Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Howard a prisoner at HMP Standford Hill on 20 June 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*

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.

While a prisoner at HMP Standford Hill, Mr John Howard died on 20 June 2017 of diabetic ketoacidosis (a condition which develops when the body produces high levels of blood acids and not enough insulin). He was 70 years old. We offer our condolences to his family and friends.

Mr Howard was appropriately monitored throughout his time at Standford Hill, and healthcare staff made sure that he was sent to hospital for treatment when his health deteriorated. Mr Howard's clinical care was overall viewed as equivalent to that which he could have expected to receive in the community. We are however concerned that he should have been referred to an external specialist for renal care (although this was not related to his death).

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 **December 2017**

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Summary

Events

1. On 14 May 2015, Mr John Howard was sentenced to five years in prison for immigration offences. He spent time in several prisons before he was transferred to Standford Hill on 15 May 2016.

2. Mr Howard had a history of diabetes, hypertension and chronic kidney disease. A doctor prescribed medication to manage his conditions, and referred him to the appropriate specialists.

3. Between May and October 2016, Mr Howard had difficulty managing his diabetes. On 4 October, he saw a specialist who informed Standford Hill that he had referred Mr Howard to the diabetes centre for further education to manage his condition, and suggested that they should refer him for specialist renal care. There is no evidence that the renal appointment took place.

4. The next month, a doctor referred Mr Howard to a haematologist to find out why he was anaemic. The haematologist believed that it was caused by his renal impairment.

5. On 22 February 2017, Mr Howard had a follow-up appointment for his anaemia. The specialist he saw believed it was caused by chronic kidney disease.

6. On 5 May, Mr Howard complained of problems with his bowels. A doctor tested his blood, and the results showed that he had impaired kidney function.

7. A week later, Mr Howard was sent to hospital and was treated for acute chronic renal failure. He returned to Standford Hill on 14 May.

8. On 19 June, Mr Howard told staff that he was too unwell to attend a hospital appointment. A prison officer referred him to see a prison GP the next day.

9. The next morning, an officer, who was completing roll checks, found Mr Howard unresponsive. Another officer radioed a medical emergency code and prison and healthcare staff tried to resuscitate Mr Howard. An ambulance arrived and despite paramedics continuing resuscitation efforts, Mr Howard was pronounced dead at 8.57am.

Findings

10. We are concerned that Mr Howard was not referred for renal care when recommended by a specialist. The clinical reviewer was of the view that this human error could occur in the community and in any case that this would not have affected the outcome for Mr Howard. He was therefore satisfied that Mr Howard received a standard of clinical care at Standford Hill equivalent to that which he could have expected to receive in the community. Nevertheless, we make the following recommendation:

Recommendation

- The Head of Healthcare should ensure that there is a robust system in place at HMP Standford Hill to ensure that prisoners are referred appropriately and promptly to specialist and secondary healthcare services.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Standford Hill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Howard's prison and medical records.

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

14. We informed HM Coroner for Mid Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

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

Background Information

HMP Standford Hill

16. Standford Hill is an open prison, holding over 400 adult men who are coming to the end of their sentences. It was previously part of the Sheppey cluster of prisons, and some services are still shared. The prison prepares the men for resettlement and release into the community.

17. There are three wings. Physical healthcare services are provided by IC 24 Primary Care Services, and GPs by the Minster Medical Group. Healthcare is available from Monday to Friday between 8.00am until 4.30pm.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Standford Hill was in July 2015. Inspectors reported that the prison had improved since their last inspection in 2011. There was a range of healthcare services that were reasonably good, although the healthcare centre needed urgent repairs. Most individuals with a long-term condition had a care plan, but some individuals with complex health issues did not have tailored treatment plans. Referral to hospital was prompt, but too many appointments were missed either because the hospital cancelled them, or prisoners refused to attend.

