Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Simon Regis a prisoner at HMP Thameside on 26 August 2016

**A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE**

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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 Simon Regis died on 26 August 2016 at HMP Thameside. He died of septicaemia and lung abscesses with bronchopneumonia, caused by a blood clot in the femoral artery in his right leg. He was 44 years old. I offer my condolences to his family and friends.

Although the initial care Mr Regis received for his abscess was appropriate, his overall care was not equivalent to that which he could have expected to receive in the community. There were missed opportunities to check whether his abscess was infected. His vital signs were not monitored, and when Mr Regis was unable to attend the medication hatch because his leg abscess stopped him from walking, nurses did not review his physical health.

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** **November 2017**

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# Summary

## Events

1. On 19 August 2016, Mr Regis was recalled to prison after breaching his licence conditions. Mr Regis was held in police custody, where he complained to a nurse of an ongoing pain in his groin. A nurse gave him painkillers, and the next day, Mr Regis was transferred to HMP Thameside.

2. At his initial healthscreen, a nurse noted Mr Regis' history of schizophrenia and that he had complained of a painful abscess in his groin. He was referred to a GP, who saw him that day. The GP assessed the abscess and prescribed an antibiotic. He told Mr Regis to see the healthcare team if it worsened.

3. On 21 August, Mr Regis was reviewed again, and attended the medication hatch every morning until 24 August. Later that day, Mr Regis fell, and told an officer that the painful abscess in his leg stopped him being able to walk. The officer fetched a nurse, who reviewed him and, unable to do anything further at the time because of her already existing duties, reported to colleagues that he was unwell. He continued to appear unwell, and was given his antibiotics by a nurse in his cell on 25 August. No vital signs were taken, and no further reviews completed.

4. At approximately 4.30pm on 26 August, an officer completing welfare checks found Mr Regis unresponsive on his bed. After trying to get a response, the officer radioed an emergency code, and both prison and healthcare staff tried to resuscitate Mr Regis. An ambulance arrived and paramedics unsuccessfully continued resuscitation efforts. Mr Regis died of septicaemia, lung abscesses and bronchopneumonia, caused by a blood clot in an artery in his right leg.

## Findings

5. We are not satisfied that Mr Regis received a good standard of care at Thameside, and it was not equivalent to that which he could have expected to receive in the community. Healthcare staff did not monitor the risk of complications as a result of his abscess, and no one took Mr Regis' vital signs.

6. When Mr Regis collapsed on 24 August, the nurse who attended to him communicated to colleagues and recorded in his electronic medical record that Mr Regis was unwell, but was not specific about what had happened. As a result, another nurse interpreted this to mean that Mr Regis was mentally unwell and did not review his physical health.

7. No one took responsibility for Mr Regis' physical care. He remained on the wing, and was not assessed by anyone from the healthcare team on 24 or 25 August.

8. When Mr Regis stopped attending the medication hatch for treatment, no one from the healthcare team questioned this or checked on him.

## Recommendations

- The Head of Healthcare should ensure that patients with infections, who are at risk of sepsis, should have their vital signs taken when there is a clear decline in their health.
- The Head of Healthcare should ensure that detailed information about a prisoner's health is clearly documented in the SystmOne record to facilitate continuity of care.
- The Head of Healthcare should appoint a named healthcare worker for vulnerable patients to monitor their health needs and ensure continuity of care.
- The Head of Healthcare should ensure that there are procedures in place to investigate why a patient with an acute illness has repeatedly not attended for treatment.

# The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Thameside informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Regis' prison and medical records.

11. The investigation was suspended while the police carried out an investigation. The investigator did not interview any staff, but worked closely with the police to share information.

12. NHS England commissioned a clinical reviewer to review Mr Regis' clinical care at the prison. The clinical reviewer interviewed a number of healthcare staff.

13. We informed HM Coroner for Inner South London District 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 initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy.

# Background Information

### HMP Thameside

15. HMP Thameside is a local prison in South East London that holds up to 1232 men. It is privately run by Serco. The Oxleas NHS Foundation Trust delivers primary health services. Turning Point delivers substance misuse services, and Atrium delivers mental health services. There is 24-hour nursing provision and an 18 bed inpatient unit.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Thameside was in September 2014. Inspectors reported that healthcare services were being transformed and that care had improved. There was an appropriate range of clinics, and care plans were in place in line with national guidance.

