The death of a man whilst released to hospital on Temporary Licence from prison

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This important report is the result of an investigation into the circumstances of the sudden death of a man in Queen Hospital, Burton on Trent whilst serving a prison sentence. The post mortem found the cause of death was bronchopneumonia, cardiomyopathy and congestive heart failure. He was aged 44.

My colleagues and I would like to extend our condolences to his mother, his sisters and brother, and all those touched by his death.

The man who died had progressed through his sentence to the extent that he worked outside the prison, and had regular home leaves to prepare for release. He had been receiving medication from the prison doctor, but the doctor was unaware that he was being prescribed additional medicine by his GP in the community who was also treating the side effects of anabolic steroid use.

The investigation was led by one of my Fatal Incident Investigators. An independent review of the man's medical care in prison was commissioned from the Derbyshire Dales and South Derbyshire Primary Care Trust and I am grateful for their assistance. The review, which is comprehensive, was received some six months later. I would also like to thank the management and staff at the prison for their assistance and co-operation during the course of this investigation.

This report focuses on a form of drug abuse (the misuse of anabolic steroids) that often receives less attention than other drugs issues. It also highlights the importance of different departments within a prison sharing information and intelligence with others.

I make five recommendations, and am pleased that they have all been accepted.

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Contents

Summary	4
The investigation process	6
Background	7
Events prior to the man's death	8
The day of the man's death	17
After the death	18
Issues considered during the investigation	20
Conclusion	23
Recommendations	24
List of evidence considered	25

Summary

1. The man who died did so in Queen's Hospital, Burton on Trent. He was a prisoner on temporary release and was 44 years old. He had been admitted to the hospital three days earlier after complaining of shortness of breath and chest pains. He died from a cardiac arrest soon after being moved to the hospital's High Dependency/Intensive Therapy Unit (HD/ITU).

2. Early in his sentence, the man had been prescribed amitriptyline for depression and he continued to take this medication for the rest of his life. He also told healthcare staff that he was asthmatic. Soon after his arrival at his final prison he joined an over 40's fitness class and began to go to additional classes whenever they were available. He was a regular visitor to the prison's Healthcare Centre and was described as being "worried well", meaning that he was generally fit and well but nevertheless worried about his health.

3. He progressed through the stages of his sentence and, as part of the resettlement arrangements, was regularly released into the community on home leave to his sister and then to work for a local wood merchant. He was a trusted and diligent worker.

4. Some two years after his arrival at his last prison, the man returned from home leave and, unusually, failed a voluntary drug test (testing positive for cannabis). The next month, gymnasium staff noticed that he was making quick muscle growth and suspected that he was taking steroids. There were no other signs of steroid use and no action was taken. Prison staff were unaware at the time that the man's community GP did know that he was using steroids. In addition to medication prescribed by the prison doctor, he had been prescribed mesterolone by the GP practice where he was still registered to combat the side effects of steroid use.

5. About one month prior to his death the man began to experience breathing difficulties. During the following month whilst he was on home leave, his sister noticed that his lips were blue which she believed was caused by dehydration. He saw the prison doctor twice and was to be referred for a chest x-ray until the referral was overtaken by events. He had returned from work one evening and told a member of staff that he had difficulty breathing and had chest pains. This was reported to the duty Evening Orderly Officer (EOO), and an emergency ambulance was called. The man was allowed to telephone his mother but she was not at home. He left a message on her answer phone to tell her that he was going into hospital.

6. On admission to Queens Hospital, Burton, it was thought that the man possibly had a pulmonary embolism and pneumonia. The next day, the Physical Education Manager learned that the man had been taken ill and told the Healthcare Manager of his suspicion that he had been using steroids. The man himself told Queens hospital staff initially that he used the drugs occasionally, revising this information later to regular usage. Three days later his condition deteriorated and he was found to be suffering from atypical pneumonia with early multi organ failure. He was able to telephone his mother to tell her that he was

moving to a high dependency unit in the hospital, but shortly after moving he collapsed. Cardio pulmonary resuscitation was attempted but the man was certified dead at 9:06am.

7. The prison's contingency plan for responding to a death in custody was initiated. This included moving the possessions out of his room. The room was sealed and remained so for about four weeks when it was reallocated to another prisoner. He was joined by a second prisoner eight weeks later. Some two weeks later, the prisoners noticed polythene protruding from the base of the fixed furniture and found a bag containing drugs and drugs paraphernalia. The find was reported to prison staff who believed that it had been there for some time and was not the property of the current occupants.

Investigation Process

8. The investigator visited the prison six days after the man died and met the Governor. He was given a full briefing about the circumstances surrounding the death. The Deputy Governor was nominated as the Liaison Officer. Offers to meet representatives of the Prison Officers' Association and the Independent Monitoring Board were accepted.

9. Notices to staff and prisoners were published inviting anyone who might have information relating to the man who had died to make themselves known to the investigator. Two prisoners spoke to the investigator immediately and one provided further information three months later. The investigator met with relevant prison staff including members of the chaplaincy, probation and medical departments. The police were informed but were not involved in the investigation.

10. Copies of the man's prison and medical records were provided. The Derbyshire Dales and South Derbyshire Primary Care Trust were commissioned to perform a clinical review which was carried out and was received some six months later.

