

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Eric Sowden a prisoner at HMP Hull on 13 December 2017

A report by the Prisons and Probation Ombudsman

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Eric Sowden died of heart disease on 13 December 2017 at HMP Hull. He was 89 years old. I offer my condolences to Mr Sowden's family and friends.

When Mr Sowden arrived at Hull in March 2017, staff noted he was on medication for high blood pressure and that he had suffered a stroke in 1999. However, healthcare staff failed to put in place an appropriate care plan to monitor his blood pressure until July, four months after his arrival. Even once the care plan was in place, staff failed to monitor Mr Sowden's blood pressure as regularly as they should have done.

I am not satisfied that Mr Sowden's clinical care at Hull was 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 the staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

January 2019

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	4
Findings.....	7

Summary

Events

1. On 28 March 2017, Mr Eric Sowden was sentenced to six years imprisonment for sexual offences and sent to HMP Hull.
2. The nurse who carried out the reception health screen noted that Mr Sowden was on medication for high blood pressure (hypertension), that he had suffered a stroke in 1999 and that he had suffered from kidney failure in the past.
3. On 24 July, a nurse created a hypertension and kidney disease care plan for Mr Sowden. It said healthcare staff should check his blood pressure regularly and do regular blood tests.
4. On 13 December, at around 8am, an officer unlocked Mr Sowden's cell. His cellmate left the cell but Mr Sowden stayed in bed. His cellmate returned shortly before 9am and found Mr Sowden collapsed on the cell floor. He could not get a response and called to an officer for help. The officer called a medical emergency code as soon as he arrived. Another officer joined him quickly and they started cardiopulmonary resuscitation (CPR).
5. Two nurses arrived and took over the resuscitation attempt. They attached a defibrillator, which advised to continue CPR. When they reattached it after two rounds of CPR, it showed a "low battery" warning light so staff fetched another defibrillator from a wing nearby. Ambulance paramedics arrived at 9.03am and took Mr Sowden to hospital. At 10.38am, hospital doctors pronounced that he had died.
6. The post-mortem examination showed that Mr Sowden died from systemic atheroma (build-up of fatty deposits on the walls of the arteries) and hypertensive heart disease (heart conditions caused by high blood pressure).

Findings

7. Healthcare staff did not put in place an appropriate care plan to monitor Mr Sowden's blood pressure until four months after he arrived at Hull. Even after the care plan was put in place, staff did not monitor his blood pressure as regularly as they should have done.
8. We are satisfied that the issues with the first defibrillator did not have a detrimental impact on Mr Sowden, as staff continued CPR throughout and another defibrillator was fetched quickly. Since Mr Sowden's death, all the defibrillator batteries have been changed and spare batteries have been obtained.

Recommendations

- The Head of Healthcare should ensure healthcare staff follow NICE guidelines for monitoring long-term conditions in accordance with NICE Guidelines NG57.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator interviewed three members of staff and one prisoner at Hull on 12 February 2018.
11. NHS England commissioned a clinical reviewer to review Mr Sowden's clinical care at the prison. The clinical reviewer attended all interviews.
12. The investigation was suspended on 10 May 2018 while we awaited the cause of death. The investigation was resumed on 24 September 2018.
13. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The investigator sent a letter to Mr Sowden's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. We did not receive a reply.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Hull

16. HMP Hull is a local prison, which holds up to 1056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison closed its healthcare inpatient unit in October 2014, which became the wellbeing unit to support and progress prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hours service at other times.
17. In August 2018, Hull was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focusing on improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Hull was in April 2018. Inspectors found that health provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. Staff in the wellbeing unit provided compassionate support to prisoners and although joint working with health services was good, the diverse mix of prisoners meant it was not sufficiently therapeutic. Care for patients with palliative or end of life needs was excellent.

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 2015, the IMB noted that the prison is effectively run, provides a safe environment for all and has benefited from the strong leadership of the Governor and Management Team.
20. The IMB noted that there was a full health screen at reception, which identified immediate risks, and outpatient clinics to manage long-term medical conditions. However, the Board had received many complaints, mostly about medication and prescribing issues. The Board reported that inpatient care is provided in the wellbeing unit and that a terminal care suite had been adapted to manage the rising population of older prisoners.

