INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN IN JULY 2007 AT HMP LOWDHAM GRANGE

Report by the Prisons and Probation Ombudsman for England and Wales

March 2008

This is the report of an investigation into the death of a man from natural causes at HMP Lowdham Grange in July 2007. He was aged 47. The man was held at HMP Blakenhurst until a month before his death. My colleagues and I would like to extend our condolences to the man's family and partner for their loss.

The investigation was carried out on my behalf by two of my investigators. A review of the man's clinical care was carried out by a Medical Practitioner who was commissioned by Nottinghamshire County Primary Care Trust (PCT). I am most grateful to the clinical reviewer for his assistance.

Although the man died suddenly and unexpectedly from a heart attack brought on by hardening of the arteries, he had many risk factors that could have been identified. He was a long term smoker, with a history of alcohol abuse and homelessness. He was also obese and had gained more weight in custody. On the day of his death, he resumed taking anti-psychotic medication.

I endorse the clinical reviewer's recommendation that healthcare staff at HMP Blakenhurst and HMP Lowdham Grange should be aware of the increased risk of heart failure in patients taking anti-psychotic drugs. The Prison Service may want to consider sharing this practice across the prison estate. I have also made two housekeeping points, one of which also relates to both prisons.

I commend the staff who attempted to resuscitate the man when he was found unconscious in his cell. Their response was quick and they continued their efforts for nearly half an hour before paramedics took over.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2008**

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SUMMARY

The man had a history of offending, particularly violent offending, which some reports attributed to his abusive upbringing. Around the age of 30, he said he started having ‘feelings in his head’ which would trigger his violent behaviour and psychotic thoughts. There is evidence that he was seeking help in the community in 2003. However, he was homeless and living in a tent in woods, so his attendance at the local surgery was unpredictable and not all support was able to be provided.

The treatment for the man’s mental health resumed when he was sent to prison. He was initially held at HMP Blakenhurst, and whilst there was in contact with mental health teams and prescribed anti-psychotic drugs. Shortly before he was transferred to Lowdham Grange he stopped collecting his medication. When he arrived at Lowdham Grange in June 2007, he was not known to be on any medication.

In July 2007, the man asked to be moved to the segregation unit because he was receiving threats from other prisoners to send money to their bank accounts or risk being assaulted. It is believed that these threats were drug related. The threats were taken seriously by the prison and the man was moved to the segregation unit, pending a transfer to another prison.

Four days after moving to the segregation unit, he told a member of healthcare that he was having ‘psychotic thoughts’ and wanted to go back on anti-psychotic drugs. These were prescribed the same day, although there is no record of any clinical observations being taken beforehand.

At approximately 3.45pm the following day (28 July 2007), the man complained of chest pains. (He was a heavy smoker, he had previously abused alcohol and was overweight, but the records show that he had not complained of chest pains since mentioning them in a reception health screen in September 2005.) Shortly after complaining of pain, the man was seen by a nurse who wanted him to have an electrocardiogram (ECG). He refused, saying that the pain had gone away.

Officers went to unlock him for his meal at approximately 4.40pm but he did not respond. They entered the cell and realised that the situation was serious. A call for emergency assistance from healthcare was made and two members of operational staff commenced cardiopulmonary resuscitation (CPR). They continued until the paramedics arrived at approximately 5.05pm. The paramedics took over but, after several minutes of unsuccessful attempts, pronounced the man dead.

The clinical reviewer has found that, although there were health risk factors, the man’s death was unexpected and not survivable despite staff’s attempts to resuscitate him.

INVESTIGATION PROCESS

1. My investigator requested all the relevant records including the man's medical and core prison records. She and another of my investigators visited HMP Lowdham Grange. Unfortunately, there was some delay receiving statements from staff at Lowdham Grange and this has affected the issuing of this report.

2. Notices to staff and prisoners were sent to the prison to be displayed. These invited anybody with information to talk to my investigator. In this instance, no-one raised any matters of concern.

3. Lowdham Grange is a contracted prison with in-house healthcare providers. Although the Nottinghamshire County PCT does not have commissioning responsibility for Lowdham Grange, the Chief Executive generously arranged for a clinical review to be commissioned. This was carried out by a Medical Practitioner.

4. HM Coroner for Nottinghamshire was informed of my investigation. The Coroner has kindly shared the post mortem with my investigators. He will receive a copy of this report.