11. One of my family liaison officers visited the man's mother and sisters, together with the investigator. During the visit, the family raised several questions about the diagnoses and treatment that the man received both at the prison and after admission to Queen's Hospital.

    The questions relevant to this investigation were:

    - On his return to prison from his last home leave, did the man have antibiotics with him (the family believed that the GP had prescribed them), and did he take them after his return?
    - In the period between returning to the prison from home leave and being admitted to Queen's Hospital nine days later, what medical intervention did the man have, was it appropriate and what was recorded in his medical notes?
    - The man had not mentioned being referred for a chest x-ray. Why had the prison medical staff not asked for an x-ray?
    - Did the man's behaviour continue as normal between the time he returned from home leave and his admission to hospital? Did he continue to walk to work from the prison?

    The other queries concerned the treatment the man received during his time at Queen's Hospital and were passed on to the clinical reviewers. In their report, the two reviewers say they are not qualified to question the care given at the hospital but note that they found nothing in the hospital record that alarmed them.

Background

The prison

12. The prison was converted from a wartime military hospital to a prison in 1948. It holds convicted adult male prisoners, many of whom work out in the community. It has a certified normal accommodation of 563, the operational capacity is 571.

13. Since April 2004, healthcare at the prison has been commissioned by the Derby Dales and South Derbyshire Primary Care Trust. There are no inpatient beds and services are provided by a doctor from a local GP practice who visits daily and sees prisoners who have applied for an appointment. The clinical staff provide a day time service, and are all appropriately qualified.

Events prior to the man's death

14. The man was first received into prison in London in mid 1997. He was prescribed Zimovane for insomnia, Temazepam and amitriptyline for depression. The amitriptyline prescriptions continued throughout his sentence until his death. During the middle and latter part of 1997, the man reported to medical staff that he was feeling low and was not eating properly. This was diagnosed as reactive depression. A month later, he was prescribed 100mg amitriptyline daily for three days which was subsequently repeated for 28 days. He received the same treatment on two further occasions during the first part of 1998, the dose being reduced to 50mg daily on 4 April. He complained about this reduction on 20 April and was re-prescribed 75mg daily which was to be reduced if possible at some later time. On 27 April, he received a prescription for 75mg for 28 days. On 12 May 1998, the man was again prescribed amitriptyline for 28 days.

15. In January 2001, the man was seen by a doctor and they discussed the relationship between taking amitriptyline and the incidence of glaucoma. The man indicated that he was happy to continue taking the medication but the doctor advised a review of the situation and an alternative to amitriptyline. The man was transferred to another prison in October and it was noted that he had problems with glaucoma which limited the work he was able to do.
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16. The following May, the man was referred to hospital as his optician suspected that he had chronic simple glaucoma. An appointment was made but was cancelled and re-arranged by the hospital. The man then cancelled the appointment himself having seen the optician who confirmed that he did not have the condition.

17. The first of many escorted visits out of the prison is recorded in February 2003. The officer escorting him recorded that the man behaved impeccably throughout, and said that he knew exactly what was required in order to be released at the earliest possible opportunity.

18. He was transferred to his final prison in August 2003 and underwent the routine reception medical examination. The following day the man saw the duty Medical Officer. The man told the doctor that he suffered from asthma but had not used his inhaler during the current year and had no allergies. He also said that he had increased pressure in both eyes, and had seen an ophthalmologist who had suggested a check up. The doctor noted that the man was to see an optician. A note on the Continuous Medical Record shows that amitriptyline 50gm was prescribed and the Full Report (dated on the same day) indicates that the man was to take two 50 mg tablets every night. On the following day the man requested treatment for migraine and was prescribed paracetamol and Metoclopramide.

19. During his first weeks at his final prison the man began to work with the prison psychologist on various aspects of his character and offending behaviour. The contact was maintained for the following year, being terminated when she left the prison.

20. Soon after his arrival at the prison the man also joined the over 40's fitness club run by the prison gymnasium staff. The class consisted of weight lifting and cardio vascular exercises. The Physical Education Principal Officer (PEPO), said that the man regularly attended classes, and would take extra classes when available, but did not take part in team games. His attendance at the gym continued throughout his sentence, but reduced when he began to work outside the prison. The PEPO said that he regarded the man who died as a healthy man who looked after himself and his appearance.

21. In October the man was escorted on his first visit from the prison, and was subsequently allowed out on unescorted town visits on a regular basis to cities in the Midlands and North West.

22. A Sentence Planning Board took place in October, after which the man was interviewed by a prison Probation Officer. At their meeting, the man said that he was looking forward to working outside the prison and wanted to complete a bricklaying course. He told the probation officer that he was eligible for home leaves from May 2004 and that he would like to settle in Blackpool on his release.

23. This meeting was the first of many, all of which appear to have been productive and the man progressed towards his eventual release. During the meetings, he and the probation officer worked from the sentence plan, reviewing his objectives and achievements to date. The probation officer said that the man met all the sentence plan targets on time, as well as achieving his personal goals and working to his tariff. He commented that the man always wanted a plan and was sufficiently focussed to keep to it. The meetings were positive and the man participated fully.

24. In June 2004, the man qualified for a period of home leave and went to stay at his sister's home in Manchester for four days. The visit was said to have gone well and he returned to the prison on time. The Resettlement Leave – Medical Examination form clearly states that, "You must also attend the Healthcare Centre at 16:30 hours on the day of return or 08:25 hours on the following day." However, in common with other prisoners returning from home leave, the man was not seen by healthcare staff when he returned. In practice, according to one of the GP's attending the prison, prisoners only see him about specific concerns or if they need to pass on information such as after consulting a doctor during the leave and needing further medication.

