Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sam Mukwaya, a prisoner at HMP Ford, on 4 April 2021

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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 Mukwaya died of a heart attack on 4 April 2021 at HMP Ford. He was 57 years old. I offer my condolences to Mr Mukwaya's family and friends.

The clinical reviewer concluded that the care that Mr Mukwaya received at HMP Ford was not equivalent to that which he could have expected to receive in the community. He was concerned that healthcare staff at Ford did not manage Mr Mukwaya's long-term health conditions in line with National Institute of Clinical Excellence (NICE) guidelines, and that the GPs at Ford prescribed Mr Mukwaya medication that is known to be less effective for patients of his ethnicity.

I am concerned that healthcare staff did not radio a code blue as soon as they were told that Mr Mukwaya was not breathing.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2022**

Contents

Summary

Events

1. In June 2015, Mr Sam Mukwaya was arrested in Japan for drugs offences and was later sentenced to eight years and six months imprisonment. He was repatriated to the UK in November 2019 and continued to serve his sentence at HMP Wandsworth.

2. In January 2020, he was diagnosed with hypertension (high blood pressure) and prescribed medication for this.

3. On 12 August, Mr Mukwaya was transferred to HMP Ford. Although he was treated for his blood pressure, it was never brought under control at Ford. Following chest pains in February 2021, Mr Mukwaya's hypertension treatment was reviewed, and his medication was adjusted. In March, he again had some chest discomfort and he complained of feeling hot and sweaty. A nurse thought his symptoms were COVID-19 vaccine side effects and told him to come back to healthcare if symptoms did not go away.

4. On 4 April, a prisoner found Mr Mukwaya in his cell not breathing and cold to the touch. A substance misuse worker and a nurse went to the cell, noticed signs of rigor mortis and did not try to resuscitate Mr Mukwaya. An officer radioed a code blue (to indicate a life-threatening medical emergency). Paramedics arrived shortly afterwards. Resuscitation was not attempted as it was evident that Mr Mukwaya had been dead for some time.

5. The post-mortem report concluded that Mr Mukwaya died of a cardiac arrest.

Findings

6. The clinical reviewer found that the care Mr Mukwaya received was not equivalent to the care he could have expected to receive in the community. He found that Ford's management of Mr Mukwaya's hypertension did not meet clinical guidelines and there were missed opportunities to investigate his chest pain.

7. This is the third time that we have raised concerns about the management of long-term health conditions at Ford, so we have escalated this matter to the attention of NHS commissioners.

8. We are also concerned that staff did not call a code blue when a prisoner informed them that Mr Mukwaya was not breathing.

Recommendations

- The Head of Healthcare should ensure that all prisoners with serious or long-term health conditions have detailed care plans in place, taking into account relevant protected characteristics, in line with National Institute for Health and Care Excellence (NICE) guidance.

- The NHS commissioner responsible for the provision of healthcare at HMP Ford should write to the Ombudsman setting out what they have done to satisfy

themselves that effective measures have been taken to address Ford's continuing failure to manage prisoners' long-term health conditions effectively.

- The Head of Healthcare should ensure that staff:
    - are familiar with the clinical risks associated with hypertension; and
    - follow the clinical guidance contained in NICE Clinical Guidance 95: *Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis*.
- The Governor and the Head of Healthcare should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Ford 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 Mukwaya's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Mukwaya's clinical care at the prison. The investigator and clinical reviewer jointly interviewed five members of staff and one prisoner at Ford. The interviews were conducted over the phone due to the COVID-19 restrictions in place.

12. We informed HM Coroner for West Sussex of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Mukwaya's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any questions but asked for a copy of the report.

14. Mr Mukwaya's next of kin received a copy of the draft report. They did not make any comments.

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

Background Information

HMP Ford

16. HMP Ford is an open prison which houses up to 448 men. Prisoners are required to be in their rooms between midnight and 8.00am (unless they leave early for work). They have their own room keys and are not unlocked by staff in the mornings as they would be in a closed prison. Staff conduct roll checks (when they check that prisoners are in their cells and count them) at 1.00am, 4.00am and 11.45am (at weekends).

