Investigation into the circumstances surrounding the death of a prisoner at HMP North Sea Camp in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is the report of an investigation into the death of a prisoner at HMP North Sea Camp in May 2007. The man was discovered in his room by an officer after failing to report for work. No signs of life could be detected and prison staff attempted to revive him until paramedics arrived. He was pronounced dead by the paramedics, and the cause of death was subsequently identified as a stroke. He was 56 years old.

I would like to offer my sincere condolences to the man's family and friends for their sad loss.

An investigator from my office, conducted the investigation on my behalf. East Lincolnshire Primary Care Trust, commissioned a clinical review into the man's healthcare at North Sea Camp.

I would like to thank the Governor of North Sea Camp, and his staff for their co-operation and assistance with the investigation. I am particularly indebted to the Deputy Governor, and the Head of Healthcare, who ensured the relevant documentation, was made available to my investigator. Thanks also go to North Sea Camp's Family Liaison Officer, who has been most helpful during the investigation process and was supportive to the man's family throughout.

The man had worked as a butcher within the prison kitchen and was well known to staff and fellow prisoners and considered a popular individual. He had been at North Sea Camp for around 18 months. Medical evidence suggests a history of hypertension within his family, and he exhibited a number of other risk factors.

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

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SUMMARY

The man was remanded into custody at HMP Leicester in August 2005. He was subsequently sentenced to six years imprisonment in September 2005.

On arrival into custody, he was given a medical health screening in which it was noted that he had a family history of hypertension and was suffering from arthritis. However, whilst on remand, his only contact with medical services was for prescribed medication for arthritic pain.

Once sentenced, he was considered suitable for open prison conditions and transferred to HMP North Sea Camp in October 2005. His medical history was noted by the healthcare staff at North Sea Camp at reception, but he made little use of healthcare services during his first six months there. In May 2006, while attending the healthcare centre on an unrelated matter, a routine check showed that his blood pressure was raised. Thereafter, his fluctuating blood pressure was monitored regularly. Of greater concern to him was the discomfort caused by arthritis in his hip and ongoing knee pain for which he was referred to the Orthopaedic Department of the local hospital.

During his time at North Sea Camp, he was employed in the kitchen and trained in butchery. He gained a great deal of satisfaction from his work and was a key member of the team working in that area. He had also started to drive the prison vehicle. He took fellow prisoners to and from the local train station for work placements, as well as other journeys around the community.

The day before the man died, he went to Nottingham to spend the day with friends. His friends said that they had no concerns about him during the day, but with hindsight they thought he might have been a little quieter than normal. He had taken some antacid tablets during the day, but had not expressed any feelings of being unwell.

He returned to North Sea Camp at around 6.24pm. After a brief conversation with the gate Officer with whom he exchanged some friendly banter, he returned to Llewellyn unit. At 10.00pm, the man reported to the unit office for roll check and spoke briefly with the night officer. In interview, the night officer recalled that during this brief exchange the man seemed fine and gave no cause for concern. During the night, the officer checked the rooms at various times, his final check being at 6.00am. Nothing unusual was reported.

At around 8.00am on the following morning, an Officer was on duty on Llewellyn unit, having taken over from the night staff. He was in the process of issuing licences and dealing with applications in the unit office when he received a telephone call from the Kitchen Manager, who said that the man had not arrived for work and asked if he could check on his whereabouts. The Officer went to the man's room and found him slumped on his bed. No response could be gained. The Officer tried to contact the healthcare unit via his radio. There was no response so he contacted the Orderly Officer, asking him to telephone immediately. The Officer explained the situation to the Orderly Officer who went to the unit immediately, along with a number of other officers who had become aware of what was happening.

Efforts to revive the man using CPR continued until the arrival of the paramedics, who had been requested by the Orderly Officer, with staff taking turns to ensure that efforts were continuous. On arrival, the paramedics took over from the staff. They continued to try and revive him for a further ten minutes, but at 8.47am declared that he was dead.

According to the clinical review, the man died of a massive haemorrhagic stroke, likely to have been caused by hypertension. He had other risk factors including smoking, obesity, and family history.

THE INVESTIGATION PROCESS

The investigation was opened at HMP North Sea Camp three days after the man's death. Notices were issued, informing staff and prisoners of the investigation and inviting anyone who had relevant information to come forward. There were no responses to the notices.

The investigator visited the prison a few days later. He met with the Deputy Governor, as well as the Head of Healthcare. The investigator liaised regularly with the prison to clarify information about the man's healthcare needs and his prison life. He also obtained relevant documentation, including the man's medical record.

One of my Family Liaison Officers (FLOs), contacted a very close friend of the man's who was authorised to act on behalf of the family. She discussed the role of the Ombudsman and asked about any concerns the family had about the man's care. His family and friends had been very shocked by his death, but told the Family Liaison officer that they were very pleased with the way the prison had dealt with them. They singled out, the prison FLO, for particular praise.

