Investigation into the circumstances surrounding the death of a man at hospital in December 2010 while in the custody of HMP Sudbury

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is a report into the death of a man at hospital in December 2010. He was 45 years old and had arrived at HMP Sudbury on 21 September. He was admitted to hospital on 27 October 2010 following an outpatient's appointment. He remained in hospital undergoing investigations but his condition deteriorated and following admission to the Intensive Care Unit he died in December 2010. A post-mortem has given the opinion that the cause of death was multi-organ failure, cause not determined.

I offer my sincere condolences to the man's family and friends. The investigator and Family Liaison Officer join me in offering our sincere condolences to his family and friends for their sad loss. I would also like to apologise for the delay in issuing this report.

Having committed serious offences, the man was sentenced to 16 years in custody. He had progressed well through his prison sentence and was transferred to Sudbury, an open prison, for what was considered to be the last stage of his custodial sentence. He was already an ill man when he arrived at Sudbury and had been feeling unwell for some time. He had been investigated for weight loss and had also suffered from nausea and vomiting.

I wish to thank the Governor of Sudbury for making the necessary facilities and information available to the investigator. I also thank the prison Liaison Officer for her assistance.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. The clinical review was led by the Lead Reviewer and an assistant. I am grateful for their thorough review. I am also grateful to the healthcare staff at HMP Stocken who assisted the clinical review team by providing information relating to the man.

As is often the case in investigations following a death from natural causes, I rely heavily on the findings of the clinical review. In this case, I make two recommendations concerning the passing of medical information between prisons and the assessment of using public transport for prisoners with acute health conditions. The Prison Service has accepted both recommendations and their comments on these can be found at page 25 in this report.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Thea Walton
Acting Deputy Ombudsman **December 2011**

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SUMMARY

1. The man received a 16 year prison sentence on 13 August 2004. He served his sentence in a number of prison establishments including HMP Stocken before being transferred to HMP Sudbury, his final prison, in September 2010.

2. He was an unwell man prior to arriving at Sudbury. At Stocken he was investigated for weight loss and had been suffering from nausea and vomiting. These investigations continued following his arrival at Sudbury. He attended the Accident and Emergency department at hospital on 27 September where he was diagnosed with a chest infection. On 13 October, he was referred to gastrointestinal surgeons via the two week wait process (which is triggered when cancer is suspected) and was seen on 27 October. He was admitted to hospital for further investigations that day.

3. He remained in hospital undergoing investigations but his condition deteriorated and, following admission to the Intensive Care Unit, he died in December 2010. A post mortem concluded that the cause of death was multi-organ failure, but could not determine a cause.

4. In this case, I make two recommendations concerning the passing of medical information between prisons and the assessment of using public transport for prisoners with acute health conditions. The Prison Service has accepted both recommendations and their comments on these can be found at page 25 in this report.

THE INVESTIGATION PROCESS

5. The investigation into the man's death was initially opened on 8 December 2010, when one of my investigators visited Sudbury. On speaking to the liaison contact and the Governor, he was informed that the man had been released from prison after his admission to hospital on 27 October, where he remained until his death. All documentation relating to him was made available, including the ROTL documentation.

6. As the man had been released, it was initially thought by my office that this case fell to be considered under my discretionary powers. It was decided that the PPO would not investigate. However, following further contact from the Coroner's officer, it was found that this initial decision was incorrect, as he had been released on temporary licence and therefore still categorised as a prisoner. Unfortunately, this caused a delay to the progression of this investigation.

7. A new investigator was subsequently appointed to investigate the man's death on behalf of the Ombudsman on 4 February 2011. Notices to staff and prisoners about the investigation were sent to the prison in advance of his opening visit on 10 February.

8. The investigator met the Head of Healthcare and the Governor. Copies of the man's medical records and prison files were made available. No members of the Independent Monitoring Board (IMB, who monitor the day to day life in prison and ensure standards of care and decency are maintained) or the Prison Officers' Association asked to see the investigator. He visited the healthcare unit and the wing where the man had lived. Three members of staff and one prisoner were interviewed on a later date.

9. A review of the man's medical care was commissioned by the local PCT. The clinical review was led by the Lead Reviewer and an assistant. I am grateful for their assistance and report which will also be shared with HMP Stocken.

10. One of my Family Liaison Officers contacted the man's mother and partner to tell them about the scope of my investigation and offer them the opportunity to raise any questions or concerns they would like to be addressed. They raised the following concerns:

    - His mother said that when he was in Stocken, he had told her repeatedly that he was unwell and staff did nothing.

    - The doctor at the hospital had told her that he had been unwell for 16 months. She said that she was not aware of this. The doctor informed her that he had a 'bug'. His mother said that she however finds it hard to believe that a 'bug' could have lain dormant and then killed her son.

    - The issue had also been raised as to whether his mobility was of a reasonable level to travel from Sudbury to the hospital on public transport as opposed to in a taxi or prison vehicle.

- His partner had raised a general concern to staff at Sudbury at the time of his death. This was that they were concerned about the level of care and treatment he received at HMP Stocken.

11. I hope that the report provides them with a better understanding of the man's time in custody and the events leading to his death.