25. The man who died continued to be prescribed amitriptyline, 100mg per day, and medication for his migraine attacks throughout 2003 and 2004. In early June 2004, the doctor and the man discussed reducing his medication and a note was made agreeing that the matter be discussed again two months later.

26. He saw the doctor five weeks later, complaining that he was suffering from tennis elbow, and ibuprofen was prescribed. The man also told the probation officer about the ailment as he was concerned whether it would interfere with his ability to continue with the bricklaying course. The probation officer said that, typically, the man discussed it fully and resolved to stay on the course for as long as possible.

27. Another four day visit to the man's sister began in mid August and again it went well. Ten days later, he told the probation officer that, having visited Blackpool during the leave, he no longer wished to consider settling there on release. He felt Manchester would have more to offer. He had also decided to complete the bricklaying course, although no longer regarding it as a future career option. The probation officer asked the man to participate in a training event being organised for new Probation Officers, which he agreed to do.

28. Another Sentence Planning Board took place in October and the probation officer recorded that it was all satisfactory. The training event occurred the following day, the man's contribution was well received and he received a formal letter from the probation officer thanking him for participating.

29. Another home leave took place in mid October, which went well in spite of a misunderstanding about the timing of his appointment with his probation officer at the outside Probation Office. Nine days after his return, the man reported to the prison's Healthcare Manager. He said that during his home leave he had undertaken some voluntary work and come into contact with someone with TB. The Healthcare Manager made an appointment for him to go to the local chest clinic, and he attended in early November.

30. In late November, the man was prescribed 75mg diclofenac to be taken once per day for his ongoing tennis elbow. In mid December, the man was informed by staff at the chest clinic that his x-ray was clear and that he would be sent an appointment to attend the clinic again in six months time. Repeat prescriptions for diclofenac (75mg daily) and amitriptyline (100mg daily) continued to the end of August of the following year.

31. The man had another period of home leave in December which went well, although he told the probation officer about his concerns for his mother's health. In mid January, the man began to work outside the prison as a volunteer at a local riding stable. He had another satisfactory home leave in mid February and, on his return to the prison, underwent a routine drug test which came back positive for cannabis. The matter was dealt with by grounding him (this entailed restricting his movements to within the prison for one month). The man was not subject to formal disciplinary procedures. This was the only occasion when he failed a test for drug use during his sentence.

32. Immediately after the drug test, the man referred himself to the prison's Counselling, Assessment, Referral, Advice, Throughcare (CARAT) worker. He told the CARAT worker that the drug used had been "skunk", a strong form of cannabis, which he smoked whilst celebrating his birthday and home leave. He said it was a one off event. He underwent two voluntary tests in late February, on the first occasion producing a positive result and on the second negative. In early March, the man again tested negative and he requested the CARAT referral to be suspended as he would drop in again if he felt the need to do so.

33. At about the same time the PEPO said that he and other gym staff began to notice quick muscle growth in the man's body which they suspected was due to

consumption of illicit steroid drugs. It is customary for the gym staff to watch out for any indication of steroid abuse, but there are no facilities at the prison to test for it. In this case, the only indication of steroid abuse was the muscle growth, and the suspicion was deemed insufficient for an official report to be made.

34. The man and the probation officer had their regular appointment in mid March, and discussed the drug test and subsequent grounding. The man repeated that he had been celebrating his birthday, had taken the calculated risk of using cannabis, knowing the outcome would be being grounded. He said that it would not happen again.

35. Later in March, when the man completed his period of confinement to the prison grounds, he started attending a local organisation which helps prisoners to formulate their curriculum vitae and arrange job interviews. He attended regularly between then and mid June.

36. In mid April, the man complained of pain in his right upper jaw following several dental crowns being fitted. The duty doctor prescribed Erythrocin four times daily for seven days. The same day the doctor referred the man to a doctor at the Orthopaedic/Fracture Clinic of the Queen's Hospital, Burton on Trent.

37. A further successful home leave took place in late April. On the day of his return, the man was prescribed co-dydramol for pain relief. The Medication Record Chart contains an undated and unsigned entry saying "medication returned".

38. In early May, the man went back to the Healthcare Centre because the dental problem had recurred. He was prescribed co-amoxiclav, an antibiotic, and Corsodyl mouthwash. The same day, he received an appointment from the Derby Royal Infirmary for his repeat x-ray in mid May. He attended this appointment, but there is no record of the outcome. A further appointment was made for late July which he attended but again no outcome was recorded.

39. The man's next meeting with the probation officer took place in late May. They talked again about his release plans, including the possibility of moving to independent accommodation rather than a hostel. The man who died said he had discussed it with his home probation officer who was happy with the prospect.

40. After several attempts to find employment, the man obtained a job with a local wood merchant, starting in mid June. The prison's Resettlement Officer reported that his record of attendance and standard of work were very good. The man himself told the probation officer subsequently that, although the work was not what he wanted, he was glad of the money.

41. The next home leave took place in late June. The man met the probation officer in early July to discuss his resettlement plans, as he was keen to make plans subject to his release conditions. Their last meeting was in late July, after which the prison probation officer sent several e-mails on his behalf to the outside probation officer.