5. The man's partner was recorded as his next of kin. One of my Family Liaison Officers offered her the opportunity of involvement in the investigation. Although the man's partner was in contact with the prison regarding some questions, my family liaison officer told her that she could also raise any concerns to be considered in the investigation. She has asked the following questions:

    1. Why did he refuse an ECG?
    2. Why was he not checked more regularly after complaining of chest pains?
    3. Why did he not have access to the telephone in the segregation unit for two days?
    4. Why are violent and non-violent prisoners mixed together in prison?
    5. Why did he go to HMP Lowdham Grange when the programme he needed to complete was not available there?
    6. Did he press his cell bell for nearly two hours before he was seen on the day he died?

6. HMP Lowdham Grange, HMP Blakenhurst and the man's partner received a copy of this report in draft and had the opportunity to make any comments.

HMP BLAKENHURST

7. Blakenhurst is a local prison and serves many courts in the West Midlands area. Following the opening of a new residential unit in 2006, the prison can accommodate 1,070 prisoners. The population consists of both remand and sentenced prisoners, and is constantly changing.

HMP LOWDHAM GRANGE

8. Lowdham Grange is a private prison, one of four managed by Serco Ltd under contract to the National Offender Management Service (NOMS). It opened in 1998 with a capacity to hold 500 prisoners, but has recently been extended to hold up to 628. It is a category B training prison for adult men serving sentences of over four years with at least 12 months left to serve.

9. Healthcare services in Lowdham Grange are provided in-house with good links to the local Primary Care Trust (PCT). Many staff work 12 hour shifts. There are no in-patient facilities, but there is 24 hour cover with one nurse on duty overnight (7.00pm – 7.00am). A doctor is contracted to provide three clinics a week. Serco Health provides out-of-hours medical cover through a call centre.

10. Her Majesty's Chief Inspector of Prisons last inspected the prison in March 2006. The Chief Inspector found Lowdham Grange to be a largely safe establishment, with mutually respectful staff-prisoner relationships. The segregation unit was reported to be well managed, clean and decent.

11. A survey and focus groups carried out as part of the inspection process found prisoners reporting generally low levels of bullying, although there were some concerns about gang-related violence and intimidation.

Incentives and Earned Privileges (IEP)

12. Prison rules require every prison to provide a system of privileges which can be granted to prisoners in addition to the minimum entitlements under the rules. This is subject to their reaching and maintaining specified standards of conduct and performance. The National Policy Framework applies to all prisons, and the national aims are:

    - to encourage responsible behaviour by prisoners
    - to encourage effort and achievement in work and other constructive activity by prisoners
    - to encourage sentenced prisoners to engage in sentence planning and benefit from activities designed to reduce re-offending
    - to create a more disciplined, better-controlled and safer environment for prisoners and staff.

Telephone system

13. Lowdham Grange has recently introduced a telephone system that allows prisoners to have a telephone in their cell. The system operates using Pinphone arrangements which only allow calls to predetermined and agreed numbers. Calls can be monitored.

Concern file

14. Lowdham Grange uses a 'concern fine' as part of the monitoring process for violence reduction. This includes monitoring any alleged bullying.

Segregation unit

15. In line with the Prison Service Order (PSO) 1700, prisoners can be moved to the segregation unit under rule 45 for their own protection. Prisoners under rule 45 should have access to all the usual facilities of the segregation regime. This should be determined with the balance of safety, risk and IEP status in mind.

16. When the man was moved to the Lowdham Grange segregation unit, at his request for his own protection, he was given access to the usual facilities including:

   - visits at weekends
   - showers daily
   - access to telephones daily
   - library, education and work on unit and in cell only
   - religious services as per risk assessment.

KEY FINDINGS

17. In 2003, prior to arriving in prison, the man had good links with a local doctor's surgery. It is clear from the medical notes that the majority of contact with the doctor was related to his mental health. The doctor at the surgery established a link with the community psychiatric nurse (CPN) services but, because the man was homeless and given the unpredictability of his visits to the surgery, the CPN was unable to meet with him. He was, however, prescribed anti-depressants.

18. The man was remanded to HMP Blakenhurst on 1 September 2005. In his first reception health screen he told staff that he had suffered from pleurisy and occasional chest pain. There is no further mention of these complaints until the day of his death. The health screen also recorded that he said he was a binge drinker and had recently smoked cannabis. The same day, he was referred to the Mental Health In-Reach Team (MHIRT) as he told staff he had a history of depression and had previously been referred to a psychiatrist.