Previous deaths at HMP Hull

21. Mr Sowden was the 12th prisoner to die at Hull since December 2014. Of the previous deaths, six were from natural causes and five were self-inflicted. There have been eight deaths since, six from natural causes, one self-inflicted and one drugs related. There were no similarities between Mr Sowden’s death and the other deaths at Hull.

Key Events

22. On 28 March 2017, Mr Eric Sowden was sentenced to six years imprisonment for sexual offences and sent to HMP Hull. He had a history of high blood pressure, had suffered kidney failure in the past and had suffered a stroke in 1999. He had also been diagnosed with first degree heart block (an abnormal heart rhythm where the heart beats too slowly) in 2011.
23. During an initial health screen, a nurse noted Mr Sowden's history of high blood pressure and stroke but did not take a blood pressure reading. She noted he was taking atenolol, felodipine and inadapamide for high blood pressure, ranitidine for acid reflux and simvastatin for raised cholesterol.
24. During a secondary health screen the next day, Mr Sowden's blood pressure was taken, which was normal.
25. On 24 July, four months after Mr Sowden's arrival at Hull, a nurse created a hypertension and kidney disease care plan. It said healthcare staff should check Mr Sowden's blood pressure regularly, complete regular blood tests and check his urine and weight as per NICE guidelines. Mr Sowden's blood pressure was not checked that day. (Mr Sowden should have been reviewed on 28 August but there is no record that a review took place.)
26. Mr Sowden complained of feeling unwell with flu-like symptoms when he went to collect his medication on the morning of 12 August. His blood pressure was checked and was normal. His temperature was high at 38.6°C (average body temperature in adults is around 37°C but is generally below 36.2°C in those aged over 65) and his blood oxygen saturation level was lower than normal at 92% (95% to 100% is considered normal and readings below 90% are considered low). After taking paracetamol, his temperature went down to 37.9°C and his oxygen levels increased to 95%. A note was made in Mr Sowden's medical record to continue with monitoring and give paracetamol if required. However, Mr Sowden was not seen again until 5 September when he saw a nurse about swelling in his legs. A blood pressure reading was not recorded during this consultation.
27. On 11 September, a doctor examined Mr Sowden's legs. He changed Mr Sowden's medication from felodipine to ramipril, and requested a blood test and blood pressure review in one month's time. A blood pressure reading was not recorded during this consultation.
28. Mr Sowden had abnormal blood test results on 14 and 26 September, and 3 October, which showed that he had a low haemoglobin level (haemoglobin is found in red blood cells and carries oxygen). This was not actioned until 11 October when a doctor made an urgent referral to the colorectal department at Hull Royal Infirmary.
29. On 13 October, a nurse saw Mr Sowden to complete care plan observations. He noted on Mr Sowden's medical record, 'hypertension fully performed', but did not record a blood pressure reading. A blood pressure reading was taken the next day and was normal, and was also recorded as normal on 16 October.

30. A doctor reviewed Mr Sowden on 17 October. He noted Mr Sowden's abnormal blood test results and diagnosed anaemia which required haematinics (medication to increase the level of haemoglobin in the blood). However, medication to treat his anaemia was not prescribed.
31. On 24 October, Mr Sowden attended the colorectal department at Castle Hill Hospital and had a sigmoidoscopy (a procedure where a camera is inserted into the rectum and lower colon). Nothing of concern was found.
32. A doctor reviewed Mr Sowden on 24 November. He noted Mr Sowden's anaemia and hypertension and requested another blood test. Mr Sowden's blood test results showed a further reduction in his haemoglobin levels. A computerised tomography (CT) scan of his abdomen, pelvis and thorax was arranged for 7 December to investigate the cause. This was rescheduled to 18 December because the hospital had overbooked.

13 December 2017

33. On 13 December, an officer unlocked Mr Sowden's cell at around 8am. He was still in bed. Mr Sowden's cellmate and care buddy, was awake and left the cell. Mr Sowden's cellmate returned to the cell shortly before 9am and found Mr Sowden collapsed on the floor with his head against the base of a radiator. He was lying diagonally across the floor with his legs under the bed. He called Mr Sowden's name but after getting no response, shouted for an officer to come and help.
34. The officer arrived at the cell at approximately 8.57am and immediately called a medical emergency code blue (used where a prisoner is unconscious or having difficulty breathing). He turned Mr Sowden over and found a small cut above his right eye where he had fallen to the floor. Another officer heard the code blue and came to the cell to help. They checked for a pulse and started cardiopulmonary resuscitation (CPR) while they waited for healthcare staff to arrive.
35. Two nurses arrived at the cell quickly and attached a defibrillator. The defibrillator instructed them to continue CPR. After completing two rounds of CPR, the nurses reattached the defibrillator pads. While analysing the heart rate a "low battery" warning light appeared. It again advised to continue CPR as a shock was not required. Staff fetched another defibrillator from K Wing nearby.
36. Paramedics arrived at 9.03am and a second ambulance crew arrived at 9.09am. Mr Sowden was taken by ambulance to Hull Royal Infirmary. At 10.38am, doctors pronounced that he had died.