12. The man's partner and her legal representative received a copy of the draft report as part of our consultation process and written representations were provided on her behalf in response to the findings of the investigation. She raised a concern at a lack of communication between HMP Stocken and HMP Sudbury at the point of his transfer and said that,

> "the absence of communication was problematic not only in respect of his presenting condition on 21 September but that better effort should have been made to conduct a comprehensive handover, in light of his extensive prior involvement with Healthcare services at HMP Stocken"

13. A number of other issues were raised and where appropriate, the investigator has amended the report. It was felt, however, that some of the concerns would be more appropriately addressed outside of this report. He has sought to address these in separate correspondence to the man's partner and legal representative.

HMP SUDBURY

14. The prison is situated in Derbyshire. It is a category D open prison holding medium to long term adult male prisoners, including a number of men serving life sentences.

15. HMP Sudbury was built as a hospital for the US Air Force for the D-Day landings and was converted to a prison in 1948. Most of the original single storey accommodation is still in use but has been converted to double or single rooms. New single storey buildings accommodate prisoners in either single or two-man rooms. A Modular Temporary Unit (MTU), containing 40 single rooms on two floors, was installed during 2003. Accommodation comprises of 213 single rooms and 175 double rooms.

16. Healthcare services are commissioned by the local Primary Care Trust (PCT) and provided by the prison. Healthcare is managed by a non-clinical healthcare manager/principal officer, supported by a band seven clinical lead nurse with line management responsibility for the nursing staff. The healthcare department is a self-contained building in the centre of the prison. The PCT have recently made a separate prefabricated building available for Counselling, Assessment, Referral, Advice and Throughcare (CARAT) work and smoking cessation groups. Patients are able to attend the healthcare department, without restriction, at designated times. During these periods, the, main door is unlocked and prisoners are able to seek advice and ask for appointments, as well as attending pre-booked consultations.

17. The regime at Sudbury offers full-time and part-time education and evening classes, workshops, training courses (bricklaying, painting & decorating and industrial cleaning), farms and gardens, kitchen and a maintenance department. Offending behaviour groups available are Enhanced Thinking Skills and Cognitive Skills Booster. There are also special features (including paid and unpaid employment, training and education in the community), a listener scheme for prisoners (a prisoner trained by the Samaritans) who may be at risk from suicide or self-harm, an anti-bullying committee. There is a voluntary drug testing unit and a drug support group offering CARATS and support for those with drug problems.

Her Majesty's Chief Inspector of Prisons

18. Her Majesty's Chief Inspector of Prisons reports on all prison establishments. The most recent report on HMP Sudbury by HM Chief Inspector of Prisons followed a full announced inspection in April 2010.

19. In the healthcare section to the latest report on Sudbury, the then Deputy Chief Inspector said,

> "Healthcare services were reasonable, and in our survey prisoners were more positive about their experience of healthcare than at comparator establishments. There was good engagement between the prison and the primary care trust. The health needs assessment was out of date and it was not clear whether services met the current population's health needs.

"Clinical governance was fragile and required urgent attention. Access to GP and primary care services, including the dentist, was good. There were no designated nurse-led clinics for patients with chronic diseases. The system of recording of medication administration exposed patients and staff to risk of error. There was no triage protocol when prisoners first presented for appointments. Access to other specialist services was good. Mental health services were limited."

Incentives and Earned Privileges Scheme (IEPS)

20. IEPs were introduced as an incentive to reward good behaviour in prisons. There are three levels, Basic, Standard and Enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell and community visits. Each prison sets its own criteria to obtain each level.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) made up of members of the public. Their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. In the first instance, the Board report any concerns they may have to the Governor, or, if considered necessary, reports directly to Parliament. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

22. In its latest report (2010), in relation to the healthcare services offered, the Board said

"Whilst the Board considers the Healthcare needs of the prisoners are met it is considered that by moving to a more structured PCT model as used by some other prisons, would enable the healthcare provision to be enhanced."

Previous deaths at Sudbury

23. This is the fifth death at Sudbury that my office has investigated since becoming responsible for investigating all deaths in prison custody in April 2004. None of the circumstances of the previous deaths were similar to that of the man.

Open Prisons

24. An open prison is the lowest category of prison (Category D) that a prisoner can be housed in. It is used as the final prison before a prisoner is released back into the community and while there prisoners maybe allowed to take town visits, resettlement leave and be able to work.

Release on Temporary Licence (ROTL)

25. In certain circumstances a prisoner will be allowed to leave prison on a temporary licence. The purpose of this is either for compassionate reasons or to help the prisoner improve their chances of resettlement after their release. The system of release on temporary licence (ROTL) is designed to ensure that suitable prisoners are released for precisely defined and specific activities, which cannot be provided in Prison Service establishments. In order to ensure public safety and maintain public confidence in the system, prisoners are only released on temporary licence after they have been rigorously assessed and approved for ROTL by an authorised senior manager.

Special purpose licence

26. Special purpose licence (SPL) is a form of ROTL. It is designed for releases of a short duration, often at short notice, that allows eligible prisoners to respond to exceptional personal circumstances. Special purpose licence may be granted for prisoners to attend medical out-patient appointments, or in patient requirements. SPL was granted to the man to attend his hospital appointments.

27. All prisoners, except those who are excluded (for particular reasons), may apply for temporary release on a special purpose licence. There is no minimum eligibility period. All releases for this type of licence are subject to the normal risk assessment process, including home circumstances report and/or victims issues where appropriate.