19. After appearing at court in November 2005, the man was sentenced to an indeterminate sentence with a minimum term of four and a half years. When he returned to the prison, another referral was made to the MHIRT. He was assessed on 19 December and referred to the prison doctor for psychiatric input and a medication review. This was followed up on 12 January 2006, but the man said that he did not feel he needed the appointment.

20. When the man arrived in prison, there were several warnings about his history of violence. He had told his probation officer that he would harm someone in prison. He was also quite negative and had been warned about throwing food out of the window. The wing history records show that he soon settled down, however, and was described as polite, friendly and hard working. By January 2006, he received enhanced status under the IEP scheme.

21. Another referral was made to MHIRT on 31 March 2006 because the man felt he was having problems and might be violent without remembering it. On 11 April, a prison officer wrote a retrospective entry in the man's wing history sheet recording that he was concerned he was 'losing the plot'. The date of the conversation is not recorded but the officer went on to note that healthcare staff were informed of this on 3 April.

22. A member of healthcare saw the man and told him he would be able to see a psychiatrist on either 4 or 5 April. Although the first entry in the history sheet notes that the appointment did not happen and that it was the doctor who saw the man, a nurse corrected it later to confirm that the man was seen by a psychiatrist and not the doctor. There is no mention in the medical record of an appointment on 5 April so it remains unclear as to who saw the man.

23. The medical records are incomplete but the wing history record notes that the man refused anti-depressant medication on 19 April because he felt that it aggravated his psychotic problems. The medical record does show that the

man was seen by healthcare staff on 21 April when he was prescribed anti-psychotic medication.

24. The wing history sheet raises concerns that the man's behaviour changed between April and June 2006. Whilst he was still polite and kept the prison rules, staff observed that he became bored with his jobs. His mood would sometimes be unpredictable and he was either in good spirits or did not want to get out of bed. It is possible that this was a side-effect of his medication. In any event, the anti-psychotic medication that he had been taking was reviewed and changed in June 2006 because it was felt he was not responding.

25. It is also during this time that security intelligence reported that the man was involved in taking and dealing in drugs within the prison. He had a mandatory drug test (MDT) in May 2006, but the result was negative. There was also intelligence to suggest that he was having money sent in to other prisoners, but when challenged he said this was so that he could spend his money on the telephone and his cellmate could buy the tobacco.

26. Over the next few months, the man continued to have medical reviews in relation to his mental health, although he responded with mixed motivation. In January 2007, the anti-psychotic medication he was taking was reviewed and changed again because of the side-effects he was suffering. The clinical reviewer has noted that, on regular occasions, the man stopped attending to pick up his daily medication, stopping altogether in May 2007. Unfortunately, the medical records between 28 January 2007 and 13 June 2007 are missing. My office only has the prescription charts for this period and therefore cannot explain why the man stopped taking the medication.

27. The man transferred to Lowdham Grange on 13 June 2007. He was transferred simply because of prison population pressures and Lowdham Grange had space. The information sent by Blakenhurst did not identify any specific offending behaviour programmes which he was supposed to complete. His reception health screen showed that he was not taking any medication. It also recorded his weight at 15½ stone and that he smoked around 20 cigarettes a day.

28. The wing history sheet for the period between 13 June and 23 July 2007 does not give much information except that the man refused work on three occasions. However, MDT records show that he tested positive for opiate drugs on 4 July.

29. On 23 July, the wing history sheet shows that the man asked to be moved to the segregation unit for his own protection. He claimed that he had been threatened with assault if he did not send money to other prisoners' bank accounts due to drug debts, and also that he had been forced to take drugs. The prison managers believed that the threats were real and moved him to the segregation unit until a transfer to another establishment could be facilitated. A concern file was opened.

30. Whilst in the segregation unit, the man had access to facilities such as the telephone, visits and library as per the regime and risk assessments. The records in the concern file note that he declined exercise in the unit (staff felt this might have been because he did not want to see other prisoners). My investigators asked about access to make telephone calls. They were shown the unit monitoring log and told that the man was offered telephone calls every day but declined them on several days.

31. The wing history sheet notes no concerns either by staff or any raised by the man. However, on 27 July, a registered mental health nurse (RMN) saw him in the segregation unit. He asked the nurse if he could go back on anti-psychotic medication because he felt that he was beginning to have 'psychotic thoughts'. The nurse wrote in the wing history sheet that he should be seen by the doctor. The next entry in the medical record that day does not give much information except that the man was prescribed 10mg of Olanzapine, an anti-psychotic drug, which he had taken before.

