

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adekola Balogun a prisoner at HMP Belmarsh on 6 January 2017

**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.

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 Adekola Balogun died on 6 January 2017 from a pulmonary embolism caused by deep vein thrombosis while a prisoner at HMP Belmarsh. He was 48 years old. I offer my condolences to Mr Balogun's family and friends.

I am satisfied that the care Mr Balogun received was the 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.

Richard Pickering
Deputy Prisons and Probation Ombudsman

August 2017

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Summary

Events

1. On 8 September 2016, Mr Adekola Balogun was remanded into custody at HMP Belmarsh. On 7 October, he was sentenced to 14 months in prison for perverting the course of justice and driving offences.
2. At his initial health screen, Mr Balogun said that he did not have any pre-existing medical conditions and he was concerned about his health.
3. On 20 December, Mr Balogun reported that he had been suffering with stomach pain. Healthcare staff gave him a pain killer and antacid. He continued to request pain relief over the following two days.
4. A prison nurse saw Mr Balogun on the 29 December, after he requested to see a GP. He told her that he had chest pain. She gave him an anti-inflammatory tablet and told him that, if the pain worsened, he should contact healthcare. She booked him an appointment to see a prison GP.
5. On 3 January 2017, Mr Balogun saw a prison nurse for his NHS health check. She recorded that he had an appointment with a prison GP that day. Mr Balogun did not attend the appointment.
6. On 6 January, Mr Balogun collapsed and had a heart attack. He was taken to hospital, where he was pronounced dead.

Findings

7. We agree with the clinical reviewer that the care Mr Balogun received at Belmarsh was equivalent to that which he could have expected to receive in the community.
8. Mr Balogun missed an appointment with a prison GP on 3 January. Although the appointment was rebooked, there is no record to explain why Mr Balogun did not attend.

Recommendations

- The Head of Healthcare should ensure that reasons for missed appointments are recorded and where they are not rebooked the reasons for this decision are entered on the clinical record

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and asking anyone with relevant information to contact her.
10. The investigator visited HMP Belmarsh on 10 January 2017. She obtained copies of relevant extracts from Mr Adekola Balogun's prison and medical records.
11. The investigator interviewed four members of staff and four prisoners at HMP Belmarsh on 10 January and 13 February.
12. NHS England commissioned a clinical reviewer to review Mr Balogun's clinical care at the prison. He conducted four joint interviews with the investigator.
13. We informed HM Coroner for Southwark of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The investigator wrote to Mr Balogun's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any concerns.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Belmarsh

16. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds about 900 men. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and a 32-bed inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Belmarsh was in February 2015 shortly before healthcare services transferred to Oxleas. Inspectors reported that health services were generally satisfactory and improving. Health screening on arrival was very thorough but staff did not use care plans systematically. Facilities in the inpatient unit were poor with inadequate toilets and showers. There was a strategy to support prisoners with palliative and end of life needs and two cells in the inpatient unit were being refurbished for this purpose.

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 2016, the IMB reported that there had been several improvements to healthcare services since Oxleas took over in April 2015. However, the IMB noted that the non-attendance of prisoners to appointments remained a concern.

Previous deaths at HMP Belmarsh

19. Mr Balogun was the fourth person to die from natural causes at Belmarsh since January 2015. There are no significant similarities to any of the previous deaths at Belmarsh.

Key Events

20. On 8 September 2016, Mr Adekola Balogun was remanded into custody and was sent to HMP Belmarsh. On 7 October, he was sentenced to 14 months in prison for perverting the course of justice and driving offences. Mr Balogun's birth name was Michael Olamiju. He used the name Adekola Balogun as an alias and provided this name to the authorities. In line with his wishes, he will be referred to by his chosen name of 'Mr Balogun' throughout the report.
21. On 8 September, a nurse saw Mr Balogun for his initial health screening. He told her it was his first time in prison and he did not have any medical conditions or concerns about his physical health. The following day, another nurse saw Mr Balogun for his secondary health screening. Mr Balogun did not report any concerns.
22. On 20 December, Mr Balogun attended the medication hatch on the prison wing complaining of stomach pain. A pharmacy technician gave him a painkiller (paracetamol) and an antacid (maalox). He saw another pharmacy technician over the following two days complaining of the same symptoms. She gave him three more doses of the antacid before she told him to make an appointment to see a prison GP.
23. A nurse saw Mr Balogun on the 29 December, after he had applied to see a doctor. He said he was suffering from pain around his chest wall when taking a deep breath. She recorded that Mr Balogun was a regular gym user but had not been to the gym in the past week. He was not experiencing nausea or numbness and concluded he might have been suffering from muscle pain and prescribed an anti-inflammatory (ibuprofen). She told him to come back to see a nurse if the pain increased or if he needed more medication and booked an appointment with a prison GP. Mr Balogun saw a pharmacy technician later that day and she gave him another dose of ibuprofen. Over the next two days, another pharmacy technician gave Mr Balogun a further two doses of ibuprofen.
24. On 3 January 2017, a nurse saw Mr Balogun for his NHS health check. She examined him and his observations were normal. She recorded that he had an appointment with the prison GP that morning to discuss the pain in his right side. A prison GP recorded that Mr Balogun did not attend his appointment.