42. The prison inmate computer system (LIDS) indicates that the man went on leave to his sister's home at 7:45am on a day in late August, returning five days later. This record contradicts his medical records and the healthcare computer which record that he saw the duty doctor on that day and was given a repeat prescription for diclofenac (75mg daily), amitriptyline (100mg daily) and some Oilatum gel (a preparation used to soothe skin irritation). An entry alongside the amitriptyline says "consider reducing dose".

43. The man's mother and sisters told my investigator that they were concerned about his health during the last home leave, as he had a constant cough, struggled to breathe and complained of feeling unwell. He had also woken up at night with a hot sweat. He thought that he might have asthma, and had asked his mother (who is asthmatic) how it felt.

44. The clinical reviewer has identified that whilst on home leave, the man visited a doctor at the medical centre, where he continued to be registered. He complained that he felt short of breath, and had had a cough and cold for the previous two weeks. His chest was examined and his peak flow breathing test was noted as 560. The doctor discussed ending the man's use of anabolic steroids, which the reviewer says he was abusing against medical advice. He was prescribed Ventolin and beclomethasone, 200mg twice daily, to assist with his breathing to be reviewed in two weeks. No antibiotics were prescribed. The reviewer also notes that the GP's medical records include prescriptions for mesterolone to counteract side effects of steroid abuse but no dates for these prescriptions are given.

45. The man saw one of his sisters on the day prior to his return to prison. She subsequently told my investigator that she noticed that his lips were blue, and she believed he was suffering from dehydration. She said he was sweating and gulped down three cups of tea in no time at all. He went back to the prison the following day, and returned to work as usual on the day after that, leaving each morning at 6:15am, resuming his normal pattern of behaviour during the rest of that week until the Friday. The investigator was unable to establish whether he walked to work or was given a lift.

46. The man did not go out to work on the Friday, but reported sick at the prison. He saw the Medical Officer and complained of being unable to draw a full breath. He told the doctor that he was managing to continue with his manual work and that he had a history of asthma but had not used an inhaler for months. The doctor examined his chest and gave him a peak flow breathing test and recorded 550. He had a slight wheeze, cough, sore throat and a temperature. The doctor diagnosed an upper respiratory tract infection (URTI) and advised that he start using his inhalers. No antibiotics were prescribed.

47. The man also told the PEPO that he felt unwell and would miss the next fitness class.

48. The man returned to the prison Healthcare Centre on Saturday and Sunday, where he saw a Nurse. On the second visit he was given a ten day course of Lactulose, a laxative.

49. Another prisoner, a friend of the man who died, knew that he smoked an occasional cannabis cigarette. He was also aware of rumours that prisoners using the gym took steroids, but did not think that his friend was amongst them. He met the man later and said that he noticed that his “sparkle had gone”. He asked if he was alright, to which he replied that he was ill. The man’s friend offered to help, but his offer was declined.

50. The healthcare computer Full Report records that the man saw the duty doctor the next day when he complained of a cough, dry mouth and wheezing. Slight hyperventilation was noted except when the man was distracted. It was also noted that the man still smoked cigarettes and he was advised to stop. An unsigned entry in his medical record for the same consultation notes “Hyperventilation. No spit says wheeze 2-3 weeks + SOBE [shortness of breath on exertion] Tachycardia [increased heart rate above normal]. Chest clear [normal breathing sounds with no abnormal chest sounds detected]. T36.4 [temperature] PFR = 510 [peak flow rate] BP110/65 [blood pressure] CXR please [chest x-ray]”. The Healthcare Centre does not have a pulse oximeter which is a piece of equipment used to assess patients with respiratory difficulties. It is not a standard piece of equipment in G.P. surgeries

51. In an interview with the investigator Healthcare Manager, said that the man had asked the doctor, during the consultation, for antibiotics. These were not prescribed but a chest x-ray was arranged. The doctor was also interviewed and he recalled that he thought the x-ray was advisable, given the duration of the symptoms and the absence of abnormal chest sounds or stress. He said that he also asked the man if he was worried about anything, which he denied. A referral to Queen’s Hospital for a routine x-ray was made and sent on the same day, with a provisional diagnosis of hyperventilation. However, this was not actioned because in the meantime the man was admitted to hospital. According to the Healthcare Manager, an appointment resulting from a referral for x-ray would normally take between 14 and 21 days.

52. According to the Healthcare Manager’s recollection, the man was unhappy at the outcome of the consultation and returned to the Healthcare Centre later in the day where he saw the Healthcare Manager again to complain that he still could not breathe properly. The Healthcare Manager said that he explained again what the doctor had said, that the man had seen two doctors in four days, and about referral for an x-ray. He said that he reassured the man about providing a self certification note for his employers, and advised him to stop worrying. The Healthcare Manager thought that the man went away in a reasonably good frame of mind.

53. The same day, the prison’s security staff were informed by what was thought to be a reliable source that the man who died was bringing drugs into the prison.

54. Another prisoner, a diabetic, lived in the same accommodation block as the man who died and met him later on the same day. The man told him that he was hyperventilating and felt unwell, wondering if these were symptoms of diabetes. The diabetic prisoner told him that he was no expert, but in his experience

hyperventilation was not a symptom of diabetes. The diabetic prisoner advised the man to go to Healthcare, to which he replied that he had been already and was told that he was imagining his symptoms. The diabetic prisoner said he found this strange because he did not think that the man would have wasted their time.