32. The next day (28 July 2007), the Deputy Director was also the Duty Director. During his checks around the prison, he visited the man at approximately 3.30pm. The man was complaining of chest pains so the duty director asked the staff nurse to see him. The staff nurse was also doing his healthcare round in the segregation unit at the time and so was close at hand.

33. The staff nurse wrote in the medical record at 3.40pm that the man told him he had an ache in the left side of his chest going down his left arm. On examination, the nurse noted that the man was not clammy and had been smoking heavily. He advised him to go to the healthcare unit for an ECG, but wrote in the medical record that the man had refused saying that the pain had gone. The staff nurse wrote that he advised the officers to contact healthcare immediately if any further episodes occurred.

34. The Prison Custody Officer (PCO) and an officer in the segregation unit, also wrote in the wing history sheet that the man was asked to go the healthcare centre but refused. The officer told my investigators that he did not know why the man refused but he assumed he did not want to leave the unit because of the threats made previously.

35. Some time afterwards (the exact time is not recorded), the PCO went to check on the man and noted in the wing sheet that the man said he was fine. Just before 4.40pm, the PCO and other segregation officers went around the unit to call people for meals. He arrived at the man's cell door and called a number of times but got no response. He entered the cell to check him, but the man did not respond.

36. The second PCO also went into the cell and tried to wake the man, but instantly realised there was a problem. An emergency call was made for healthcare assistance and the second PCO, who is first aid trained, began cardiopulmonary resuscitation (CPR). A manager heard the call for assistance and made his way to the segregation unit. When he arrived he helped the

second PCO carry out CPR. The staff nurse and the wing nurse arrived shortly afterwards and, under their direction, the officers continued with CPR and an ambulance was called.

37. The paramedics arrived at approximately 5.05pm. They took over CPR with the continued assistance from the second PCO. After several more minutes, the man could not be resuscitated and was pronounced dead at 5.12pm.

38. The clinical reviewer has concluded that the man's death from a heart attack was unexpected. However, he did have risk factors for cardiovascular disease that could have been identified. The man was a long term smoker with a history of alcohol abuse. He was obese and had gained 20kg in a year and a half. He had also recently tested positive for taking opiates.

39. The anti-psychotic medication is linked with sudden death through fatal cardiac arrhythmia, and the clinical reviewer does not think it is unreasonable to suggest that the side-effects from the medication could have been contributory to the man's death. However, the toxicology report does not suggest this and confirms that death was caused by severely sclerotic coronary artery atherosclerosis.

After the man's death

40. Several months after the man's death, his partner passed information to my investigator which suggested that he had been trying to get assistance by pressing his cell bell for nearly two hours but had been ignored.

41. My investigator requested an electronic printout for the cell bell usage in the segregation unit however, the system currently in place at Lowdham Grange does not have this facility.

42. After identifying and tracing some other prisoners who had been in the segregation unit at the time, and speaking to the prisoner who passed on the information to the man's partner, there is no evidence to suggest that this happened.

ISSUES

Location in the segregation unit

43. The man was moved to the segregation unit at his own request on 23 July 2007 for his own safety. His partner has raised concerns about violent and non-violent prisoners living together in prison in relation to threats made against the deceased.

44. There are a range of policies and procedures designed to minimise and manage the problems of drug use and bullying in prisons. However, given the make-up of the prison population, it would be impossible to ensure complete separation of those with records of violence from other prisoners. Indeed, the man himself had a history of violence.

45. Although it is clearly undesirable for the victims of intimidation to find themselves in segregation, this may again be unavoidable at least in the short term. Moving the man to the segregation unit, and making plans for his onward transfer, demonstrates that Lowdham Grange took the threats against him and his safety seriously. I am satisfied that the staff at Lowdham Grange took appropriate action in these circumstances.

Access to telephones in the segregation unit

46. I have described how prisoners at Lowdham Grange have their own telephones in their cells. The man took full advantage of this and regularly spoke to his partner. His partner is concerned that the man was unable to telephone her when he was in the segregation unit.

47. I am satisfied that the opportunity to use the telephones in the segregation unit is reasonable. The officers in the unit showed my investigators the unit monitoring log and told them that the man would often decline to use the telephone when he was there. I cannot know why he did not telephone his partner as regularly as he had when on the residential wing.

Prescription of anti-psychotic medication

48. The man had successfully taken anti-psychotic medication in the past, albeit sometimes suffering side-effects. When this occurred, the medication would be reviewed and changed as necessary. In May 2007, he stopped collecting his medication. As explained, the medical notes are missing and so it is not possible to explain why, or what follow up action took place.