17. Practice Plus Group provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 8.00am to 6.00pm and on weekends from 8.00am to 12.00pm. An Integrated Drug Treatment Service dispenses medication to prisoners at the weekend. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

18. The most recent full inspection of HMP Ford was in June 2016. Inspectors reported that long-term health conditions were well managed and that care plans were used properly in line with national clinical guidance.

19. HMIP conducted a scrutiny visit (a shorter inspection during the COVID-19 pandemic) at Ford in April 2021. They reported that prisoners had good access to health provision and that 71% of prisoners said that it was easy to see a doctor, 78% that it was easy to see a nurse and 80% said the overall quality of health services was good. They also reported that the management of prisoners with long-term conditions was improving, with most monitored under a care plan.

Independent Monitoring Board

20. 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 2020, the IMB reported that the healthcare service was of a high quality.

Previous deaths at HMP Ford

21. There were two deaths at Ford in the two years before Mr Mukwaya's death, both from natural causes. Unfortunately, we repeat some of the findings from our previous investigations in this report.

22. In our previous investigation into a death in June 2019, we found that the prison's management of long-term conditions (LTCs) was poor. We recommended that the prison review the management of long-term conditions, including hypertension, so that prisoners received continuity of care and were reviewed in a timely manner.

23. The prison's healthcare provider at that time, Sussex Partnership NHS Foundation Trust, told us in response that they had reviewed the management of LTCs in

November 2019 and had produced a patient journey protocol for all LTCs. This included an LTC review algorithm and detailed information on all work streams.

24. The following investigation into a death in July 2020 again found that healthcare staff did not manage and review the long-term health conditions of the prisoner. Practice Plus (at that time called Care UK) had taken over as the healthcare provider on 1 April 2020. We recommended that the Head of Healthcare should ensure that LTCs, such as hypertension, are managed in line with the patient journey protocol for long-term conditions. In response, the Head of Healthcare told us that nurse managers would check that all LTC training was up to date for staff and that clinical supervision and performance reviews would include training about the management of LTCs.

Key Events

HMP Wandsworth

25. On 16 June 2015, Mr Sam Mukwaya was arrested in Japan for unlawful trafficking of narcotics and was later sentenced to eight years and six months imprisonment. In November 2019, he was sent to HMP Wandsworth after the Japanese authorities repatriated him to serve the remainder of his sentence in the United Kingdom.

26. Mr Mukwaya's blood pressure was high when he arrived at Wandsworth. He was diagnosed with hypertension (high blood pressure) on 14 January 2020 and prescribed losartan (to treat high blood pressure). He was also diagnosed as pre-diabetic.

27. Mr Mukwaya's blood pressure was high on 22 January and elevated (at risk of being high) on 3 February. He was seen at the hypertension clinic for an annual review on 3 July and his blood pressure was elevated. A care plan was created.

HMP Ford

28. On 12 August, Mr Mukwaya was transferred to HMP Ford. His blood pressure was high, and he was added to the routine hypertension review waiting list.

29. For the rest of 2020, Mr Mukwaya's blood pressure was taken six times and it fluctuated between high blood pressure and elevated blood pressure. On 24 December, the GP again recorded Mr Mukwaya's blood pressure was high and prescribed felodipine (a different type of blood pressure medication) to be taken with his existing hypertension medication.

30. On 5 February 2021, Mr Mukwaya told a nurse that he had chest pain. The nurse noted that he had taken on a new job involving physical lifting and that his blood pressure was high. The nurse told Mr Mukwaya to try Gaviscon (for indigestion) and reviewed him the next day. Mr Mukwaya said that he still had chest pain, but the pain had eased. The nurse made an appointment for Mr Mukwaya to see the GP. Mr Mukwaya saw the GP on 11 February, and she increased his dosage of felodipine.