28. The duration of any temporary release on a special purpose licence should normally be of no more than the few hours needed to achieve the stated purpose. Reasonable travelling time must be taken into account.

29. The Governor has discretion whether or not to allow a licence to cover overnight absences. The maximum duration of this licence should ordinarily be no more than four nights in a calendar month although, exceptionally, the Governor may agree to grant back-to-back licences. There is no maximum duration of a special purpose licence where a prisoner is receiving in-patient treatment in hospital.

KEY EVENTS

30. The man was born in December 1964 in Leicester. His offending history dates back to 1977 with a pattern of offending for financial gain, illicit drug misuse and driving offences. He was convicted and sentenced to a seven year term in prison on 26 August 1999. He was released on licence on 21 October 2002 but was later remanded back into custody during April 2003, in relation to further serious offences. As a result, his licence was revoked and he was recalled. He was subsequently charged with Conspiracy to Commit Robbery and after appearing in court on 13 August 2004, was later sentenced to a 16 year jail sentence.

31. The man served his sentence in a number of prison establishments including HMP Channings Wood, HMP Leicester, HMP Nottingham, HMP Dovegate and HMP Stocken before being transferred to HMP Sudbury. Whilst in custody he completed a number of educational classes, was a listener (a prisoner trained by the Samaritans) and a mentor. He was an IEP enhanced prisoner who regularly received negative Mandatory Drug Test (MDT) results.

Prior to the man's arrival at HMP Sudbury, from November 2009

32. On 16 November 2009, the man transferred from HMP Dovegote to HMP Stocken. As is usual procedure, he underwent the prison reception and secondary health screenings within the first few days. Following a nurse assessment, on 19 November, it was noted that he was awaiting blood test results (taken whilst at Dovegate) and that he had chest pain, back pain and weight loss and that he was anxious that something was wrong with him. It was also noted that he was under the care of the hospital for problems with his hands (which were generally cold).

33. The nurse prescribed analgesia (drugs used to relieve pain), referred the man for physiotherapy and arranged for him to see the doctor. It was also noted that Dovegate should be contacted for the results of his blood tests and that his medical file should be checked regarding his appointment at hospital.

34. The man was seen by the doctor on 1 December. It was noted that he had blood tests prior to his transfer to investigate symptoms of tiredness. His appetite was low and that he had lost weight (going from 16½ stone to 15 stone). He was also experiencing chest pains and was a smoker. Following examination, his heart and chest were considered to be normal and further investigations (blood tests and an electrocardiogram[1]) were arranged. He was to be reviewed following the results of the tests. (The test results were completed on 8 December 2009.)

35. On 24 December, he was seen by the doctor to review his test results. It was noted that his red blood count was at the lower end of the normal range and that two of his liver function tests were slightly elevated. He had previously been an intravenous drug user. Examination of his chest and abdomen were

[1] Electrocardiogram is a test commonly used to detect abnormal heart rhythms and to investigate the cause of chest pains.

normal and further blood tests were arranged. These tests were to include a check on whether he had any possible blood borne viruses.

From January 2010

36. The man was seen by the doctor again on 14 January 2010. His blood tests were again noted to be within the normal range, but he was complaining of tiredness because of recent poor sleep pattern. He was prescribed a short course of amitriptyline (used to treat symptoms of depression and/or insomnia) to help. It was noted that he had eczema on his leg and he was prescribed cream. His hand problem was diagnosed as Dupuytren's contracture (a condition that affects the hands and fingers) and surgery was discussed, although the doctor believed it would only be beneficial if it reached a more advanced stage.

37. In March, the man was seen by a nurse after complaining of having pins and needles in the ends of his fingers and both big toes. His hands were also cold to touch. An appointment with the prison doctor was arranged although he did not attend.

38. The man was next seen by the doctor on 15 April when he presented with three problems. These were otitis externa (an infection of the ear canal), Dupuytren's contracture of his hand, for which he was referred to the orthopaedics department at hospital and thickened toe nails, for which he was advised to see a chiropodist.

39. The following month the man complained of numbness in his feet and arm which lasted 15-45 minutes. When he saw the nurse, he said that he had felt that way for the last two to three weeks. An appointment was made for him to see the doctor who thought that the numbness and tingling in his finger tips and toes might be due to Raynaud's disease (a disorder of the blood vessels, usually in the fingers and toes). The doctor ordered further blood tests to be carried out so this could be confirmed.

40. Results of the man's blood tests were received on 2 June and he was seen by the doctor to discuss these. The blood tests showed the following:

    - An abnormal level of creatine kinase (an enzyme made by muscle cells. When muscle cells are injured or diseased, enzymes leak into the blood)
    - Raised C-reactive protein (a marker of inflammation)
    - Raised platelets (platelets help the blood clot)
    - Neutrophil count and a blood electrophoresis that suggests an acute phase reaction (a neutrophil is a special kind of white blood cell, the levels of which can be raised if an infection is present)

41. The doctor conducted an electrocardiogram and also took a urine sample. The doctor noted that the man had no chest or muscle pain. The man was however still not happy with his weight loss. Further investigations were planned.