Contact with Mr Sowden's family

37. The prison was unable to trace a next of kin when Mr Sowden died. One month later, on 18 January 2018, the Coroner's office managed to locate Mr Sowden's brother and sister-in-law.
38. A prison manager spoke to Mr Sowden's sister-in-law who said that she and her husband had not been in contact with Mr Sowden for over 35 years. She said that they did not want to be involved in the funeral or have any further contact

with the prison. The prison arranged and paid for Mr Sowden's funeral, which was held on 23 January 2018.

Support for prisoners and staff

39. After Mr Sowden's death, another prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
40. The prison posted notices informing other prisoners of Mr Sowden'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 Sowden's death. Mr Webb, Mr Sowden's cellmate, said that additional support was offered to him after the death.

Post-mortem report

41. A post-mortem examination found that Mr Sowden died from systemic atheroma (build-up of fatty deposits (plaques) on the walls of the arteries) and hypertensive heart disease (heart conditions caused by high blood pressure).
42. The pathologist considered it possible that the plaques in Mr Sowden's arteries had ruptured, causing a blood clot and then a stroke, which had caused him to fall. The pathologist also found that the wall dividing the pumping chambers of the heart was thickened (left ventricular hypertrophy), which commonly occurs as a result of high blood pressure and is a risk factor for sudden cardiac death. The pathologist considered it possible that Mr Sowden had collapsed due to a sudden cardiac event and that his hypertensive heart disease had contributed significantly to his death after his collapse.

Findings

Physical healthcare

43. Mr Sowden's history of high blood pressure and his previous stroke were noted by healthcare staff during both the initial and secondary health screenings. However, healthcare staff did not start a chronic disease management plan until 24 July 2017, four months after Mr Sowden arrived at Hull. Even after the care plan was in place, healthcare staff failed to monitor his blood pressure regularly. This is not in accordance with NICE Guidelines. NICE Guidance 57, 'physical health of people in prison' states:

"Hypertension is one of the key chronic conditions that requires monitoring alongside chronic heart failure, chronic kidney disease, chronic obstructive pulmonary disease, epilepsies, secondary prevention of myocardial infarction and type 1 and type 2 diabetes".

44. The clinical reviewer noted that high blood pressure was a major cause of atherosclerosis, the artery-clogging process that leads to heart attacks and strokes. The post-mortem report also noted that Mr Sowden had left ventricular hypertrophy, caused by high blood pressure.
45. Mr Sowden's high blood pressure was not monitored in line with NICE guidelines and we therefore conclude that the healthcare provided to Mr Sowden was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure healthcare staff follow NICE guidelines for monitoring long-term conditions in accordance with NICE Guidelines NG57.

Emergency response

46. During the resuscitation attempt, a "low battery" warning light appeared on the defibrillator and staff had to fetch another defibrillator from K Wing. We were told that there were six defibrillators placed around the prison, all with batteries, and they were checked daily by nursing staff. They had had their yearly service in August 2017, by 'Medical Physics'. The defibrillators were purchased three years before and had a normal battery life of five years. Medical Physics advised the Head of Healthcare, that while they were in good working order, new batteries should be ordered. The Head of Healthcare did this straightaway but there was a delay in receiving them from the supplier.
47. A nurse checked the defibrillator on the morning of 13 December, and signed the equipment safety log to say it was working. Due to the close proximity of K Wing to Mr Sowden's cell, we are satisfied that the short delay in fetching another defibrillator (while CPR continued) did not have a detrimental effect.
48. All defibrillator batteries were changed following Mr Sowden's death. The Head of Healthcare also purchased additional batteries to ensure they always had

extra ones in stock. As Hull has taken measures to avoid such an issue occurring again, we do not make a recommendation.

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