31. On 16 March, Mr Mukwaya received the Astra Zeneca COVID vaccine. On 17 March, he said he felt hot and sweaty, and his chest was briefly tight while walking to work. His blood pressure was elevated. The nurse thought his symptoms were vaccine side effects and told him to see a nurse again if his symptoms did not go away.

32. There were no further recorded interactions with healthcare staff until 4 April.

33. A prisoner who was friends with Mr Mukwaya told the investigator that in the weeks before his death, Mr Mukwaya had seemed unwell. He had seen healthcare staff about what he thought was acid reflux, and he was feeling tired and short of breath, had developed dark circles under his eyes and was finding it hard to finish his usual cleaning tasks.

3 - 4 April 2021

34. Mr Mukwaya was last seen alive by his friend at around 10.00pm on 3 April 2021. He said that when he saw him on 3 April, Mr Mukwaya still seemed tired, but he was himself, smiled and asked how he was. He thought Mr Mukwaya was fine that evening.

35. A night officer checked the roll at 1.00am and 4.00am. Mr Mukwaya was marked as being in his cell. The officer completing the roll check did not note anything out of the ordinary.

36. At 8.30am on 4 April, Mr Mukwaya's friend noticed that Mr Mukwaya had not come out of his cell, which was out of character for him. He looked through the observation flap and saw that Mr Mukwaya was in bed, apparently asleep. He went back to check Mr Mukwaya at 9.00am and then again just before 11.00am. Mr Mukwaya was still in bed in the same position. On his third check, he noticed that Mr Mukwaya's cell door was ajar. He went into Mr Mukwaya's cell and found him unresponsive and cold to the touch.

37. He went to the healthcare centre, which was about 20 yards away, and spoke to a substance misuse worker. The substance misuse worker told the orderly officer (the person operationally in charge of the prison that day) that Mr Mukwaya was not responding. A nurse immediately went to Mr Mukwaya's cell and the substance misuse worker soon followed. Neither could find a pulse and they noted signs of rigor mortis, so did not attempt resuscitation, in line with local and national guidelines. About two minutes later, at about 11.00am, an officer arrived at the cell and radioed a code blue, indicating a medical emergency when someone is not breathing.

38. Paramedics arrived at 11.10am and confirmed that Mr Mukwaya had died.

Contact with Mr Mukwaya's family

39. On 4 April, the prison's family liaison officer (FLO) checked Mr Mukwaya's prison records and discovered that he had not identified any next of kin. She checked Mr Mukwaya's contact list and mail addresses and contacted Sussex Police and the Ugandan High Commission.

40. On 16 April, the FLO contacted Mr Mukwaya's ex-partner, who agreed to be listed as his next of kin and helped the FLO to contact Mr Mukwaya's friends in London and his family in Uganda. Mr Mukwaya's funeral was organised by Ford in line with national policy.

Support for prisoners and staff

41. After Mr Mukwaya's death, Ford 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.

42. The prison posted notices informing other prisoners of Mr Mukwaya'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 Mukwaya's death.

43. Ford named a garden in its grounds ‘Sam’s Garden’ in Mr Mukwaya’s memory.

Post-mortem report

44. The post-mortem report concluded that Mr Mukwaya died of a cardiac arrest caused by coronary artery thrombosis (a blood clot inside a blood vessel of the heart), which in turn was caused by coronary artery atherosclerosis (a condition where the arteries in the heart become clogged with fatty deposits). He also had hypertension which did not cause but contributed to his death.

Findings

Clinical Care

45. The clinical reviewer found that the care Mr Mukwaya received at Ford was not equivalent to the care he could have expected to receive in the community. This was due to the management of Mr Mukwaya's hypertension and missed opportunities to further investigate his chest pain.

