# Investigation into the circumstances surrounding the death of a man, who was a prisoner at HMP Swaleside, in July 2006

**Report by the Prisons and Probation Ombudsman for England and Wales**

**February 2007**

This is the report of an investigation into the death of a man who was a prisoner at HMP Swaleside. The man died from natural causes on 19 July 2006 in outside hospital. He was 36 years old.

I would like to express my personal condolences to the man's family and friends on their loss.

The investigation was undertaken by one of my investigators. He and I are grateful to the Governor of Swaleside and his staff for their cooperation and assistance. We also appreciate the assistance of the doctor who was asked by Eastern and Coastal Kent Primary Care Trust to undertake a review of the man's clinical care.

As is the case in many of my investigations following a death from natural causes, I am much influenced by the findings of the clinical reviewer. In the case of the man, the reviewer raised a number of concerns that the prison and its health provider will need to consider. I endorse the recommendations made in the clinical review and urge the Primary Care Trust and prison to develop an action plan to address them in a timely manner.

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

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

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## SUMMARY

The man was born in 1969. He was 36 years old when he died on 19 July 2006 in outside hospital.

The man had been remanded into custody on 11 April 2005, and was sentenced to 11 years imprisonment in August that year. He was initially held at HMP High Down and transferred to Swaleside on 19 May 2006.

During his first health screen, it was noted that the man had suffered from asthma and that he had been injured in a shooting incident whilst living in Northern Ireland.

During the early evening of 18 July 2006, the man complained of chest pains and was taken to the prison's healthcare centre for observation. The man was offered admission to the healthcare centre, but declined and returned to his cell. Around 4:15am, healthcare staff saw the man in his cell as he was again complaining of chest pains and problems with his breathing. Once more he was offered admission to the healthcare centre, but again he declined. However, at 4:40am healthcare staff were informed that the man now wished to be admitted to the healthcare centre. He went into the centre at 05:06am.

At 5:45am, a Healthcare Officer heard noises coming from the man's cell. He observed the man convulsing on his chair and then falling onto the floor of the cell. The Healthcare Officer summoned assistance and staff entered the man's cell. Cardio pulmonary resuscitation (CPR) was commenced immediately and this was continued by the ambulance crew after they arrived at 6:09am. The ambulance left the prison at 6:50am, but sadly the attempts to resuscitate the man were unsuccessful. He was pronounced dead on arrival at hospital at 7:22am.

The clinical reviewer concludes that the man's clinical care was less than satisfactory. He makes six recommendations which I endorse.

## THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by prisoners and staff.

2. The Eastern and Coastal Kent Primary Care Trust identified a doctor to carry out a review of the man's clinical care. I am grateful for this review being undertaken in a most timely manner.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to meet with the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that they would like explored and addressed. In the event, the family raised no specific matters of concern about the man's care and treatment whilst he was in custody.

5. My investigator discussed aspects of the man's treatment with both staff at Swaleside and the clinical reviewer.

**HMP SWALESIDE**

6. Swaleside opened in 1988 as a category B training prison. It accepts prisoners who are serving four years or more or who have at least 18 months left to serve. It also has a high proportion of foreign national prisoners. The maximum number of prisoners who can currently be held at Swaleside is 778.

7. Swaleside has an active regime with a focus on resettlement. The prison provides a range of accredited offending behaviour courses and other non-accredited courses, including victim awareness and anger management.

8. Provision of healthcare within the prison is the responsibility of Eastern and Coastal Kent Primary Care Trust. The healthcare centre employs a full-time doctor and provides 24-hour nursing services; it has 15 in patient beds. Healthcare staff run nurse led clinics such as: Diabetes, Asthma and Wellman.

9. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable for holding it in their own possession. It is administered on a daily basis to other prisoners, when they are considered to be at risk or the medication is considered unsuitable to be held in their possession.

## KEY FINDINGS

10. The man was first received into custody at High Down prison on 11 April 2005 where he was initially held on remand. He was convicted of his offences on 14 July and sentenced to 11 years imprisonment in August 2005. The man transferred to Swaleside on 19 May 2006. During the health screening procedure at both prisons, it was noted that the man suffered from asthma and that he had been injured in a shooting incident whilst living in Northern Ireland. A range of medication was prescribed to treat his various conditions and he was allowed to keep these in his possession for self administration.

11. On 12 July 2005, the man was recorded as having refused food for five days and, as staff were worried about his state of mind, he was admitted to High Down's healthcare centre. He was interviewed the following day by a member of the Mental Health In-Reach Team who noted that there was "no evidence of mental illness" and that the man was "protesting against the withdrawal of a deal", presumably to do with his court appearance. On 14 July, on his return from court having been sentenced, the man was recorded as eating and drinking normally and wanting to return to his house block.

12. On 13 October, the man was described by a dental worker as eating three bags of sugar per week. On 1 November, the man was diagnosed by a Mental Health In-Reach worker as "depressed and anxious". A care plan was prepared and follow-up arranged. The man continued to be supported by the Mental In-Reach Team. This included attempts to deal with his fear of seeing a dentist. The man was in urgent need of help with his dental health to try to remedy the damage being caused to his teeth by his addiction to sugar.