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 April 2016, the IMB reported that the prison was a safe, well-managed and productive environment. They noted that the healthcare department provided a good range of services, although budget cuts meant a counselling service had not been implemented as planned.

Previous deaths at HMP Standford Hill

20. Mr Howard was the fifth prisoner to die from natural causes since January 2012. There has been one further death since. There are no significant similarities between the deaths.

Key Events

21. Mr John Howard was sentenced to five years in prison for immigration offences, and was sent to HMP Pentonville on 14 May 2015. He spent time in several prisons before he was transferred to HMP Standford Hill on 15 May 2016, where he remained until his death.

22. At Mr Howard's initial health screen, a nurse noted that he had been diagnosed with type one diabetes as a child, was dependent on insulin, had hypertension and chronic kidney disease. He took several medications to manage his various conditions, including his insulin levels (novarapid and levimir), fluid retention (bendroflumethiazide), high blood pressure (perindopril and simvastatin) and low iron levels (ferrous sulphate).

23. On 9 June, a nurse saw Mr Howard in triage and he reported that he was occasionally hypoglycaemic in the mornings. He said that his blood sugars were sometimes as low as 2.9mmol (milli-moles per litre). She arranged for him to see a doctor to discuss how to control his diabetes. She advised him to increase his fluid intake and to return to the healthcare team if he had further problems.

24. On 15 June, Mr Howard saw a prison GP who acknowledged that his diabetes was poorly managed. They discussed how he could improve this.

25. On 4 October, an entry in Mr Howard's medical records said that after a hospital appointment, a diabetes specialist at Medway Community Health Service had written to the prison, suggesting that Mr Howard was referred for specialist renal care. There is no record that this happened. The letter also noted that Mr Howard's management of his diabetes had deteriorated during 2016, and that the specialist had referred him to the diabetes centre for further education.

26. Throughout October, Mr Howard continued to take his medication and manage his diabetes. On 10 November, a nurse saw Mr Howard. At this appointment, his blood glucose levels were recorded within a range of 7-10mmol. (Normal blood sugar levels are between 4.0 to 6.0 mmol/L and up to a maximum of 7.8 after eating.) The nurse recorded that his diabetes control was poor and booked an appointment for him to see a doctor.

27. On 11 November, a prison GP saw Mr Howard and referred him for an assessment in the hospital's memory clinic. He also referred him to see a haematologist to investigate the cause of Mr Howard's anaemia (low iron levels). The haematologist concluded that Mr Howard's anaemia was caused by renal impairment.

28. During the following months, healthcare staff at the prison continued to review Mr Howard's diabetes and ensure that he was managing it effectively.

29. On 22 February, Mr Howard had a follow-up appointment about his anaemia. The oncologist wrote to the prison to say that his anaemia was likely caused by chronic kidney disease, and that they planned further tests in two months to confirm this. There is no record of whether this appointment took place.

30. On 5 May, Mr Howard complained of constipation and then diarrhoea. A prison GP tested Mr Howard's blood and examined Mr Howard's abdomen, which was uncomfortable, and his prostate. The GP created a care plan to manage his diabetes.

31. On 10 May, a prison GP recorded Mr Howard's blood pressure as 132/70. (This was slightly high – 120/80 is considered ideal.) The next day, the blood results showed high creatinine levels (which indicate impaired kidney function). That day, a prison GP sent Mr Howard to hospital to be treated for acute chronic renal failure as a non-urgent case. The hospital found that his blood sugar levels were high and that he had raised ketones (which can indicate diabetic ketoacidosis, a potentially life-threatening condition) and raised haemoglobin levels. Mr Howard was treated with insulin and received a blood transfusion, and was then returned to prison on 14 May.

32. On 16 May, a nurse saw Mr Howard and recorded that he felt 'brighter in himself'. The nurse asked the kitchen to provide Mr Howard with specific foods, in addition to his usual meals, in line with the hospital's advice. The nurse booked an appointment for him to see a prison doctor the following week.