49. Two months later (by which point he had transferred to Lowdham Grange), the man was prescribed the medication again. The clinical reviewer has highlighted that there is an increased risk of cardiac death in patients taking anti-psychotic medication especially if their lifestyles also present a risk. Although the post mortem does not link the medication to his death, prisons should take precautions before prescribing these drugs.

Healthcare staff at HMP Blakenhurst and HMP Lowdham Grange should be aware of the increased risk of cardiac death in patients taking anti-psychotic medication. All patients identified with an increased cardiovascular risk should routinely have electrocardiograms and blood screening, for cholesterol and diabetes, before initiating or increasing anti-psychotic medication.

50. The fact that parts were missing from the medical record meant that my investigators and the clinical reviewer could not ascertain what observations and treatment took place during the first few months of the year. It also meant that healthcare staff at Lowdham Grange did not have full information.

51. I raise this as a housekeeping matter for the Heads of Establishment and Heads of Healthcare at Blakenhurst and Lowdham Grange, to ensure that full histories are transferred or followed up as necessary.

Regular checks on 28 July

52. In hindsight, it is easy to feel that the man should have been checked more regularly. Indeed, my investigator asked if this had happened. One of the officers did go back at least once and checked on the man who told the officer he was fine. The clinical reviewer has commented that it was not unreasonable for the nurse to believe that the pain had subsided and was of a trivial nature at the time.

53. I make no formal recommendation but the Director and Healthcare Manager may want to consider putting in place more regular monitoring if a prisoner is complaining of chest pains and is generally at risk of cardiovascular disease.

RECOMMENDATIONS

1. **Healthcare staff at both Blakenhurst and Lowdham Grange should be aware of the increased risk of cardiac death in patients taking anti-psychotic medication. All patients identified with an increased cardiovascular risk should routinely have electrocardiograms and blood screening, for cholesterol and diabetes, before initiating or increasing anti-psychotic medication.**

   Accepted in principle by Lowdham Grange.

   Accepted by Blakenhurst.

HOUSEKEEPING POINTS

2. **The Heads of Establishment and Heads of Healthcare at Blakenhurst and Lowdham Grange may wish to remind all staff of the need to transfer full prisoner records.**

   Accepted in principle by Lowdham Grange.

   Accepted by Blakenhurst.

3. **The Director and Healthcare manager at Lowdham Grange may wish to consider putting in place more regular monitoring if a prisoner is complaining of chest pains and is generally at risk of cardiovascular disease.**

   Accepted in principle by Lowdham Grange.

After consultation with the man's family regarding the publication of the anonymised report, the following extracts from the clinical review have been annexed.

SUMMARY AND RECOMMENDATIONS

1. This incident occurred on a Saturday afternoon when staffing levels are expected to be low. Whilst in segregation, the man was found unresponsive in his cell; and at this point the man was, in fact, already dead. Earlier in the afternoon he had complained of chest pain and these were the warning signs of the subsequent heart attack. However, if the man had dismissed these pains when talking with healthcare staff, because they had already resolved, then it is not unreasonable to assume that these pains were considered to be only of a trivial nature at the time. Healthcare staff have to satisfy themselves that a sufficiently detailed history was taken in the circumstances of the presenting complaint. Healthcare staff also need to be satisfied that every effort was made to encourage the man to attend healthcare for further examination; or to have allowed a more detailed examination in his cell, with the taking of clinical observations, not least blood pressure and pulse.

2. In my opinion, the man's death from a heart attack was unexpected, with little warning and was not survivable. This is not to say that he did not have risk factors for death from cardiovascular disease, which could have been identified. He was a long term smoker with a history of alcohol abuse and homelessness; he was obese (BMI 34) and his weight had increased by 20kg in 18 months and it is not unreasonable to suggest that medication side effects were contributory; he had recently tested positive for taking heroin; he had recently been subject to threats against himself which must have caused increased levels of stress; and on the day of his death he had restarted anti-psychotic medication which is linked with sudden death through fatal cardiac arrhythmia. However, it is far more likely that his diseased coronary arteries were the primary factor in his death, which triggered the fatal cardiac arrhythmia. Indeed, the post-mortem identified 'moderate to severe atherosclerosis (or narrowing of the arteries) in all three coronary arteries, with a critical stenosis in the left anterior descending and left circumflex arteries' and showed old ischaemic changes in the heart muscle. It is more than likely that the man had been suffering from angina/chest pains prior to the day of death because of his diseased coronary arteries and ischaemic (oxygen–starved) heart muscle.