13. The man was seen by a diabetic specialist nurse on 14 March 2006 and again on 25 April. He was found to have elevated blood cholesterol, but his blood sugar levels were normal. The man was started on cholesterol lowering medication on his first consultation, and had the dose increased at the second consultation.

14. On 18 July 2006 at 6:30pm, the man complained that he was having chest pains. He was taken to the Swaleside healthcare centre for observation. The man's blood pressure and blood oxygen saturation levels were normal. The reading from an electro cardio gram (ECG) was recorded in the medical records as showing a "normal sinus rhythm". A computer generated report printed on the ECG trace in fact recorded both "normal sinus rhythm" and "incomplete bundle branch block".

15. A Healthcare Senior Officer (HSO) offered the man admission to the healthcare centre, but he declined and returned to his cell on B Wing. At 4:15am on 19 July, healthcare staff were again asked to see the man in his cell, as he was once more complaining of chest pains and was also experiencing problems with his breathing. He was again offered admission to the healthcare centre and again declined. Healthcare received a further call from the staff on B wing at 4:40am and were told that the man now wished to be admitted to the healthcare centre.

16. The man was admitted at 5:06am for observation and it was noted that his chest pain had subsided. He was settled down in a cell and the door was shut. At 5:45am, a Healthcare Officer heard a grunting noise coming from the man's cell. The Healthcare Officer observed the man convulsing on his chair and then falling onto the floor. As a Prison Officer had just arrived in healthcare to conduct security checks, he was asked to open the man's cell and assistance was summoned via the prison communications system. A Senior Officer and another Prison Officer responded to the call. Staff entered the man's cell and noted that although he appeared to be breathing he did not have a pulse. Staff immediately commenced cardio pulmonary resuscitation (CPR) and an ambulance was called.

17. When the ambulance crew arrived at 6.09am, they decided to move the man onto the landing and took over responsibility for CPR. The ambulance crew left the healthcare centre at 6:50am. The ambulance crew and those prison staff who escorted the man were unsuccessful in their attempts to resuscitate him, and death was pronounced on arrival at hospital at 7:22am.

18. The prison contacted the man's family to inform them of his death and to offer condolences and support. The prison appointed a member of staff to act as the prison's family liaison officer. She maintained contact with the family and assisted with the arrangements for the funeral. The prison family liaison officer also invited the man's mother to the prison, where she met with staff and visited her son's cell. Swaleside provided financial assistance for the funeral costs and a memorial service was also held at the prison.

19. The post mortem report records the cause of death as natural causes as a consequence of coronary artery disease (this is when damage to the heart is caused by narrowing or blocking of the arteries).

## CLINICAL REVIEW

20. The clinical review was undertaken by a doctor, on behalf of Eastern and Coastal Kent Primary Care Trust. The reviewer found that the man had suffered from significant long-term chronic diseases. He noted that the man's complaint of chest pain was appropriately investigated by the attending healthcare staff, but that their interpretation of the electro cardio gram (ECG) carried out at the time was incomplete and only partly correct.

21. The reviewer noted that an abnormality, not previously recorded in the man's prison or General Practitioner medical records, was demonstrated on the ECG. Although a computer generated report to this effect was on the ECG trace, it was apparently not noticed by healthcare staff. The reviewer also noted that no first aid treatment of a suspected or possible heart attack was given, and there was no apparent attempt to seek qualified medical help or advice at the time the man developed his chest pain, or subsequently.

22. Despite his relatively young age of 36 years, the man was at high risk of heart disease. He was overweight, a smoker, was said to be addicted to sugar, had a high cholesterol level, and there was a family history of ischaemic heart disease. The man is recorded as having previously overused his salbutamol inhaler (asthma medication), which is a well recognised cause of fast and sometimes irregular heart rhythm. The reviewer noted that the man was recorded on four occasions in 2005 as having an abnormally fast and/or irregular heart rhythm. This was at the time the man was said to have chicken pox pneumonitis.

23. The reviewer judged that the clinical picture should have suggested a possible diagnosis of chicken pox myocarditis (inflammation of the heart muscle caused by the chicken pox virus, which could have weakened his heart further). There was nothing in the medical records to suggest that this diagnosis was considered and certainly no investigation or referral was made concerning this possible diagnosis.

    **Disease Registers, Clinical Protocols, robust procedural guidelines and standardised staff training and appraisal should be implemented.**

24. The reviewer also noted that there are no written protocols in the Sheppey Prison Cluster (Elmley, Stanford Hill and Swaleside prisons) for the management of chest pain or indeed for any other common emergency situations. Staff respond to such emergencies according to their individual training and interpretation of the event. The reviewer believed it was of considerable concern that a prisoner complaining of chest pain was not referred to a Medical Officer, or at least a doctor's opinion sought at the time of the complaint. First aid advice could have been given, and the man's admission to healthcare or transfer to hospital insisted upon, rather than simply accepting his request to return to his cell on B wing where he was unsupervised and at greater risk.

