

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Duncan Campbell a prisoner at HMP Woodhill on 2 October 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 Duncan Campbell died on 2 October 2017 of ischaemic heart disease at HMP Woodhill. He was 49 years old. We offer our condolences to Mr Campbell's family and friends.

The investigation found that the standard of healthcare provided to Mr Campbell was not equivalent to that which he could have expected to receive in the community.

Mr Campbell, who was a challenging prisoner, had been in prison custody for only six days when he died, during which time he collapsed on several occasions and received significant medical attention. Prison GPs failed to review his community medical record, which recorded that he had an automatic cardiac defibrillator fitted. Mr Campbell did not disclose this information and it was not identified during his dealings with healthcare staff. As a result, Woodhill missed the opportunity to investigate whether Mr Campbell's repeated collapses were related to a problem with this device.

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

May 2018

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Summary

Events

1. Mr Duncan Campbell was remanded into custody on 27 September 2017 and sent to HMP Woodhill. He had a history of stroke, high blood pressure and type 1 diabetes.
2. Mr Campbell had been fitted with an automatic cardiac defibrillator (a device implanted just under the chest wall that detects when the heart is beating abnormally and sends electrical pulses to regulate the heart) earlier that year, but did not disclose this to prison or healthcare staff. His community GP record arrived at Woodhill on 29 September and was passed to prison GPs to review.
3. During his six days at Woodhill, Mr Campbell collapsed on five occasions but recovered quickly. Prison GPs decided that Mr Campbell was not acutely unwell and did not need further assessment in the prison's inpatient unit.
4. On 2 October, a prison nurse saw Mr Campbell after he collapsed in his cell. Later that day a prison GP examined Mr Campbell after he complained of chest pains. The results of an electrocardiogram (ECG – a test used to monitor the heart's rhythm) were normal.
5. At 4.10pm on 2 October, prison officers found Mr Campbell unresponsive in his cell. An officer made an emergency radio call and paramedics took Mr Campbell to hospital. Mr Campbell's condition continued to deteriorate and he died at 5.45pm.

Findings

6. Although the prison obtained Mr Campbell's community medical record, there is no evidence that this was reviewed. Prison GPs failed to highlight important clinical information contained in the community record, such as the presence of the automatic cardiac defibrillator, in Mr Campbell's prison medical record. As a result, prison healthcare staff missed the opportunity to investigate if Mr Campbell's unexplained episodes of collapse were related to a problem with this device.
7. The clinical reviewer was not satisfied that the care Mr Campbell received at Woodhill was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that GPs review a prisoner's community medical record and use the front page of the electronic medical record to highlight important clinical information.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Woodhill on 9 October 2017. She obtained copies of relevant extracts from Mr Campbell's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Campbell's clinical care at the prison.
11. We informed HM Coroner for Milton Keynes of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The investigator wrote to Mr Campbell's ex-partner 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.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Woodhill

14. HMP Woodhill is both a local prison and a high security prison and can hold 727 men. Central and North West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides mental and physical healthcare, including end of life palliative care, for prisoners. Woodhill also houses a self-contained Close Supervision Centre.

HM Inspectorate of Prisons

15. The most recent inspection of Woodhill was in September 2015. Inspectors reported that primary health services were good, although a high non-attendance rate meant prisoners waited too long for some services. The inpatient unit continued to provide good care, but the regime still needed to focus more on recovery. Clinical records were of a high standard and included effective care planning for those with complex health needs.

Independent Monitoring Board

16. 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 May 2017, the IMB reported that staffing problems continued with 50% of healthcare staff being agency. There was an increased reliance on staff goodwill to keep the healthcare system going.

Previous deaths at HMP Woodhill

17. Mr Campbell was the third prisoner to die from natural causes at Woodhill since January 2017. There has been one death since. There were no similarities with the other deaths.

Key Events

18. On 27 September 2017, Mr Duncan Campbell was remanded in custody charged with possession of an offensive weapon and sent to HMP Woodhill.
19. Mr Campbell arrived at Woodhill at 12.25pm. Shortly afterwards, he collapsed in the holding cell after deliberately banging his head against a wall. Prison officers called an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) and the control room immediately called for an ambulance. A nurse arrived and noted that Mr Campbell was conscious but his oxygen saturation level was 88% (normal range is 95-100%). The nurse gave Mr Campbell oxygen therapy which increased his saturation level to 99%. The paramedics arrived at 12.35pm and decided that Mr Campbell did not require hospital admission.
20. A prison GP and a mental health nurse assessed Mr Campbell in reception and noted that he was not acutely unwell and did not need admission to the prison's inpatient unit. Mr Campbell had a history of alcohol abuse and the GP and nurse concluded that his behaviour was caused by alcohol detoxification. The GP asked a healthcare administrator to request Mr Campbell's medical record from his community GP. (This arrived on 29 September and was passed to prison GPs to review.)
21. Later that day, Mr Campbell was moved to a cell on the prison's induction wing. Prison staff put him on an ACCT (Assessment, Care in Custody and Teamwork - the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm). Staff initially kept Mr Campbell under constant watch but, on 28 September, reduced this to one visit every hour.
22. At 1.46pm on 27 September, a member of the prison's Substance Misuse Service (SMS) saw Mr Campbell but he refused an assessment. At 2.39pm, a nurse went to Mr Campbell's cell for a routine assessment and saw him lying on his cell floor. Mr Campbell was conscious and prison officers helped him sit up. The nurse recorded his observations were normal apart from a raised pulse. Mr Campbell refused medication for alcohol withdrawal. At 5.05pm, a nurse saw Mr Campbell in his cell and noted that he had pressure sores on both legs and bruises on his arms. She changed the dressings on his legs and arranged an appointment with a prison GP.
23. At 9.10am on 28 September, a prison GP examined Mr Campbell and prescribed antifungal cream for skin wounds. The GP noted that healthcare had received a medication summary from Mr Campbell's community GP. A prison GP prescribed Mr Campbell medication for the prevention of stroke, high blood pressure, fluid retention caused by congestive heart failure and to lower his cholesterol. Mr Campbell took insulin for type 1 diabetes.
24. At 11.37, a nurse completed Mr Campbell's initial health assessment. He noted that Mr Campbell had a history of stroke, diabetes and high blood pressure. Mr Campbell said he did not smoke or drink alcohol and complained of a persistent cough for the previous two weeks. The nurse noted that Mr Campbell was on an open ACCT and referred him to a prison GP for further assessment. Later that day a mental health nurse assessed Mr Campbell and noted that he had a