42. The man was reviewed on 8 June. It was noted again that he was tired. His hands were generally cold and, over the last three to four weeks, he had developed some darkened areas on his forehead and cheeks. A referral to the Rheumatology Unit (which deals with disorders affecting the musculoskeletal system, particularly the joints and surrounding soft tissues) in Peterborough and the hospital was made with the doctor querying whether he had an unusual connective tissue disease.

43. The next week, on 16 June, following an appointment with the nurse, it was noted that the man had a stomach ache. The doctor saw him and noted a new onset of epigastric pain (in the upper middle region of the abdomen) which was thought to be due to gastritis (an inflammation of the lining of the stomach). Antacids (which are taken to neutralise the acid made in the stomach) were prescribed.

44. On 25 June, the doctor recorded the man's weight as 89kg (14 stone). When he saw the nurse on 7 July, his weight had decreased to 84kg (13.2 stone). An appointment with the doctor was made and he was to be reweighed in a week. The nurse also noted that he had mouth ulcers, periodic stomach pains and no appetite to eat. His medical record showed that when examined on 14 July, his weight had increased to 86kg (13.5 stone), although he was still experiencing sharp abdominal pains.

45. Since arriving at Stocken the man had been accepted on the Kainoe course (a programme that addresses prisoners' offending behaviour through course work, community living, team building, social interaction and ongoing individual assessment) and was a role mentor. Having held enhanced IEP status for a number of years, all staff spoke highly of him. He was working towards his category D status, where he would be progress to open prison conditions. He believed that this was being delayed because of his scheduled hospital appointments.

46. The man saw the doctor the next on 20 July where his weight was noted as 84kg (13.2 stone). His hospital outpatient's appointment was scheduled for 3 August and it was noted he should not miss it. Omeprazole (a treatment for stomach inflammation and ulcers) was prescribed.

47. Further to his referral, the man saw the Consultant Rheumatologist (a physician who is qualified in the diagnosis and treatment of arthritis and other diseases of the joints, muscles and bones) on 3 August at hospital. Suspecting that he may be suffering from dermatomyositis (a muscle disease), further blood tests and an electromyography (a test that checks the health of the muscles and the nerves that control the muscles) was arranged. The Consultant also noted that he saw no reason why his current treatment should delay his transfer to an open prison and that he (the Consultant) could liaise with a local rheumatologist should he be transferred.

48. The man received this information on 5 August and submitted a complaint to the Offender Management Unit (OMU) in the prison. He stated that his move to a Category D open prison was being delayed due to his medical condition. He

had however now seen the hospital consultant who stated that there was no reason, from a treatment point of view, that he could not be transferred. The following day, healthcare responded to his complaint by contacting OMU who said that he would need to re-apply for "Cat D status". The prison doctor would also be contacted to review the information received from the hospital consultant and inform OMU of any issues that may arise.

49. On 20 August, the Rheumatology Department at the hospital contacted Stocken healthcare department to make an appointment for the man. However, there were no escorts available on the day that was offered. It was noted that the hospital asked for another referral stating the appointment was not urgent.

50. The man was seen by a healthcare nurse on 26 August. He had complained of vomiting which had started the previous night and was experiencing abdominal pains. His weight was recorded as 83.4kg (13.13 stone). The next day the doctor examined him. The doctor noted a two day history of epigastric pain and vomiting. He was found to be tender in the epigastrium (the upper central region of the abdomen) and it was thought that this may have been due to a stomach ulcer. The dose of the medicine that he was prescribed to treat his stomach ulcers and gastritis was increased. He was also prescribed medicine (domperidone) to stop him vomiting

51. A review of the man's symptoms was diarised for a week's time (or sooner if further symptoms showed or if he displayed no improvement). Should this occur, he was to be referred to a gastroenterologist (a medical professional who specialises in the treatment of patient conditions affecting the liver, intestine and pancreas).

52. On 8 September, a risk assessment for the man's move to a lower category prison was conducted. The OMU and wing staff supported his application. He was re-categorised to Category D, with a move to Sudbury, an open prison, was recommended.

53. On the morning of 20 September, the man was seen by the nurse on duty. He had been seen the previous night by the out of hours doctor because he had been vomiting. The nurse noted that he had been vomiting daily and that increasing the dose of his stomach medication had not helped. He had not however been given the anti sickness medication and so this was dispensed. No reason was recorded for this. It was noted that he was to be transferred to Sudbury the following day.

The man's arrival at Sudbury

54. The man transferred to Sudbury on 21 September. As is normal, he went through the prison reception screening and induction process. As part of this, he was assessed by a member of the healthcare team who had sight of his medical record. The nurse noted that he had been vomiting and was apparently no better despite being on an antiemetic (domperidone) and a tablet for stomach ulcers. He said that had not wanted Stocken to investigate his condition further as this might have impacted upon his move.

55. The following day, the man was examined by the prison doctor. It was noted that he had been vomiting regularly but that his weight had recently stabilised. A chest x-ray and blood tests were arranged, to be followed by a review with a view to referring him for an endoscopy (a test to look inside the oesophagus, stomach and duodenum).