55. The man asked the diabetic prisoner to use his diabetic testing kit to test his blood sugar, which he agreed and used a clean lancet to prick the man's finger and test his blood. He said the result was 8.1, which he thought was a bit high as he said that the normal result should be under 6. He asked the man if he had eaten anything sweet, to which he replied that he felt so unwell that he had not eaten anything all day. The diabetic prisoner said that he again advised the man to go back to Healthcare. He also said that, because the test result could have been an anomaly, he offered to repeat it the following morning. As the man did not return, the diabetic prisoner assumed that he felt better.

56. The Healthcare Manager noticed the man going to work early the next morning, and said that he formed the opinion that he was "worried well". The man arrived back at the prison at 5.45pm. This was after the time that the Healthcare Centre closes. A prison officer was on duty in the man's accommodation block that evening who said that, at about 6.00pm, the man approached him complaining of difficulty breathing and chest pains. The officer immediately took the man to the prison centre, which is very close by, and sat him down.

57. The officer reported the matter to the Evening Orderly Officer (EOO) a Senior Officer (SO), who came to speak to the man. The man told the EOO that he had been in pain and experienced shortness of breath throughout the day. The EOO asked why he had not gone to the hospital earlier in the day, to which the man replied that he thought he would wait to see how things went, mentioning that he had already been to the Healthcare Centre. The EOO immediately telephoned the Communications Officer to request an emergency ambulance. He then allowed the man to telephone his mother and inform her that he was going to hospital. She did not answer the call and so the man left a message on her answerphone. The officer waited with the man for the ambulance, during which time he said the man seemed relaxed but continued to have difficulty breathing.

58. Shortly after the telephone request, an ambulance paramedic arrived at the prison. After assessing the man's condition, the paramedic called for an emergency ambulance to take him to Queen's Hospital, Burton. The EOO arranged the necessary Release on Temporary Licence paperwork to support the man's release to the hospital. The man left the prison at 6:35pm, arriving at the hospital at 7:16pm. His room was locked with his own key.

59. The clinical review records show that the man was diagnosed as possibly having a pulmonary embolism and pneumonia. An x-ray showed cardiomegaly (an abnormal enlargement of the heart) and there was pneumonia in the left lung. At around 7:45pm, the EOO said that he received a telephone call from one of the man's sisters, but that he was unable to give her any news and asked her to telephone again after 9.00pm. The sister says that the EOO told her that he thought that the man was suffering from anxiety and advised her not to panic.

She said that she then asked what medical experience he had based the diagnosis on, to which he admitted that he had none. The sister then telephoned two hospitals to try and locate her brother. She was allowed to speak to him when she did manage to locate him, by which time she said her brother could hardly speak or breathe.

60. The Orderly Officer Occurrence Book records that, at 9.15pm, the man was in the hospital's Accident and Emergency Unit waiting to be admitted. At midnight, the Night Orderly Officer (NOO) telephoned the hospital and established that the man had been admitted to a ward.

61. During the routine Governor's morning meeting at 9.00am on 15 September, an announcement was made about the man's admission to hospital. The PEPO spoke to the Healthcare Manager, to pass on the suspicion that the man had used steroids, and the Healthcare Manager passed the information to the duty doctor. Healthcare staff recorded in the man's medical records that he had been admitted to hospital, where he was expected to remain for the next two days, and that he was receiving intravenous antibiotics. A Principal Officer at the prison visited the man at 5.00pm that day and recorded that he was very poorly, with pneumonia and pleurisy. He thought that the man would remain at the hospital for some time, and probably into the following week.

62. The man's family visited him later that evening, and say that they were shocked by his condition. He had already had an x-ray which showed an embolism in his lung. His mother spoke to him later that evening by telephone and he told her that he felt shocking. His family planned to visit again on the Saturday.

63. The clinical reviewer has noted that, at some point after his admission to hospital, the man told staff there that he had occasionally used steroids. He later amended the information, saying that he had used the drugs for 12 months but stopped four weeks earlier. The duty nurse at the prison telephoned the ward the next day, and ward staff said that the man remained short of breath and on antibiotics. She also spoke to the man himself to ask if he needed anything, to which he replied that he did not.

64. One of the prison's sessional chaplains telephoned the man's sister on the day before he died and was told that the man was concerned about the medical treatment he had received at the prison. His sister said that they were both reluctant to complain too much because the man liked being at that prison. The sessional chaplain asked whether she would like a chaplain to visit the man, and she said that she would. The request was discussed with the prison Chaplain later that day and she was advised that usually the head of the chaplaincy team would make such visits. In the event, the visit did not take place.

65. Between 2.30 and 3.00pm the same day, an SO from the prison visited the man in hospital and took him some money and clothing. The SO described him as looking ill, but said that he did not think he looked too bad. He said that the man's breathing did not appear normal and he was being given oxygen. The SO also said that the man was normally an upbeat and positive person, and his attitude remained the same as he was not someone who moaned. The man told

the SO that he was worried whether his job would remain open after his illness. He also sent a message to thank the EOO for his prompt action in calling an ambulance. The man said he was expecting his family to visit him later on that day.