history of self-harm. Mr Campbell denied any mental health or substance misuse problems and the nurse advised him to contact healthcare if he required support.

25. On 29 September, Mr Campbell became unsteady on his feet during a routine appointment with a nurse. Mr Campbell's oxygen saturation level was low at 88%, but increased to 99% after oxygen therapy, and his blood sugar level was raised (16mmols). On 30 September, Mr Campbell refused his prescribed medication and to have his blood sugar level checked.
26. On 1 October, a nurse assessed Mr Campbell and noted his oxygen saturation level, temperature and blood pressure were within normal ranges and his blood sugar was raised (16mmols). At 9.45am, a prison officer found Mr Campbell collapsed in the shower and called an emergency code blue. A nurse attended and noted that Mr Campbell was conscious and his observations were within normal ranges. The nurse was satisfied that Mr Campbell did not need an ambulance. Mr Campbell continued to refuse his prescribed medication.
27. On 2 October, a nurse checked Mr Campbell's blood sugar level which had reduced to 7.6mmols. Mr Campbell refused to take his insulin but agreed to take his other prescribed medication. At 11am, Mr Campbell collapsed again and a nurse attended. Mr Campbell's observations were normal and he recovered quickly. At 3.15pm, he complained of chest pain and numbness in his left leg. The nurse recorded Mr Campbell's observations as normal and arranged a GP appointment.
28. At 3.20pm, a prison GP examined Mr Campbell who complained of a headache and left side lower chest pain. Mr Campbell did not feel nauseous or short of breath and his observations were normal. Mr Campbell had an electrocardiogram (ECG – test to monitor the heart's rhythm) with normal results. The GP arranged a full set of blood and urine tests.
29. At 4.10pm, three officers went to Mr Campbell's cell to complete his hourly ACCT observation. The officers opened Mr Campbell's cell and found him collapsed on the floor. An officer radioed an emergency code blue and the control room immediately called an ambulance. Two nurses arrived and checked Mr Campbell's vital signs but could not find a pulse. A nurse and an officer started cardiopulmonary resuscitation (CPR). Paramedics arrived at 4.25pm and took control of Mr Campbell's care. At 5.08pm, Mr Campbell was taken from Woodhill to Milton Keynes General Hospital. His condition continued to deteriorate and he died at 5.45pm.

Contact with Mr Campbell's family

30. An officer and a senior officer acted as the prison's family liaison officers. At 6.50pm on 2 October, they visited Mr Campbell's ex-partner, his nominated next of kin, and informed her of Mr Campbell's death. They offered condolences and support.
31. The family liaison officers remained in contact with Mr Campbell's ex-partner. Woodhill arranged and paid for Mr Campbell's funeral in line with national instructions.

Support for prisoners and staff

32. After Mr Campbell's death, a prison manager 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.
33. The Governor posted notices informing other prisoners of Mr Campbell'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 Campbell's death.

Post-mortem report

34. A post-mortem examination found that Mr Campbell died of ischaemic heart disease.

Findings

Clinical care

35. Mr Campbell was a challenging prisoner who had a range of medical conditions. He did not regularly take his medication and had a history of alcohol abuse.
36. He was fitted with an automatic cardiac defibrillator (a device implanted just under the chest wall that detects when the heart is beating abnormally and sends electrical pulses to regulate the heart) in April 2017 but he did not disclose this to healthcare staff at Woodhill. There was no evidence that this device was regularly monitored in the community. Examinations by prison GPs and paramedics did not identify that Mr Campbell had undergone this procedure. The Head of Healthcare told the clinical reviewer that Mr Campbell was a very large, obese man and this prevented healthcare staff from seeing the implantation scar.
37. Mr Campbell's community medical record arrived at Woodhill on 29 September 2017 and his prison medical record states that it was passed to prison GPs to review. The Head of Healthcare told the clinical reviewer that a prison GP reviewed Mr Campbell's community medical record the same day. However, we found no evidence that this took place.
38. The clinical reviewer commented that GPs should use the front page of a prisoner's electronic medical record to highlight important clinical information. There was no record of Mr Campbell's automatic cardiac defibrillator on the front page of his medical record. As a result, healthcare staff missed the opportunity to investigate if Mr Campbell's unexplained episodes of collapse were related to a problem with his automatic cardiac defibrillator. We are concerned that prison GPs did not review Mr Campbell's community medical record. Had they done so, they would have been aware that Mr Campbell had an automatic cardiac defibrillator and his collapses would have prompted further investigation to ensure it was working correctly. We make the following recommendation:

The Head of Healthcare should ensure that GPs review a prisoner's community medical record and use the front page of the electronic medical record to highlight important clinical information.

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