Events on 6 January 2016

25. On 6 January, Mr Balogun collapsed in the shower area after experiencing chest pain and shortness of breath. He then suffered cardiac arrest. A prisoner alerted prison officers and sat Mr Balogun down on a chair in the shower area.
26. A prison officer called an emergency radio code blue (indicating that someone is unconscious or having breathing difficulties) at 8.15am. A prison GP arrived at approximately 8.18am. He said that he saw Mr Balogun in the shower area. Mr Balogun struggled to speak, due to shortness of breath, but told him his name and that he had chest pain and pointed to his chest. A nurse took Mr Balogun's clinical observations, which were outside of the normal range.

27. A prison GP administered a spray for angina (glyceryl trinitrate), aspirin and oxygen. Mr Balogun's pulse remained irregular. He requested to lie down on the floor and as staff helped him, he collapsed and suffered a heart attack. Attending staff started cardio pulmonary resuscitation (CPR) and continued until paramedics relieved them at approximately 8.40am. Mr Balogun left the prison with paramedics at 9.38am and was transferred to hospital. He was pronounced dead at 9.53am.

Contact with Mr Balogun's family

28. Belmarsh appointed a prison chaplain as the family liaison officer immediately after Mr Balogun's collapse on 6 January. While staff were attending to Mr Balogun, the chaplain attempted to contact Mr Balogun's next of kin by telephone. He spoke to the next of kin who said that Mr Balogun might know people in Spain and Nigeria and provided him with further telephone numbers.
29. The chaplain eventually made contact with Mr Balogun's brother in Nigeria on 8 January and made contact with his sister on 18 January. They informed him that Mr Balogun's birth name was Michael Olamiju. He regularly spoke to Mr Balogun's siblings, providing support and arranging Mr Balogun's funeral.
30. At the time of writing this report, HMP Belmarsh is organising Mr Balogun's funeral and contributing to the costs, in line with national policy.

Support for prisoners and staff

31. After Mr Balogun's death, a custodial manager and a senior 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.
32. The prison posted notices informing other prisoners of Mr Balogun'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 Balogun's death.

Post-mortem report

33. The post mortem report showed Mr Balogun died from a pulmonary embolism (blood clot in a lung blood vessel) caused by deep vein thrombosis (a blood clot in the leg).

Findings

Mr Balogun's clinical care

34. Mr Balogun arrived at Belmarsh and informed staff that he did not have any pre-existing medical condition or health concerns. He was appropriately screened on his first night at Belmarsh and a second health screen was completed the following day. While at Belmarsh Mr Balogun did not complain of symptoms associated with deep vein thrombosis. However, he did complain of symptoms associated with pulmonary embolism in the days leading up to 6 January.
35. The clinical reviewer concluded that pulmonary embolisms are sometimes missed within the community and the diagnoses require specialist hospital investigations. Mr Balogun did not have any of the known significant past medical problems or risk factors associated with deep vein thrombosis and pulmonary embolism. The emergency response was quick and CPR was administered appropriately. We agree with the clinical reviewer that the care Mr Balogun received at Belmarsh was equivalent to what he would have expected to receive in the community.
36. At interview, Mr Balogun's fellow prisoners stated that he had been complaining of chest pain and had been trying to see a prison doctor. A prison GP said that Mr Balogun had an appointment to see him on 3 January and did not attend. He was not aware of a reason for Mr Balogun's non-attendance. There is no evidence to explain why Mr Balogun missed the appointment. His medical records suggested that he was aware that he was due to see the GP when he attended his NHS health check with the nurse that morning. At Belmarsh, appointments that are missed are automatically rebooked. However, if a third appointment is missed a new request to see the GP must be submitted. There is no record that healthcare staff rebooked Mr Balogun's appointment. The primary care lead said that Mr Balogun's appointment was rebooked, but she was unable to confirm the date. There is also no written policy to support this process. We are concerned that healthcare did not follow up on Mr Balogun's non-attendance or enquire as to why the appointment was missed. We make the following recommendation:

The Head of Healthcare should ensure that reasons for missed appointments are recorded and where they are not rebooked, the reasons for this decision are entered on the clinical record

Restraints, security and escorts

37. 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.

38. On 6 January, the Deputy Governor authorised for Mr Balogun to be escorted to hospital uncuffed by two escorting officers. We are satisfied that the decision not to restrain Mr Balogun was appropriate.

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