### Independent Monitoring Board

17. 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 June 2016, the IMB reported that staff did not communicate satisfactorily with prisoners and there was reluctance from some staff to take responsibility for finding answers about prisoners' needs.

### Previous deaths at HMP Thameside

18. Mr Regis was the fifth prisoner to die of natural causes at Thameside since January 2013. One prisoner has since died of natural causes. We have previously made recommendations about the adequacy of healthcare records.

# Key Events

## Background

19. On 19 August 2016, Mr Simon Regis was recalled to prison for breaching his licence after he was charged with theft. Mr Regis was initially held in police custody, where he complained to a nurse of pain in his groin, which he had had for three weeks. The nurse noted that there was a hard area in his right groin but there were no signs of infection and no abscess. Police records indicate that he appeared generally well and his temperature was normal. The nurse gave Mr Regis painkillers.

## HMP Thameside

20. On 20 August, Mr Regis was sent to HMP Thameside. At his initial health screen, a nurse noted that Mr Regis had schizophrenia and referred him to the mental health team. He told the nurse that he had a painful abscess in his groin. The nurse explained to the clinical reviewer that Mr Regis had tried to show her the abscess. She had noted that his groin was inflamed but did not have a clear view of the whole area.

21. Later that day, a prison GP met Mr Regis. He examined him, and Mr Regis reiterated that he had had the abscess for three to four weeks but had not seen his GP in the community. As there was no obvious change in skin colour, no discharge and it was not significantly tender, he diagnosed an early stage abscess. He prescribed Mr Regis erythromycin (an antibiotic) and advised him to contact the healthcare team if his condition deteriorated.

22. On 21 August, a nurse met Mr Regis for his secondary health screening. She had no concerns about his physical health, and recorded that a prison GP had prescribed him antibiotics for the abscess. She assessed Mr Regis as unsuitable to have his medication in possession. This meant that he would need to attend the medication hatch for healthcare staff to administer his medication, when required. Mr Regis' medical records indicate that up to the morning of 24 August, he went to the medication hatch for his antibiotics.

23. On 24 August, an officer was working on A wing, where Mr Regis lived. He said that Mr Regis fell when returning to his cell from lunch, and that Mr Regis told him that he was unable to walk due to the pain he had from an abscess in his groin. The officer went to the nurses' room on the wing, and spoke to a nurse. As Mr Regis could not walk up the stairs to his cell, the officer and nurse helped Mr Regis into a cell on the ground floor. The officer asked the nurse whether she needed more help. She said that she did not, and said that she had dealt with Mr Regis before. The officer had no further contact with Mr Regis that day.

24. The nurse noted that she could not assess Mr Regis properly as she was too busy with her duties. She noted in his SystmOne that he was unwell and reported that she told two members of nursing staff at a multidisciplinary team meeting and a community mental health nurse, that Mr Regis was unwell, but said nothing more specific.

25. The community mental health nurse contacted Mr Regis' community mental health nurse to verify his medication. She noted that he had been prescribed modecate (a treatment for schizophrenia) and that his next injection was due on 30 August.

26. Later that afternoon, an officer saw Mr Regis lying on the bed in the foetal position. He said that Mr Regis told him he was not feeling well and was unable to walk. He recorded that another prisoner told him that a nurse had already checked Mr Regis and was aware of his situation.

27. At 10.10pm on 25 August, a nurse gave Mr Regis a dose of antibiotics in his cell rather than at the medication hatch. She confirmed that Mr Regis had complained of groin pain and had difficulty walking. This was the last time that he was given medication, and his healthcare records indicated that it was the last time that a member of the healthcare team saw him.

### 26 August 2016

28. At approximately 12.00pm on 26 August, an officer was completing prisoner welfare checks on A wing. He said that he spoke to Mr Regis who told him that he was "okay" and wanted to sleep.

29. Mr Regis remained in his cell, and at 4.30pm, an officer opened Mr Regis' door so that he could get his evening meal. The officer said that he called out to Mr Regis but he got no response. He then went into his cell and saw Mr Regis lying on the lower bunk. He called again, but Mr Regis did not respond. The officer said that he immediately felt that something was wrong, and at 4.41pm, radioed for healthcare assistance. At 4.42pm, the officer again used his radio and called a medical emergency code blue (that indicates a prisoner is unconscious or having problems breathing). The control room called an ambulance when they received the code blue.