56. On 23 September, the prison chaplain received notification from the hospital that the man's mother was seriously ill. This was documented on the form "Action to be taken in case of Notification of Serious Illness or Death of an Inmate's Relative or Partner", at section one. Sections two to four on the form were been completed. (These sections confirm who the information has been checked by, how and when the information was passed onto the prisoner, any risk associated with receiving the information and any action to be taken, such as arranging for the prisoner to visit the relative.) My investigator spoke with the chaplain who said that she had informed him of his mother's illness. However, she could not recall what he said and did not record this conversation on any prison records.

57. On 27 September, the man was taken to the Accident and Emergency department at hospital suffering from chest pains and breathing difficulties. He was discharged to Sudbury the following morning. A chest X-ray was conducted as part of the investigations and he was later diagnosed by the doctor as having a chest infection. He was prescribed co-amoxiclav (a penicillin antibiotic used for infections) and it was arranged that he would be reviewed daily by the nurses on duty who would refer him to the doctor if they had any concerns.

58. The man completed Release on Temporary Licence (ROTL) application forms in the following few days. He had applied for two periods of one day's ROTL for December 2010 to visit his partner. He also completed a further ROTL form for a four day visit to his partner in January 2011. The forms were then risk assessed by the Risk Assessment department and his probation officer.

59. The man's discharge letter from Accident and Emergency department was received by Sudbury on 1 October. It noted that he attended the hospital feeling generally unwell and attached copies of his test results. His chest x-ray result arrived on 4 October. It showed a diffuse opacification (shadowing on the lungs) in the left lower zone, which was believed to be indicative of infection or inflammatory changes. It was recommended that a follow up x-ray be carried out after treatment to ensure that the problem had been resolved.

60. At the man's doctor's appointment on 7 October, it was noted that he felt much better, having completed his course of antibiotics. The follow up chest x-ray was arranged for four to six weeks time.

61. On 13 October, the man was seen again by the prison doctor. It was noted he was feeling unwell, had a poor appetite, had lost further weight and suffered from shortness of breath. Test results showed that he was anaemic (suffering from a lack of iron which can lead to anaemia) with raised inflammatory blood

tests (indication of possible inflammation or infection. The doctor made an urgent referral to the gastroenterology department using the two week wait rule (which is triggered when cancer is suspected). Two days later, the healthcare department received notification of two hospital appointments for him, on 27 October and 2 November.

62. Over the next two weeks, the man was seen on two occasions by healthcare. On 22 October, he went to the nurse with a sore throat, decreased appetite and a temperature. He was given paracetamol. Then, on 25 October, he was seen by the doctor. It was noted that he should refrain from any work activities until after his hospital appointment scheduled for 27 October.

63. In preparation for the man's pre-arranged hospital appointments, ROTL forms for his special licence were completed. A ROTL 4 (risk assessment) form was completed on 25 October and identified that he was to attend a hospital appointment on 27 October. A ROTL 7 (licence and conditions) and ROTL 8 (Inability to Return to Prison due to Medical Reasons form – to be completed by hospital doctor if necessary) were subsequently generated on 26 October and 27 October respectively. The ROTL 7 highlighted that his special licence was for him to attend his hospital appointment between 12.30pm and 4.30pm on 27 October.

64. A Senior Officer told my investigator that he completed the ROTL 4 form. After the ROTL 4 form was completed, it was sent for approval to a governor who was the Head of Operations and Security. He noted on the form "agreed with assessment" and "ROTL Approved", dated 25 October 2010. Further additional information had been added after these words stating "for appts + also if admitted". At interview the governor confirmed authorising the ROTL.

65. The man had shared a cell with another prisoner since his arrival at Sudbury in September. The cellmate told the investigator that the man was happy to be at Sudbury. He got to know him in the short time they spent together during which the man often talked about his wife and children.

66. The cellmate said that the man did not talk about his health issues much, but his breathing difficulties caused enough concern for the cellmate to ask him on a number of occasions if he was okay. He would say he was okay and just needed to catch his breath by sitting down. He was unsure of exactly what was wrong with him, and told the cellmate that his problems may have related to his heart. The cellmate described him as looking "drawn" in his face, having lost lots of weight. Prisoners who had previously known him had commented to the cellmate, that the man was unrecognisable.

67. The man could do the day to day things by himself but he could not walk very far as he would get out of breath. The cellmate believed that he was a very ill man who, on occasions, had almost collapsed in their cell. When this occurred he advised him to see the prison doctor, but he refused stating he would be okay once he sat down and caught his breath. Knowing that he was not a well man, the cellmate helped him as much as he could by at times by making his bed and getting him a drink if he needed one.

Events from 27 October 2010

68. On the morning of the man's hospital appointment (on 27 October), he was described by his cellmate as being in a happy mood. He left their cell and told him he would be back later. Although he was able to walk unaided, the cellmate said he looked unsteady on his feet.

69. While he was on his way to his outpatient's hospital appointment the man telephoned his partner to talk to her about his appointment. After his death, his partner told the prison's Family Liaison Officer that he struggled with the lengthy walk to the nearest bus stop whilst getting to the hospital. He had also experienced breathing difficulties.

70. When the man saw the hospital consultant, it was decided that he should be admitted to hospital as an in-patient. The prison was informed. The consultant responsible for his care also confirmed this in a letter to the prison healthcare department. The letter said,

> "Thank you for this UCR (Urgent Care Referral) in a man with quite profound weight loss, anaemia, shortness of breath and epigastric and chest pain. His x-ray today in clinic was no more revealing than the previous one done some weeks ago but in view of his severe illness I am arranging to admit him as an emergency today for a CT scan [computerised tomography] scanner is a special kind of X-ray machine."