Management of long-term conditions

46. Mr Mukwaya's was diagnosed with hypertension in January 2020, and a care plan was developed with reference to the National Institute of Clinical Excellence (NICE) guidelines on hypertension. According to the NICE guidelines, healthcare staff should calculate the risk of a patient developing cardiovascular disease (the disease of heart and blood vessels) and doctors should offer patients of black African heritage a calcium-channel blocker (such as felodipine) as a first line of treatment.

47. The clinical reviewer said that Mr Mukwaya was probably at an increased risk of developing cardiovascular disease, but this was never addressed. A formal assessment of his risk, as recommended in the NICE guidelines for managing hypertension, was never made. The clinical reviewer said that if Mr Mukwaya's cardiovascular risk had been assessed, he might have been offered advice and possibly treatment, including better control of his blood pressure, to lower this risk.

48. The clinical reviewer also found that neither Wandsworth nor Ford took Mr Mukwaya's ethnicity into consideration when they prescribed his medication or when they reviewed it. A calcium-channel blocker was not added to Mr Mukwaya's medication until 24 December 2020, 11 months after Wandsworth prescribed losartan and four months after Mr Mukwaya transferred to Ford. The clinical reviewer said that this may have been relevant as Mr Mukwaya's hypertension was never really well controlled although he was reviewed on several occasions.

49. The clinical reviewer concluded that healthcare staff at Ford did not follow the NICE guidelines and therefore Mr Mukwaya's long-term disease management was not sufficient. We make the following recommendation:

    The Head of Healthcare should ensure that all prisoners with serious or long-term health conditions have detailed care plans in place, taking into account relevant protected characteristics, in line with National Institute for Health and Care Excellence (NICE) guidance.

50. This is the third successive death at Ford where we have found concerns about the management of a prisoner's long-term health conditions. We, therefore, make the following recommendation:

    The NHS commissioner responsible for the provision of healthcare at HMP Ford should write to the Ombudsman setting out what they have done to satisfy themselves that effective measures have been taken to address Ford's continuing failure to manage prisoners' long-term health conditions effectively.

Management of chest pain

51. The clinical reviewer noted that Mr Mukwaya consulted healthcare with chest pains on three occasions - 5 February, 11 February and 18 March - and on every occasion these were not considered to be cardiac in origin. Healthcare staff concluded that Mr Mukwaya's symptoms suggested he was suffering from as acid reflux and COVID-19 vaccine side effects.

52. The clinical reviewer said that chest pain and shortness of breath on walking were not recognised side effects of the COVID-19 vaccine. He considered that Mr Mukwaya's symptoms on 18 March merited further investigation, particularly since this was not the first time Mr Mukwaya had experienced them, regardless of his recent vaccination.

53. The clinical reviewer found that, although it is impossible to know whether Mr Mukwaya's death was preventable, healthcare staff at Ford missed crucial opportunities to intervene. If he had been referred for further investigation when he first presented with chest pain, even though he might already have suffered a myocardial infarction, he might have been offered treatment which would have reduced his risk of a recurrence.

54. We recommend:

The Head of Healthcare should ensure that staff:

- **are familiar with the clinical risks associated with hypertension; and**
- **follow the clinical guidance contained in NICE Clinical Guidance 95: *Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis*.**

Emergency codes

55. When Mr Mukwaya's friend discovered that Mr Mukwaya was not breathing, he went to healthcare and told a substance misuse worker. The substance misuse worker told the orderly officer but did not use his radio to alert staff to the medical emergency. Once the substance misuse worker and the nurse got to Mr Mukwaya's cell, they could see that Mr Mukwaya had signs of rigor mortis and, still, they did not use their radios to alert staff to the medical emergency.

56. It was only when an officer got to the cell that a code blue was raised, and an ambulance was called. This made no difference to the outcome as Mr Mukwaya had been dead for some time. However, in other circumstances such a delay could be crucial. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100