30. A prison manager, responded to the code blue. She tried to wake Mr Regis but he did not respond. An officer and a custodial manager, went into the cell, checked for Mr Regis' pulse, moved him onto the ground and started cardiopulmonary resuscitation. A nurse arrived and took over chest compressions. At 4.50pm, the ambulance arrived at the prison, and at 4.51pm, arrived at Mr Regis' cell. Paramedics took over and continued resuscitation efforts. At 4.55pm, a member of the healthcare team called a prison doctor, to the wing. While paramedics continued cardiopulmonary resuscitation, the prison doctor examined Mr Regis and recorded that he had no pulse, no heartbeat, that he was unresponsive and his pupils were dilated. At 5.21pm, the prison doctor confirmed Mr Regis' death.

### Contact with Mr Regis' family

31. On 26 August 2016, a prison manager contacted Mr Regis' family and told them that it was likely that he was being taken to hospital, so they began to make their way to the prison. An Imam in the prison chaplaincy team, received a call from the prison at 5.30pm, informing him that Mr Regis had died. He was appointed as the family liaison officer (FLO).

32. When the FLO arrived at the prison at 7.40pm, Mr Regis' family were already there. Both he and the prison manager met Mr Regis' family and informed them of his death. They also contacted Mr Regis' nephew who was a prisoner at HMP Isis.

33. The FLO offered ongoing support until Mr Regis' funeral, which was held on 30 September 2016. The prison contributed towards the cost in line with national policy.

### Support for prisoners and staff

34. After Mr Regis' death, the Assistant Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

35. The prison posted notices informing other prisoners of Mr Regis' death, and offering support.

### Post-mortem report

36. The post-mortem examination confirmed that Mr Regis died of septicaemia (an infection in the blood stream) and lung abscesses with bronchopneumonia, caused by right femoral mycotic aneurysm (a blood clot in the femoral artery in the right leg).

# Findings

## Clinical care

37. The clinical reviewer identified a number of healthcare issues that the Head of Healthcare will need to address.

38. We agree with the clinical reviewer that Mr Regis' care was not equivalent to that which he could have expected to receive in the community. The clinical reviewer found that Mr Regis had appropriate health screenings at Thameside, and when he told staff that he had a painful groin, they took the necessary steps to address this and a nurse referred Mr Regis to see a GP. The GP recorded that Mr Regis' condition was stable, that he did not have a fever, and the clinical reviewer concluded that the GP prescribed Mr Regis an appropriate choice of treatment for a suspected abscess.

39. Over the next three days, there was no evidence of any decline in Mr Regis' health and his medication history record shows that he took his antibiotics routinely. There is, however, no evidence that his vital signs were checked after his routine health screening. We make the following recommendation:

**The Head of Healthcare should ensure that patients with infections, who are at risk of sepsis, should have their vital signs taken when there is a clear decline in their health.**

40. After Mr Regis fell on 24 August, a nurse was unable to assess him due to time constraints but informed her colleagues of her concerns. She made no entry in Mr Regis' SystmOne record (his electronic medical record) of her specific concerns, only that he was unwell. Although the record of the multidisciplinary meeting notes her concerns, these should have been recorded in Mr Regis' medical record. We make the following recommendation:

**The Head of Healthcare should ensure that information about a prisoner's health is clearly documented in the SystmOne record to facilitate continuity of care.**

41. The nurse had only told her colleagues in the multidisciplinary team meeting and the community mental health nurse that Mr Regis was unwell. The mental health nurse understandably misinterpreted this as relating to his mental health and she contacted his community mental health nurse to find out when his next injection to manage his schizophrenia was required. As a result of this, no one took responsibility for Mr Regis' physical care. He remained on the wing, and was not assessed by anyone from the healthcare team on 24 or 25 August. We make the following recommendation:

**The Head of Healthcare should appoint a named healthcare worker for vulnerable patients to monitor their health needs and ensure continuity of care.**

42. Mr Regis did not attend the medication hatch for his antibiotics after he fell on 24 August, and therefore missed necessary treatment. The clinical reviewer noted that the nature and type of Mr Regis' infection, particularly in the latter stages,

was unlikely to respond to the antibiotic that he was prescribed, and that he would have required specialist hospital care.  His non-attendance for medication should have triggered healthcare staff to check on his wellbeing and to review him.  We make the following recommendation:

**The Head of Healthcare should ensure that there are procedures in place to investigate why a patient with an acute illness has repeatedly not attended for treatment.**

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