71. Looking at the man's ROTL 4, it seems that at this time it was amended to include "for appts also if admitted", as mentioned earlier in my report. At this point, however, a new licence, ROTL 7, should have been created as the original ROTL was only valid for 27 October between 12.30pm and 4.30pm. However, no record of a new ROTL 7 was found in his prison records.

72. The hospital contacted the healthcare department again on the morning of 29 October. The man was to remain as an inpatient over the weekend. They also sent a further letter to the prison on 4 November. The letter stated that a number of tests and investigations had been completed and the cause of his illness could not be found. His blood tests raised no concerns apart from him having a persistently raised white cell count, and it was also identified that he had a possible lung infection. The letter concluded by saying the following,

> "Today I performed a gastroscopy [a test to look inside the oesophagus, stomach and duodenum] which is basically normal apart from some mild gastritis [an inflammation of the lining of the stomach]. A CLO test [a rapid test for diagnosis of Helicobacter pylori] was negative and I imagine we will be discharging him back to your care within the next few days but he will need to come back for a colonoscopy [a procedure which is the inspection of the large bowel with a colonoscope] which I will organise in the next 2 or 3 weeks."

73. Over the next three weeks, the man remained in hospital. His partner visited him every day. The hospital spoke with the prison healthcare department every

one to two days with an update on his condition. Prison staff also visited and spoke directly with him about how he was feeling. The Head of Healthcare reported daily to the management meeting with an update on his health. Whilst undergoing investigations, he also had a fever which he told the prison staff was thought to be a form of pneumonia. He was treated with antibiotics whilst hospital staff continued their investigations which included further x-rays and scans. The hospital was still not sure when he would be discharged.

74. On the morning of 29 November, the hospital contacted the healthcare department. The man had been transferred to the Intensive Care Unit (ICU) because he had experienced a fit during the previous night. His condition subsequently deteriorated and he was placed on a ventilator to assist with his breathing. This information was passed onto the duty governor and was discussed in the management meeting the following morning. The hospital was asked to keep the prison informed of any changes to his condition.

75. The hospital contacted the prison on the morning of 30 November. They said that the man's condition was now critical and he was currently on a life support machine. Because of his poor prognosis, the Deputy Governor appointed a Family Liaison Officer (FLO) so that contact with the next of kin could be made. She subsequently contacted the hospital and spoke with the nurse who was caring for the man. He was described as having multiple organ failure and on complete life support with his condition believed to be irreversible and his death imminent. He was heavily sedated and unresponsive. The nurse said that the FLO could visit him. His next of kin, his partner (who referred to herself as his wife) and their son had been visiting him whilst in hospital and were at his bedside at this time.

76. The FLO attended the hospital to provide support to the family. The consultant responsible for his care briefed his partner and the FLO of his prognosis. He said that his condition had continued to deteriorate and that hospital staff did not know exactly what was wrong with him. The FLO remained at the hospital until late afternoon offering support to his partner. She later returned to the prison to inform the Governor that his death was expected to be imminent.

77. The FLO spoke the man's partner about what support she had from other family members or friends and offered to help in any way she could. She said her parents were deceased and that his mother was critically ill in hospital. There was no mention of his father. She said she visited his mother regularly in hospital. Given his mother's poor health, the FLO believed that as she was liaising with the man's wife (which is what she referred to herself), it would be inappropriate to try to contact his mother, presuming his partner would do this. The FLO did provide her full contact details to her which could be passed on to any other members of the family who wanted to be informed of his current health condition. This included the man's other son, who was in contact with his partner.

78. The following morning at 5.00am, the man died. His partner was at his bedside. The FLO was immediately telephoned (at home) by the hospital and updated on what had occurred. She in turn contacted the prison to inform the

duty governor. The prison's death in custody contingency plan was immediately activated with all the necessary agencies contacted.

79. The FLO and the Deputy Governor attended the hospital around 9.00am. The man's partner had already left but they spoke with the consultant who was treating the man. The FLO telephoned the partner afterwards and her telephone was answered by her son. Thereafter, the FLO kept in daily contact with her and her son offering support whilst they arranged the funeral. The prison also made a financial contribution towards the funeral expenses. The man's partner also visited the prison and collected his personal belongings and was given the opportunity to speak with the cellmate.

80. Following the man's death, the FLO arranged for a case conference to be held with the healthcare staff in place of the standard hot debrief meeting, because of the circumstances in which he died. This was so all involved could gain a clearer idea of the circumstances leading up to his death. This found that in the short time that he had been at Sudbury, multiple tests and hospital appointments had been arranged, and his health needs were seen to be addressed. Staff and the cellmate had also been offered support.

Post mortem

81. A post mortem report gave the cause of the man's death as multi-organ failure, with a cause not determined.

ISSUES

Clinical Care

82. The clinical review has highlighted that the man was unwell for some time before he died. For the last five weeks of his life, he was an inpatient in hospital undergoing tests to discover the cause of his illness. However, staff at the hospital were unable to establish the cause despite many investigations. The clinical reviewer suggests that the diagnosis of the underlying illness was therefore not an easy one to make.