66. The man spoke to his sister on the telephone that afternoon, saying that he felt a little better. She then called back at around 10.00pm when he had difficulty talking, struggled to get his breath and said that he was very poorly. He also spoke to his mother.

The day of the death

67. The man's health continued to deteriorate during the night. The clinical reviewer has identified from the hospital records that, at 3.20am on the morning of his death, the man was jaundiced, his liver was enlarged and it was thought that he had hepatitis and pneumonia. At 6.00am, the Intensive Therapy Unit (ITU) consultant indicated that he was likely to be suffering from atypical pneumonia, with early multi organ impairment.

68. At approximately 8.00am, the man telephoned his mother to tell her that he was being moved from the ward to the High Dependency/ Intensive Therapy Unit (HD/ITU). His mother telephoned his sister and some family members went immediately to the hospital.

69. Shortly afterwards at 8:20am, the man was admitted to the HD/ITU where he suddenly collapsed. The man's sister telephoned the hospital to say that his relatives were on their way to see him, and the ward sister said that the family should come as soon as possible to the hospital. Cardio pulmonary resuscitation (CPR) was attempted on the man, but after 40 minutes was stopped and he was certified dead at 9:06am.

After the death

70. At approximately 9.15am on the day of the death, an entry was made in the prison's Duty Governor's Log, recording that the man's sister had telephoned the Duty Governor to tell her that he was being taken to intensive care. The Duty Governor had been unaware that the man was being moved. His sister asked to meet the Duty Governor at the hospital because she wanted to obtain information about prison procedures in such circumstances. It was arranged that they would meet during the afternoon. The man's sister also asked to see his prison medical records, but was told these were unavailable at that point.

71. Ten minutes later, at 9.25am, a signed entry was made in the Orderly Officer's Occurrence Log recording a telephone call from the Duty Governor to say that the man had died. His sister telephoned the prison at 9.33am and left a message on the Duty Governor's answerphone saying that he had passed away. She also left a telephone number, with a request to be rung back. When she returned the call, the Duty Governor spoke to the man's brother-in-law.

72. At 9:45am, the Duty Governor began to coordinate the prison's plan for responding to a death in custody. The prison's Death in Custody Contingency plans were initiated at 9.55am after a prison Senior Staff Nurse had telephoned the hospital and confirmed the man's death. All necessary Prison Service personnel were informed, the man's prison and medical records were secured and his room sealed. The local police were informed at 10:30am. A notice informing both prisoners and staff of his death was published, including an invitation for prisoners to contact a Listener if needed. Staff were offered the support of the local and national staff care teams.

73. The Duty Governor left the prison at midday to meet the man's family at the hospital. The duty chaplain, heard about the man's death at about 12.30pm and passed the information to the prison's Listeners so that they were informed as they carried out their duties. (Listeners are prisoners trained by the Samaritans to assist other prisoners who are experiencing personal problems that may lead to suicide or self harm.)

74. The duty Chaplain also went to the hospital where she joined the Duty Governor to meet the man's sister and her husband. They spent about one and a half hours together, during which time the property the man had at the hospital was given to his family. His sister requested that no prison staff attend the funeral, and also asked for the man's address book to be sent to them. She invited the duty Chaplain and the Duty Governor to see the man's body and pray for him. They knelt together to say a decade of a rosary and highlight the resurrection in keeping with the man's Catholic background. The duty Chaplain thought that the family appreciated the spiritual support. Following the act of prayer, the Duty Governor and duty Chaplain spoke to the ward sister and left the hospital.

75. On their return to the prison both the Duty Governor and the duty Chaplain went round the prison to speak to prisoners. The duty Chaplain also checked with the Listeners later in the week to establish whether they had received any feedback

regarding the death. She said that a Book of Condolence was opened in the prison chapel and a collection made by prisoners and staff.

76. The Governor sent a letter of condolence to the man's mother, and included a card from the prisoners. The man's Probation Officer, also sent his sympathies to his mother and sister. The Duty Governor kept in contact with the man's sister and later, on behalf of the prison, offered to meet additional funeral expenses.

77. The man's room was cleared of his possessions which were listed and stored. The officers clearing the room found a small amount of herbal cannabis which was later disposed of by the local police. The room was sealed with an additional padlock and limited circulation key to ensure that unauthorised access to the room was prevented. Apart from a few personal effects which were returned to the man's family, most of his property was donated to charity in accordance with his family's wishes.

78. Some months after the man's death, the Duty Governor contacted the investigator and provided information about property found in the room which the man occupied before being admitted to hospital. Interviews were arranged with another prisoner who now lived in the room and an SO.

79. The man who died had occupied the room from late 2004 until his admission into hospital just prior to his death.

80. Prisoner A said that he moved into the room in October and some eight weeks later, he was joined by another man prisoner B. Prisoner A said that, in early December, prisoner B had been looking in a drawer which he pulled out. He then noticed a piece of polythene protruding between the bottom fascia board and the base of the piece of furniture. Prisoner B showed the polythene to Prisoner A who pulled it out and revealed a carrier bag containing vials, apparently of steroid drugs, hypodermic syringes and needles. He took the bag to an officer who reported the find to the Orderly Officer (OO). The two members of staff searched the room, finding more steroid drugs and drugs paraphernalia. The staff believed that the material had been there for some time and disciplinary procedures were not taken against either prisoner who had made the find.