I am grateful to Her Majesty's Coroner for providing the post mortem report. The report records the cause of death as 'left intracerebral haemorrhage' and 'hypertension'. A copy of my report will be sent to the Coroner to assist with the inquest process.

HMP NORTH SEA CAMP

HMP North Sea Camp is located in the Lincolnshire fens. It is a category D open prison that holds up to 314 prisoners.

Built using prison labour from Stafford prison, it opened in 1935 as a Borstal and became an open male establishment in 1988. Most of the accommodation is in the original buildings, but two new units, Llewellyn and Harrison, were built in 2002 to accommodate up to 40 prisoners on the resettlement regime.

As an open prison, North Sea Camp has good links with the local community, with some prisoners working for local businesses as part of their resettlement.

Ms Anne Owers, HM Chief Inspector of Prisons, conducted an announced inspection in April 2004. The Inspection team said of North Sea Camp:

> "Overall, it was a safe place. However, the inspection found clear evidence of the need to bolster systems to monitor, support and sustain this safe environment, in order to manage a growing and changing population."

Ms Owers further commented on the need to strengthen systems for monitoring bullying and substance abuse, but highlighted good relations between staff and prisoners.

Healthcare at North Sea Camp has been provided by East Lincolnshire Primary Care Trust since April 2005. The inspectorate considered the quality of healthcare to be good to very good. Ms Owers recommended construction of a new building to house the healthcare department and this has since been achieved.

KEY FINDINGS

On 16 August 2005, the man was charged with the unlawful importation of cigarettes and remanded into custody at HMP Leicester. During health screening on reception at Leicester, he informed medical staff of a family history of hypertension (a condition that occurs when blood is forced through the arteries at an increased pressure). He also complained of pain in his left hip caused by rheumatoid arthritis that limited his mobility. It was recorded that he was a smoker with a habit of around 25g of tobacco per day who had "no desire" to give up.

The man had little contact with healthcare services while on remand. He was seen in September 2005 for the arthritic pain in his hip for which he was given pain relief medication. He also started on a remedial gymnasium programme to build up a thigh muscle that had been adversely affected by the arthritis.

On 30 September 2005, he was sentenced to six years imprisonment at Nottingham Crown Court. The sentence came as a shock to him. He had maintained his innocence throughout, as he did not consider the nature of his offences as 'criminal'. During the man's initial sentence planning interview, he made clear his intention to appeal against his sentence.

After he was sentenced, he was classified as a category D prisoner and transferred to North Sea Camp on 11 October 2005. On reception, his medical history was noted, but the clinical record suggests he had little contact with healthcare services in his first six months. The man spent intermittent spells in Nottingham prison when attending court for ongoing matters related to his case.

On 10 May 2006, while attending the healthcare centre on an unrelated matter, his blood pressure was taken and a reading of 150 over 100 was recorded. (A normal blood pressure reading for a man of his age is considered to be around 120 over 80.) The man was advised to return for a follow-up check within a week. This took place on 16 May, when his blood pressure was recorded as 180 over 100. He was therefore referred to the doctor.

The man continued to have his blood pressure monitored on a regular basis for several months, with no cause for concern. During this time, he continued to work in the kitchen and never missed a day as a result of illness. On 9 December 2006, he reported to the healthcare centre that he had felt dizzy when standing up and described feeling 'fuzzy' headed. His blood pressure was taken and a reading of 140 over 104 was recorded. The man said that he otherwise felt generally well and was instructed to return in the afternoon for another test after he had taken his medication. He did not return for the second test and there was no follow up by healthcare staff. (At North Sea Camp, which operates an open regime, it is apparently common for prisoners to choose not to attend pre-arranged appointments - as often happens in the community.)

The man's next visit to healthcare was on 13 December when he attended the chronic disease clinic. His blood pressure was recorded as 148 over 97. He said that he had recently had 'palpitations' but no real chest pain. Arrangements were

made for him to be seen by the doctor and for a blood test. His blood pressure continued to be monitored, but he did not experience further significant problems.

As well as working in the kitchens as a butcher, he also worked as a driver. This entailed driving one of the prison vans to take fellow prisoners to work placements or medical appointments in the local community. He had only been driving for a short while and it helped towards his resettlement plans. The last time that he drove the van was two days before his death. He did not mention feeling unwell to anyone.

The following day, the man went on a home visit to Nottingham to spend the day with friends. He left at the prison at 8.20am. His friends said they had no concerns at the time, but with hindsight he might have been a little quieter than normal. He had asked for some antacid tablets during the day, but his friends simply assumed that he had indigestion as he did not say that he was feeling unwell or display any outward signs.

He returned to the prison at 6.24pm. The man spoke to an Officer who was working on the gate and had known him since his arrival at the prison. The Officer recalls having a “bit of banter” with him, which he often did. In his opinion, the man was his usual chatty, happy self. He said that he had no concerns about his wellbeing either during the conversation or on the other occasions he saw him during his shift.