83. In general, the investigators felt that the clinical management of the man before admission to hospital was equitable to that he could have expected to receive in primary care outside of the prison healthcare system. It is worthy of note that between 17 November 2009 (when the medical records provided to the investigation team start) and 25 October 2010, he had 33 documented contacts with the healthcare teams at HMP Stocken and 11 whilst at HMP Sudbury.

Delays in routine doctor's appointments at HMP Stocken in 2009/2010

84. During his time at HMP Stocken, the man attended the healthcare unit several times. The system for seeing a doctor at Stocken at the time was that patients were seen by a nurse initially to establish the severity of the symptoms before an appointment is booked to see a doctor if necessary. On several occasions there were delays of up to two weeks between the nurse triage and the doctors' appointment (November 2009, December 2009 and May 2010). Where the situation was thought to require a more urgent appointment, he was, however, seen promptly.

85. The clinical review notes that at the time that the man was in Stocken, there were several staff vacancies within the nursing team and a local GP (doctor) practice provided six sessions of routine GP care during the week (a session is half a day in length). The report of a HM Chief Inspector of Prisons inspection carried out in August 2010 highlighted that primary care services were affected by staff shortages and that there were delays for patients wanting to see a GP.

86. On discussion with the Head of Healthcare and Clinical Matron at HMP Stocken, the clinical review team were told that changes had been made following this inspection, with an increase in nursing staff and a reduction in the delays for routine GP appointments to around one week.

Referral to Rheumatology in 2010 and issues around follow up when a patient moves prison

87. The investigation considered whether it would have been preferable for the man to continue under the care of the Rheumatology Department at hospital after his transfer or whether the transfer to Sudbury should have been delayed. In doing so, the clinical review team were told by Stocken that in Category C prisons, 'medical holds' were not undertaken (a medical hold means that a prisoner will

not be transferred until appropriate medical treatment has been completed). In addition, it was noted that he was keen to move to Sudbury. When considering whether he could have attended further appointments at hospital from Sudbury, the clinical review team were informed that the responsibility for providing an escort to existing hospital appointments lies with the sending prison. Usually, therefore, when a prisoner is transferred to a different prison, hospital appointments are cancelled and, if required, referrals are made to hospitals closer to the receiving prison.

88. It is noted that the Consultant Rheumatologist at hospital felt that there was no reason why the man's transfer to an open prison should be delayed.

89. The clinical review team note that in primary care, when a patient moves areas, existing hospital appointments would not be routinely cancelled by GPs and a patient could continue to receive care from their consultant. In practice, often a patient will ask their new GP to make a referral to a more local hospital. The GP will do this and state the name of the previous consultant so that liaison can take place. Thus the system is different for prisoners than for the wider public.

90. It is noted that, as with all prisons, new prisoners are seen at Sudbury by healthcare teams on their day of transfer. In the man's case a thorough history was taken on arrival when it was established that he had ongoing health needs. An appointment with a doctor was arranged for the next day when it was noted that he had seen a rheumatologist, but at that stage his symptoms pointed to a possible respiratory or gastrointestinal cause to his illness. Blood tests and a chest x-rays were arranged and a follow up appointment organised to see him with the results with a view to a referral to hospital.

91. Thus, in conclusion it does not appear that the man's care was compromised by the cancelling of the rheumatology follow up appointment when he transferred to Sudbury.

Communication of the man's clinical condition on the day of transfer to HMP Sudbury on 21 September 2010

92. The man was unwell with an acute vomiting episode when he was transferred to Sudbury. There was no communication from Stocken to Sudbury of this fact before he arrived. His condition was identified during the initial healthcare assessment at Sudbury on the day of his transfer and it was noted that he had not wanted his transfer delayed. Prisoners are assessed at Stocken also before their departure and transfer to another establishment to ensure they are fit to be transferred.

93. The investigators felt it would have been good practice for Stocken to have telephoned the healthcare department at Sudbury on the day of his transfer to explain his medical condition and the fact that he had been previously vomiting and was unwell. Prison Service Order 3050 entitled "Continuity of Healthcare for Prisoners" states under the section Continuity of Care between Establishments that,

> "Ensuring continuity of care and the effective communication with colleagues that this implies is essential to patient care and thus central to good practice. This will vary depending on the patients needs.
>
> An up to date patient summary card [significant events/problems page], the clinical record and a sufficient supply of medication will often be all that is required. However, patients with more complex health care needs may require more detailed planning such as communicating directly with the receiving health care team in advance of transfer."

I therefore make the following recommendation:

> **The Governor at Stocken should develop a policy of summarising healthcare interventions as a communication tool when transferring prisoners from prison to prison. This should include direct communication via the telephone between healthcare teams if the patient has an acute illness.**

Referral to outside hospital

94. The man arrived at Sudbury on 21 September 2010 and it was identified on arrival that he was unwell. He had some initial investigations and then was referred to hospital through the two week wait suspected rule process on 13 October 2010. This was three weeks after his arrival at the Sudbury. During this time, he had also attended the Accident and Emergency Department of another hospital, where it had been found that he had a chest infection which could have explained many of the presenting symptoms.

95. The referral to hospital appears to have been made within a reasonable time frame following his transfer to Sudbury. It was clear that the doctors considered that he should be seen urgently.