81. A post mortem examination was carried out on the man by a Consultant Histopathologist. His results indicated that the cause of death was bronchopneumonia, cardiomyopathy and congestive heart failure. There was no evidence of pulmonary embolism. A toxicology examination was undertaken which confirmed that the man had been taking anabolic steroids.

Issues considered during the investigation

Use of illicit drugs

82. When the man was received into prison in May 1997, he said that he had never used illegal drugs. He made similar statements as he moved through the prison system. He arrived at his final prison in August 2003 and the next February began to go out of the prison without an escort. Many such visits took place and eventually he had a full time job, as well as spending long weekends with his family.

83. During early 2005, the prison's Security Department received three security information reports that the man was listed amongst others as a user or dealer of illicit drugs. This was followed by seven similar reports were, but no action was taken against the man because it was decided that the information was insufficient.

84. After a home leave in early 2005, the man tested positive for cannabis, and was grounded but not proceeded against through formal disciplinary procedures. This was the only time that he failed a drug compliance test during the whole of his sentence. He referred himself to a drugs advice worker and said that it had been a one off event. He had two more tests before producing a negative result. During the drug worker's assessment, the man said that he was registered with a GP outside the prison, and had never received treatment for substance use either inside or outside of prison.

85. Later in 2005, gymnasium staff began to suspect that the man who died was using illicit steroids. The clinical review says that abuse of such drugs is likely to have played a major part in the development of cardiomyopathy, the condition which caused his death. There are no facilities to test for these drugs, and, in the absence of other indications, the suspicions were not reported and no action was taken. Had they been acted upon, the man's drug use might have been detected, and his movements outside the prison restricted which might in turn have limited his access to the drugs. Whether such restrictions could have avoided the deterioration to his health is uncertain.

Medical treatment

86. The clinical review was extensive and included assessment of the care provided for the man who died by his community GP and the hospital where he died, as well as by the prison's GP and healthcare team.

87. As noted above, the review says it is likely that steroid abuse played a major part in the development of his cardiomyopathy. The reviewers say there is no evidence of any other reason for its development. As steroid abuse is often hidden, it is difficult to research the effects of the drug on the body. There is research which includes cases of severe cardiac damage and sudden death in users of the drugs. Both the man's prison medical records and those of the hospital suggest that he was much more unwell than could be ascertained from

normal procedures. His underlying problems rapidly overtook him and overwhelmed the treatment he was being given.

88. Prison healthcare staff were unaware that the man had been using steroid drugs, and had been prescribed medication by his GP in the community to deal with the side effects. The man had many contacts with the prison's healthcare and probation staff. These appeared to be open and trusting, but he did not disclose his drug use. The clinical reviewers say they do not know what healthcare staff would have done if they had been aware, other than to have advised him of the consequences of his actions. However, the reviewers note that awareness of the steroids might well have altered decisions taken when the man consulted the prison doctor in the last few days before he was admitted to hospital.

89. The prison operates a system that requires prisoners to have a "medical call up" prior to going on resettlement leave and again when they return to the prison after the absence. The requirement on returning is to attend the Healthcare Centre at 16:30 hours on the day of return or 08:25 hours on the following day." and is identified in the Resettlement Leave – Medical Examination form which is given to them when their leave application is granted. There is no record of the man who died reporting to healthcare following his absence. The prison doctor said in interview that, in common with other returning prisoners, the man was not seen by him on his return. Returning prisoners only see the doctor if they are referred by healthcare staff with specific concerns or if they need to pass on information, such as any medical consultations made whilst they were away. The man did not take the opportunity to report the consultation with his GP which may have led to him disclosing the GP issued prescriptions and his drug use. It would certainly have reminded him of his responsibility to provide accurate and up to date information.

90. The clinical review also comments on the usual arrangements for registration with a doctor. Patients are usually registered in the place where they spend most of their time, which in the man's case was at the prison. If they see another GP, it should be as a temporary resident, and the consultation should be recorded on the appropriate form and sent to the registered GP. However, the arrangements for prisoners are different. They are treated by the prison's doctor, but not registered there, and maintain their registration with their GP in the community. There are no formal arrangements for information to be exchanged between the medical practioners.

91. The clinical review team conclude that the medical care the man received at the prison was not below current medical standards. The availability of a pulse oximeter would have improved the assessment of his respiratory difficulties.

Concerns raised by the man's family

92. During their visit to the man's family, my Family Liaison Officer and the Investigator were told of questions and concerns the family had about medical treatment he received both at the prison and at Queen's Hospital following admission. The man had told his mother that, "the doctors didn't want to know". He also told her in the past that he thought things needed changing and would do

something about them when he got out of prison. No formal complaints were made by the man during his time at the prison.

93. The man's family asked whether he had antibiotics with him on his return to the prison after his lat home leave and whether he took them subsequently. It is apparent that his GP did not prescribe antibiotics during his last home leave. It is therefore unlikely that he had antibiotics with him on his return. There is no record of him having drugs with him on his return to jail.

94. The family also asked what medical intervention the man had between returning to prison after his last home leave and admission to Queen's Hospital, and whether it was appropriate and what was recorded in his medical notes. The man is detailed in his prison medical record as having attended the Healthcare Centre on four occasions between in the week prior to his death, seeing two different doctors on those dates. He also saw a nurse during the same period when no treatment was issued but a brief note of the consultation was made in the computerised medical record. The man saw the nurse again on the following day when he was given a course of laxatives; again a brief note of the consultation was made in the computerised record. The prison medical notes contain details of the consultations with the doctors and include the physical observations they made, advice given and a follow up x-ray request made on the last occasion the man saw a doctor at the prison.

