Investigation into the circumstances surrounding the death of a man at HMP Brixton in June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is the report of an investigation into the circumstances surrounding the death of a man on 25 June 2006 at HMP Brixton. The man died as a result of a myocardial infarction (a heart attack), secondary to coronary artery disease. He was 36 years old.

My colleagues and I would like to extend our sincere condolences to his family and friends for their loss.

Two of my investigators conducted the investigation. A Clinical Review was carried out by a doctor on behalf of Lambeth Primary Care Trust.

I am grateful to the Governor of Brixton and his staff for their co-operation with my investigators.

The sudden death of a relatively young man is always a great shock. However, I have found no evidence to suggest that the prison authorities could have anticipated or known that the man was suffering from heart disease.

At the request of the man’s family I delayed the issue of this report for some time as they endeavoured to obtain legal representation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2007**

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SUMMARY

The man who died was sentenced to seven years imprisonment in February 2003, following a conviction for armed robbery. During the course of his sentence, he moved around many prisons across the country, mainly due to his challenging behaviour. At the time of his death, he was in HMP Brixton.

On 25 June 2006 at about 8.30am the man was found on the floor of his cell by a fellow prisoner. He had seen the man on the floor via the observation panel in the cell door. The prisoner called for help, alerting officers who arrived promptly. Healthcare staff attended, but the man who is the subject of this report was clearly dead and resuscitation was not appropriate. Formal certification of death was made by the doctor present at 9.44am.

A post mortem was carried out by another doctor, a Home Office pathologist, on 26 June. He concluded that death was due to a myocardial infarction (heart attack) secondary to coronary artery disease. Toxicology tests were also carried out and the man tested positive for Dihydrocodeine and Cyclizine (both of which were prescribed medications).

The doctor's clinical review indicates that the care the man received in custody was comparable to that which he would have received in the community.

I make one recommendation relating to Brixton's family liaison arrangements.

INVESTIGATION METHODOLOGY

1. One of my investigators visited Brixton on 28 June 2006. He was given access to the man's prison records and shown around the wing where he was located. In September 2006, another investigator took over the investigation. She has reviewed the available documents and has liaised with Brixton Police and HM Coroner. She herself went on maternity leave in May 2007 and this report has been issued by my Assistant Ombudsman.

2. Notices to staff and prisoners were sent to the Governor to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express. Neither of the Investigators was made aware of anyone wishing to see them.

3. As part of my investigation, a prisoner was identified as a possible witness. However, it has not been possible to interview him as he has been released from custody. He is part of a travelling community and his present whereabouts are not known.

4. Lambeth Primary Care Trust (PCT) was invited to commission a review of the clinical care that the man received while in custody.

5. One of my family liaison officers made contact with the man's brother. She explained the nature and scope of this investigation and the family was invited to raise any concerns or questions they had. The family complained about the frustrations they encountered when trying to obtain the man's personal belongings. They also wanted the investigation to establish if he received appropriate medical care whilst in custody.

HMP BRIXTON

6. Brixton is a local prison, serving mainly the Inner London and Southwark Crown Courts. It holds remand and convicted prisoners. There are four main residential units and a healthcare centre.

7. Her Majesty's Chief Inspector of Prisons carried out an inspection of Brixton in February 2004. The inspectors had some concerns about reception procedures, but described improvements in first night and induction arrangements. They said that healthcare staff were able to assess new prisoners and give basic information on the availability of healthcare services. However, the Chief Inspector's report said that the healthcare staff who worked in reception were under considerable pressure.

8. Brixton's operational plans for a death in custody were last updated in October 2003. They say that when dealing with the apparent death of a prisoner, the communications room is to contact 'Hotel 6' (the healthcare officer carrying the emergency radio) to indicate that urgent medical assistance is required, and then call an ambulance. The Communications Officer must not wait for further details before calling an ambulance.

9. Brixton also has healthcare protocols for medical response codes. These say that in a Code 1 emergency, Hotel 6 should attend, assess the patient, and decide whether an ambulance is definitely required. A Code 1 emergency is defined as life threatening, including situations where a prisoner is hanging and not responsive.

EVENTS LEADING UP TO THE MAN'S DEATH

10. When the man arrived at Brixton on 28 September 2005, his general health was assessed, as it had been in previous prisons. He gave a detailed history which included cholecystectomy (removal of gall bladder), arthritis, short achilles tendon, fracture of an ankle, possible peptic ulcer, Marfan's syndrome and drug dependence. His weight and height were both recorded and some routine blood tests were arranged.

11. On 17 October, a psychiatric referral was made by a prison doctor. He questioned whether the man would benefit from being prescribed an antipsychotic drug.