**There should be written protocols in the Sheppey Prison Cluster (Elmley, Stanford Hill and Swaleside prisons) for the management of chest pain and other common emergency situations. Healthcare staff should receive appropriate training, and there should be a formalisation and standardisation of response to emergency situations.**

**The prominent identification of individuals in custody at high risk of medical problems must be urgently implemented, and appropriate Care Plans prepared.**

25. The reviewer judged that the handwritten and often barely legible notes created confusion and misinterpretation as well as greatly increasing the chances of missing vital pieces of information, especially in emergency situations. The poor quality of the record keeping and the failure to "label" the man as being "at risk" was regrettable, and clearer evidence of his "at risk" status might have caused healthcare staff to respond differently at the time of the onset of his chest pain.

**The recording of accurate, detailed and contemporaneous record keeping of notes is mandatory. Healthcare staff must ensure that all entries on a prisoner's medical notes adhere to a standard of professional competence and expertise.**

**The computerisation of Inmate Medical Records (IMRs) should be regarded as a matter of urgency.**

26. In the reviewer's opinion, a clinically unqualified person should not be expected to make a judgement on an ECG tracing. Although computer printouts are helpful, this is only in the context of the whole clinical situation. In addition, as in this case, ECG reports may not be completely read or properly understood by non-medical staff.

**A review of when to undertake an electro cardio gram (ECG) recording and establish a subsequent protocol must be developed in terms of complaints of chest pain or angina. This would also empower nursing staff as part of their triage and management roles following agreed algorithms, as medical staff are not always onsite.**

## CONCLUSIONS

27. The man died from natural causes in July 2006. He had arrived in prison with a history of severe asthma, but was not identified as having a number of risk factors for coronary artery (heart) disease. Whilst these factors were individually identified in his prison and GP medical records, no cohesive or personal care plan was prepared as would have been expected in a community setting.

28. In the opinion of the clinical reviewer, the development of acute chest pain in July 2006 did not trigger an appropriate first aid response, nor was there any apparent attempt to seek the help or advice of better qualified medical personnel. An electro cardio gram (ECG) carried out at the time of the onset of the chest pain was misinterpreted by healthcare staff who, in the opinion of the clinical reviewer, should not have been expected to make an interpretation of the ECG tracing.

29. It is regrettable that the man declined admission to the healthcare centre when it was first offered at the onset of his chest pain, and declined transfer to healthcare on a second occasion before changing his mind. The clinical reviewer felt that the man should not have been allowed to return from healthcare to his cell on B wing, having developed chest pain which was undiagnosed.

30. In light of the findings of the clinical review, it would seem that the man's medical care was not satisfactory. I have endorsed the recommendations from the clinical review, and these need to be addressed by the Eastern and Coastal Kent Primary Care Trust in partnership with the Governor of Swaleside.

## RECOMMENDATIONS

### Medical

1. **Disease Registers, Clinical Protocols, robust procedural guidelines and standardised staff training and appraisal should be implemented.**

   Accepted - Chronic disease register is held on CHD, Asthma, Diabetic etc this remains a paper system but EMIS clinical information system will provide more immediate and detailed information. Staff training is now standardised across the cluster. EMIS problems are with the 2 systems, paper and EMIS. Note summerizers now in place.

2. **There should be written protocols in the Sheppey Prison Cluster for the management of chest pain and other common emergency situations. Healthcare staff should receive appropriate training, and there should be a formalisation and standardisation of response to emergency situations.**

   Accepted - Protocol for management of chest pain developed and published standardised training – life support including defibrillation has been undertaken for the cluster 100% of Swaleside staff are trained and in date.

3. **The prominent identification of individuals in custody at high risk of medical problems must be urgently implemented, and appropriate Care Plans prepared.**

   Accepted - Reception screening identifies pre-existing conditions. Doctors and healthcare referrals takes place and care plans are formulated however, the full implementation of the EMIS system will resolve this issue

4. **The recording of accurate, detailed and contemporaneous record keeping of notes is mandatory. Healthcare staff must ensure that all entries on a prisoner's medical notes adhere to a standard of professional competence and expertise.**

   Accepted - Staff have signed to state that they are aware of their professional clinical responsibility for accurate record keeping in line with the guidelines of the NMC and the GMC

5. **The computerisation of Inmate Medical Records (IMRs) should be regarded as a matter of urgency.**

   Accepted - Notes summarizers are employed and beginning to transfer information from paper notes to electronic (EMIS)

6. **A review of when to undertake an electro cardio gram (ECG) recording and establish a subsequent protocol must be developed in terms of complaints of chest pain or angina. This would also empower nursing staff as part of their triage and management roles following agreed algorithms, as medical staff are not always onsite.**

   Accepted - Random audit is performed as part of practice meeting to establish quality of entry within IMR's. ECG was part of the training within the I.L.S and there is now an algorithm clearly instructing staff how to deal with a client with chest pain.