events of 18 May 2017

20. At approximately 11.30am on 18 May, Mr Brown climbed over the railings on the third landing of his wing and threatened to jump. An officer immediately attended and persuaded Mr Brown to return to his cell. Mr Brown told him he was suffering from heartburn and a nurse had refused to give him Gaviscon. The officer said he would arrange for Mr Brown to discuss his concerns with a GP. He noted that Mr Brown's behaviour was erratic and he decided to start suicide and self-harm monitoring (known as ACCT). Mr Brown declined to talk to the Samaritans or a Listener (a prisoner trained by the Samaritans). The ACCT plan said that staff should monitor Mr Brown on an hourly basis. At 12pm and 1pm the officer went to Mr Brown's cell and noted that he was talking to another prisoner in his cell and his mood was calm. Mr Brown was locked in his cell shortly after 1pm and did not express any concerns.
21. At 2pm, an officer opened Mr Brown's cell to complete the ACCT check. Mr Brown was lying on his cell floor and was unresponsive. He radioed an emergency code blue (which is used to indicate a prisoner has chest pain and difficulty in breathing) and the control room immediately called an emergency ambulance. Another officer arrived at Mr Brown's cell and started cardiopulmonary resuscitation (CPR). At approximately 2.07pm, two nurses arrived and continued with CPR and advanced life saving procedures.
22. At 2.18pm, the paramedics arrived and took control of Mr Brown's care. Mr Brown did not respond to treatment and at 3.08pm, paramedics recorded that he had died.

### **Contact with Mr Brown's family**

23. At 3.15pm on 18 May, the prison appointed a prison manager as family liaison officer (FLO). She was unable to identify a next of kin for Mr Brown. Mr Brown had previously told prison staff that he had no contact with anyone in the community. She made further enquiries with the National Probation Service and Kent Police and obtained contact details for Mr Brown's ex-wife.
24. At 10am on 19 May, the FLO and the Deputy Governor visited Mr Brown's ex-wife at home and told her Mr Brown had died. They offered condolences and support. The prison arranged and paid for Mr Brown's funeral which took place on 19 June.

### **Support for prisoners and staff**

25. After Mr Brown's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
26. The prison posted notices informing other prisoners of Mr Brown'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 Brown's death.

### **Post-mortem report**

27. The Coroner told us that Mr Brown had died from an acute myocardial infarction (heart attack).

# Findings

## Clinical care

28. The clinical reviewer noted that healthcare staff at Swaleside appropriately completed a routine cardiovascular risk assessment. This included Mr Brown's blood pressure, weight and cholesterol level, which were all within normal ranges. Nurses discussed the benefits of stopping smoking but Mr Brown declined help. When Mr Brown gained weight in May 2017, he declined a referral to the weight management clinic.
29. Mr Brown's death from a heart attack was sudden and unexpected. The clinical reviewer concluded that the standard of care provided to Mr Brown was equivalent to that which he could have expected to receive in the community. We make no recommendations.

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