12. On 26 October, the man was seen by a visiting psychiatrist from a nearby NHS Trust. This consultation recorded that the man had Post Traumatic Stress Disorder (PTSD) and a psychological disorder. The psychiatrist thought that this was as a result of serving in the army. The man described his problem in the following words: "I sometimes get depressed and my head goes."

13. A prison psychologist made an entry in the man's medical record on 29 November. She noted that he was currently undergoing a course of counselling. He was keen to engage in any help offered, but reported that he would not take any medication.

14. The man saw the psychiatrist again on 7 December. At the end of the consultation, the psychiatrist suggested that he should continue to see the psychologist to explore difficulties he might be having. No further out patient appointment was required.

15. On 28 December, the medical records show that the man complained of abdominal pain. The doctor who saw the man queried if he had pancreatitis or peritonitis. An ambulance was called and the man was taken to hospital. He was discharged on 18 January 2006 following a diagnosis of gallstone induced pancreatitis. He had a laparascopic cholecystectomy (removal of gallstones) as treatment for this.

16. There is little else of note in the man's medical records. There are several other consultations, but they pertain to him arguing with doctors about his medication. The man was prescribed medication on a daily basis. The doctor who carried out the Clinical Review says that the man was prescribed dihydrocodeine. This is confirmed by toxicology at post mortem.

Sunday 25 June 2006

17. At 8.27am, after prisoners on the landing had been unlocked, a prisoner made his way to the man's cell (A1-37) to collect a cigarette. The man's cell door was still locked, so the prisoner looked through the cell observation window. He saw the man lying on the cell floor beside his bed.

18. The prisoner immediately called for staff. A Senior Officer went straight to the cell, and called a Code 1 on his prison radio. (A Code 1 emergency is defined as life threatening and alerts other staff that assistance is required). Two Nurses, who were in A wing treatment room, heard the call and went to the cell straight away. It was apparent to the nurses arriving at the cell that the man had been dead for some time. Rigor mortis had set in and there was dried blood and vomit around his mouth. It was very clear to both nurses that resuscitation would have been to no avail.

19. A Governor arrived at the man's cell shortly after 8.30am. The London Ambulance Service was called and arrived at 8:40am. The prison's on call doctor was also called and arrived to pronounce life extinct at 9:44am.

20. Following the man's death, a letter of condolence was sent to his family, including an offer to help with funeral expenses. However, I am aware that the man's brother experienced a delay in retrieving his belongings from the prison. This caused unnecessary distress at what was already a difficult time. The man's brother made several approaches to the appointed prison FLO (family liaison officer) to obtain these belongings. In the end, out of frustration, he contacted my Family Liaison Officer for assistance with this matter.

    I recommend that the Governor ensures that a prisoner's personal belongings are returned to his family in a timely manner.

CLINICAL REVIEW

21. A clinical review was commissioned by Lambeth Primary Care Trust.

22. The doctor who carried out the Clinical Review found that the medical records for the man were easy to follow and would meet standards set out in the GMC (General Medical Council) "Good Medical Practice". The doctor said that it is difficult to make an absolute judgement about completeness and it does appear that some of the hospital correspondence may not have been filed. However, it would be straightforward for any practitioner to have taken over the man's care. The difficulty for doctors involved with the man throughout his time in custody was that he never allowed them to have access to his community medical records. This is clearly evidenced within the man's medical record (it was entirely within the man's rights to withhold this consent).

23. The doctor who carried out the Clinical Review noted that it was not possible to clearly establish the history behind the possible diagnosis of Marfan's syndrome, due to a lack of access to the man's medical records. Whilst in custody, the man saw two hospital consultants, including a cardiologist and the diagnosis of Marfan's syndrome was disputed by both.

24. In relation to ischaemic heart disease, the doctor says that the post mortem identified this condition, although it was clearly not made while he was alive. The medical records show that, whilst in Parkhurst in 2005, the man had a two day admission to hospital for investigations following chest pain. Musculoskeletal rather than cardiac pain was diagnosed.

25. The man had a range of physical health problems. It is clearly unfortunate that, despite investigations, a diagnosis of ischaemic heart disease was not made. That said, the doctor's opinion is that such a diagnosis would have been very unusual for a man of his age, and the more so considering the investigations in 2005 were negative.

CONCLUSION AND RECOMMENDATION

26. I conclude that the care the man received was compatible with the level of care he would have received in the community and make just one recommendation regarding the return of personal possessions.

I recommend that the Governor ensures that a prisoner's personal belongings are returned to his family in a timely manner.