33. Mr Howard continued to attend appointments with prison doctors, and healthcare staff monitored him and gave him his medications.

34. On 19 June, Mr Howard declined to attend a scheduled renal appointment in hospital because he said that he felt too unwell. An officer spoke to Mr Howard and arranged for him to see a prison doctor the next day.

20 June 2017

35. At 7.45am on the morning of 20 June, a Senior Officer (SO) was completing a roll check on A wing, with two officers. When checking on Mr Howard, the SO saw that he was lying on the floor of his cell. In a statement he provided to the PPO, the SO said that when he looked at Mr Howard's chest for movement, he realised that he was unconscious and shouted for help. An officer arrived and at the SO's instruction radioed a medical emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing), recorded at 8.01am. The SO then cleared a space on the floor to which to move Mr Howard. The SO asked the officer to collect the defibrillator, and he started cardiopulmonary resuscitation (CPR). The control room called an ambulance at 8.03am.

36. The officer returned with a defibrillator, attached it to Mr Howard and the reading advised to continue CPR. A healthcare assistant and a nurse arrived at Mr Howard's cell at 8.04am and continued CPR until the paramedics arrived at 8.17am. Paramedics asked for Mr Howard to be moved out of his cell onto the landing to allow easier access. The paramedics asked the SO to continue with CPR so that they could focus on giving Mr Howard medical treatment. An officer and the SO took turns in administering CPR. The paramedics then asked staff to stop resuscitation efforts, took further observations and, at 8.57am, pronounced Mr Howard's death.

Contact with Mr Howard's family

37. The prison appointed a chaplain as the family liaison officer. He visited Mr Howard's wife and son to break the news of his death to them on 20 June at 11.10am. He told the investigator that Mr Howard's wife wanted limited contact with the prison and that they respected her position.

38. Standford Hill offered to contribute towards the funeral expenses in line with national policy. Mr Howard's wife initially refused the offer of a financial contribution, and accepted at a later date after she had already paid the funeral directors. The prison's finance department could not give Mr Howard's wife the money directly as it was against standard procedures to pay funeral expenses to an individual. Prison staff instead contacted the funeral directors, who agreed to invoice the prison and reimburse Mr Howard's wife. Standford Hill received the invoice on 16 July and on 28 August the invoice was processed and sent to a manager for approval. Due to a technical issue, the manager was not notified, and this resulted in a delay in paying Mr Howard's wife. The prison has told us that she has now been paid.

Support for prisoners and staff

39. After Mr Howard's death, the Deputy Governor and a member of the health and wellbeing team 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.

40. The prison posted notices informing other prisoners of Mr Howard's death, and offering support. Staff spoke to prisoners who had lived on Mr Howard's wing.

Post-mortem report

41. The post-mortem report gave the cause of Mr Howard's death as diabetic ketoacidosis. (This condition occurs when the body produces high levels of blood acids called ketones and cannot produce enough insulin.)

Findings

Clinical care

42. We agree with the clinical reviewer that Mr Howard received appropriate care while a prisoner at HMP Standford Hill and this was equivalent to that which he could have expected to receive in the community.

43. The clinical reviewer noted that while Mr Howard's death could not have been anticipated, he had risk factors (long term diabetes and renal impairment) that would have contributed to his death. Despite this, he noted that diabetic ketoacidosis was not always associated with raised blood sugar levels and could progress very rapidly, sometimes in less than 24 hours.

44. The clinical reviewer concluded that the failure to refer Mr Howard to the specialist renal team would not have detrimentally affected his health. He viewed this as an oversight, as can happen in the community, and he would therefore not judge the care that was offered in the prison to be lacking in equivalence based on this episode. Nevertheless, we are concerned that in other instances, such a failure might have negative consequences. We make the following recommendation:

The Head of Healthcare should ensure that there is a robust system in place at HMP Standford Hill to ensure that prisoners are referred appropriately and promptly to specialist and secondary healthcare services.

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