96. The man's family raised the question as to whether he was well enough to travel to this appointment on the bus. This is routine practice for the majority of prisoners at Sudbury when they have to attend appointments in the community. He was seen by a doctor two days before his hospital appointment and although it was recorded that he should not undertake work until after the appointment, there is no record of a discussion as to whether he was fit or not to travel to the appointment on his own.

97. At Sudbury, the normal practice is for prisoners to make their own way to appointments. They are given a licence by the Governor which allows them offsite for a period of time and money for the bus. If someone is unwell and not able to travel by public transport, a taxi is arranged or they are taken by prison minibus. The ability of the prisoner to travel should be determined by a multidisciplinary approach which should include input from healthcare and prison staff. The clinical lead of the healthcare team should also be made aware by the prison staff if an individual was felt to be too unwell to travel on the bus so that alternative arrangements could be made. There was no evidence that such a request was made. Whilst I accept that when such

prisoners are released on a temporary basis they are expected to make their own way to appointments, I do make the following recommendation in view of the fact that Sudbury do not appear to have procedure in place for the assessment and recording of a prisoner's needs in such circumstances.

The Head of Healthcare should review the use of public transport for patients who are unwell and should develop an assessment tool that clearly documents why decisions are made.

Liaison by HMP Sudbury with the hospital when the man was an inpatient

98. During the man's admission to hospital there is evidence of regular contact between the prison healthcare and the hospital with the prison keeping up to date with his condition. This is to be seen as an example of good practice.

Lack of Old Records

99. The investigators were unable to find clinical records for the man pre-dating his admission to Stocken. When we enquired further, we were supplied with some additional drug charts. We suspect there are some older clinical records somewhere within the prison system, which have not yet been found. However, on balance, we consider that the lack of older records had not impeded our investigation.

Notification of a sick relative

100. Prisoners are encouraged to maintain contact with family and friends. It was recorded that the prison received information that the man's mother was seriously ill. It was not clear from the documentation how he was informed and supported. The chaplain told the investigator that she had informed him of his mother's poor health, but could not recall any other details.

101. On passing on sad news such as this, staff should ensure that support mechanisms are in place should the prisoner become upset or distressed. It should also be documented to allow all staff to be aware that the prisoner has had a change in personal circumstances which could impact on his well being and mood. I note that Sudbury already has the procedures in place to do this, and so, rather than make a recommendation, I suggest the Governor reminds all staff at Sudbury of the need to make a clear record of all significant events and decisions relating to prisoners.

Release on Temporary Licence (ROTL)

102. The investigation does not question that the man was permitted to be granted ROTL for the initial purpose of attending a pre-arranged hospital appointment. However, when he was admitted into hospital, his present licence (ROTL 7) conditions (which only covered a four hour period) became invalid. It would appear that when this occurred, his ROTL 4 form, which was initially used for his attendance at a hospital appointment, was amended to cover his admittance

to hospital. A new licence however was not issued for his admittance as an in-patient in hospital, as is required under guidance in PSO 6300.

103. Whether this oversight was as a result of a new ROTL 4 form not being completed is unclear. Although this did not have any effect upon the healthcare the man received as by this time he had been admitted to hospital. I am aware that Sudbury completes a high volume of ROTL forms each week. Although I make no recommendation on this matter, to reduce such oversights occurring, the Governor may wish to remind staff to ensure that the completion of ROTL forms are carried out in a logical and systematic way to make sure that stages in the ROTL process are not missed out.

CONCLUSION

104. The man was already an ill man when he arrived at Sudbury, which was noted by reception healthcare staff. He subsequently had a number if interactions with the healthcare department and outside hospital. None of these interactions found an underlying cause for the symptoms he was presenting with.

105. When the man attended his pre-arranged hospital appointment on 27 October, it was believed he would return to prison that day. However, the hospital consultant took the decision to admit him for further tests. After a few days, it was expected that he would be discharged but his health continued to deteriorate. The underlying cause of his illness was still unknown at the time of his death.

106. Given that the man was very ill for quite a lengthy period of time and had a lot of healthcare intervention in prison and at outside hospital, I do not believe that his death was preventable. The clinical reviewer has found that his treatment while he was in prison was equivalent to that which he would have received in the community.

RECOMMENDATIONS

1. The Governor at Stocken should develop a policy of summarising healthcare interventions as a communication tool when transferring prisoners from prison to prison. This should include direct communication via the telephone between healthcare teams if the patient has an acute illness.

   The National Offender Management Service accepted this recommendation, writing:

   "The policy currently in place is that all prisoners requiring medical intervention or not have a summary of their notes and ongoing treatment needs printed from their electronic record. This is sent to the receiving prison's Healthcare department in the IMR with the prisoner's records. In the case of acute illness, Healthcare will contact the receiving prison's Healthcare team by phone if the prisoner is deemed fit for transfer. This would be recorded on the SystmOne electronic record which all prisons now have access to."

2. The Head of Healthcare should review the use of public transport for patients who are unwell and should develop an assessment tool that clearly documents why decisions are made.

   The National Offender Management Service accepted this recommendation, writing:

   "Although informal arrangements are in place to undertake this assessment following the man's death, these will now be formalised and reflect a holistic responsibility for all prison & healthcare staff to feed into."