95. The man's family said he had not mentioned being referred for a chest x-ray. In fact, he was referred for a chest x-ray by the prison doctor following a consultation. A copy of the request is present in the prison medical record. The doctor says that he requested the x-ray because of the duration of the man's symptoms, the lack of abnormal chest sounds and his assertion that he was not worrying about anything. The admission to Queen's Hospital on the following evening and their procedures overtook the x-ray request.

96. Other queries the man's family made were concerning the treatment he received during his time at Queen's Hospital. We passed these on to the clinical reviewers. In their report, they say they are not qualified to question the care given at the hospital but report that they found nothing in the hospital record that alarmed them.

Conclusion

97. The man who died was a frequent user of healthcare services throughout the earlier part of his prison sentence, and continued to do so when he transferred to his final prison. He was regarded by medical staff as "worried well", in that he appeared to look after himself and wanted to appear fit and healthy, but frequently attended the Healthcare Centre with different complaints. He had a long term prescription for antidepressants, the dosage having been increased several times with unsuccessful attempts made to reduce it.

98. Illicit drug use did not appear to staff to be significant in the man's case and, despite his name being mentioned in security information reports as amongst prisoners suspected of using drugs, no action was taken and he continued to be allowed to leave the prison every day. Similarly, the suspicions of gym staff that he was using steroid drugs were not reported. It is now known that his GP in the community was already aware that the man abused anabolic steroids, but neither the GP nor the man himself communicated the information to prison healthcare staff. It may be that drugs prescribed by the GP masked the side effects of steroid abuse, and so gym staff saw no other signs of that abuse.

99. It appears that the man was an occasional user of what are sometimes called recreational drugs. I think it is likely that he started taking steroids soon after arriving at his final prison to assist in his desire to appear fit and healthy. It is not known where the steroid drugs originated. It is unfortunate that there was no communication between the man's GP and the prison healthcare staff. However, it is not known whether his GP in the community was ever aware that he was serving a prison sentence.

100. A large quantity of steroid drugs and paraphernalia for their use was well hidden in the room that the man formerly occupied which were found some three months after his death. It is not certain that these items were the man's property or where they originated but I think that their presence is significant. The balance of probability must surely be that this was his secret store.

101. Whilst I find no evidence of negligence or failure regarding the treatment and care the man received from either prison or healthcare staff, it is most unfortunate that gym, medical and security staff were unaware of their respective knowledge and suspicions. Had their suspicions been shared, it may be that action would have been taken to make his drug use less likely. However, it was of course the man and the man alone who knew which drugs he was taking and, when his health deteriorated, he could have informed staff so that they could take this into account when diagnosing his condition.

Recommendations.

Prison Service and Department of Health

1. The findings of this report should be considered with a view to improving communication between a prisoner's registered GP and prison healthcare staff.

   Response – Accepted

   Department of Health (DoH) to review issues of GP's records and confidentiality for prisoners who are on extended home leave, as part of a wider review to produce guidance on all GP confidentiality issues.

2. Consideration should be given to the provision of targeted screening of prisoners for the illicit use of steroid drugs.

   Response – Accepted

   Targeted screening for prisoners is already available in prisons and DSU will issue guidance making fully explicit the availability of steroid screening.

Local

3. A pulse oximeter should be purchased for use in assessing prisoners with respiratory problems.

   Response – Accepted.

   This equipment is in place and available for use.

4. Prison and healthcare staff should work together to raise awareness of the risks inherent in the use of steroid drugs.

   Response – Accepted.

   Referred to the Drug Strategy Committee for implementation

5. The Governor should remind staff to ensure that information or suspicions that a prisoner is exhibiting indicators of drug misuse should be shared with other relevant departments.

   Response – Accepted.

   A Notice to Staff issued. Staff drug awareness training to be delivered on 18.12.2006

Evidence considered

1 Post Mortem report
2 Derbyshire and South Derbyshire PCT Clinical Review
3 The man's prison medical record
4 The man's CARATS Confidential file
5 The man's LIDS computerised prison record
6 Extract from Orderly Officers Occurrence Log 14 – 17 September 2005
7 Extract from Wing Observation Book 14 - 17 September 2005
8 Probation Officer's Record of Contact
9 Contingency Plans – Death In Custody
10 Duty Governor's Death in Custody Actions Log
11 Duty Governor's Note of Hospital Visit
12 Orderly Officer's Death in Custody Actions Log
13 Healthcare Death in Custody Actions Log
14 Temporary Release Licence
15 Policy Document – Release on Temporary Licence as Hospital In-Patient
16 Operational Order – Admission to Hospital as an In-Patient (Licensed)
17 Record of Visits to Licensed Hospital In-Patient
18 Property List – Hospital
19 Property List – Prison
20 IISU Incident Report
21 Deputy Governor's Notice to Staff and Prisoners
22 Deputy Governor's e-mail to staff
23 Copy of Inmate Intelligence Card
24 Evidence bag containing ampoules and drug administration paraphernalia
25 Notes of a meeting with the man's family