The open regime at North Sea Camp requires the prisoners to be responsible for reporting their presence to the Officer on duty so that a full roll check can be completed. At approximately 10.00pm, the man reported to the office on Llewellyn unit to give his room number to the Officer on night duty. The Operational Support Grade (OSG) said that he exchanged ‘pleasantries’ with the man who appeared well and gave him no cause for concern. As part of his duties the OSG checked all the rooms on the unit, on an ad hoc basis, throughout the night. There was no indication of a problem when he checked the man’s room. The OSG recalled that, during his final roll check at around 6.00am, the man’s leg was slightly out of bed but he felt that there was nothing unusual or of concern. At the end of his shift, the OSG handed over to the day Officer.

The day Officer had only recently started to work in the resettlement unit. He was in the unit office issuing work licences and taking prisoner applications (the normal morning routine) when he received a call from the Catering Manager. He told the Officer that the man had not arrived for work. The Officer checked the man’s whereabouts on the roll board and confirmed that he had two work placements, kitchen and CSV driver. He told the Kitchen Manager that he would check on the man to clarify the situation after he had finished issuing the licences.

At 8.15am, the Officer went to the man’s room. On entering the room, he found him sitting on the edge of the bed ‘slumped’ to one side, with his chin on his chest. The Officer touched the man’s shoulder, but there was no response and he felt cold to the touch. The Officer attempted to contact healthcare using his radio. He did not receive an immediate verbal response, so contacted the Principal Officer (PO) who was the Orderly Officer, requesting that he telephone him at Llewellyn unit. The Officer then returned to the unit office to collect the first aid equipment. In the office he spoke with the PO on the telephone and told him that he had found the man in his

room and that he did not appear to be breathing. The PO immediately made his way to Llewellyn unit and directed other staff to contact the healthcare team. The healthcare team were already on their way after hearing the call for assistance over the radio net.

When the PO arrived, he went straight to the man's room to meet the Officer. They moved the man onto the bed so that he was on his back. The PO said that the man's face and extremities were blue and that he could find no signs of life. Another Officer arrived on the unit and assisted the PO with cardio pulmonary resuscitation (CPR). An ambulance had been requested. Other members of staff arrived, including two nurses from the healthcare centre, and they took it in turns to administer continuous CPR until the paramedics arrived.

The paramedics arrived at 8.37am and took over the CPR from staff. They continued efforts to revive the man until 8.47am when they declared that he had died. At this point all staff in the vicinity, including the paramedics, left the room to allow the chaplain to enter and offer prayers.

EVENTS FOLLOWING THE DEATH

After the man's death, the Governor appointed a prison Family Liaison Officer (FLO). Along with an Administrative Officer from North Sea Camp, they drove to Nottingham to inform the man's girlfriend and next-of-kin. They remained with his family for most of the day, making arrangements with the Coroner's officer for the family to see the man. They escorted the family to the homes of other family members to tell them of the man's death. The prison FLO invited the family to a memorial service that was to be held at North Sea Camp. They also offered the family financial assistance towards the funeral expenses.

The day after the man's death, the FLO met the man's family at North Sea Camp to accompany them to view his body. After a meeting with the Coroner, the FLO and the man's family returned to the prison. They were shown Llewellyn unit and visited the chapel to meet other prisoners who had been friends with him.

The FLO subsequently returned the man's property to the family. He also met with the chaplain who would be conducting the man's funeral who happened to be at the family home while he was visiting.

The Deputy Governor, FLO and Kitchen Manager attended the man's funeral. A number of serving and ex- prisoners also attended, which was a sign of the man's popularity. The family were pleased with the attendance of the prison staff and picked out the FLO for particular mention during the service for all the help and assistance he had given.

On 12 June, members of the family attended a memorial service held in the chapel at North Sea Camp.

ISSUES CONSIDERED

Healthcare

My investigation has shown that the man's ongoing hypertension was regularly monitored. However, it is also apparent that there was no system in place to follow up patients who failed to attend for scheduled appointments. I fully appreciate that this is also the case with many GPs when members of the public fail to attend for routine appointments. However, the prison would benefit from a system to follow-up prisoners suffering from chronic conditions who fail to attend for their appointments.

The Prison Health Partnership at North Sea Camp may wish to consider introducing a system to contact prisoners receiving ongoing treatment who fail to attend for appointments and to record the reasons for their non-attendance.

Family

The actions of the prison following the man's death, in particular the prompt and personal way that the next of kin were informed, was entirely appropriate and compassionate. At his funeral, the family made particular reference to the professional way that they had been treated by the prison and singled out the actions of the prison FLO.

The Governor and staff at North Sea Camp should be commended for their quick response and the compassionate way in which they dealt with the man's next of kin following his death. In particular, the FLO should be recognised for his wholly professional approach in carrying out his role.

CLINICAL REVIEW

Lincolnshire Teaching Primary Care Trust conducted the Clinical Review. The appointed Doctor produced a comprehensive report of the medical care given to the man whilst in custody and makes four recommendations. The report is attached in full as an annex, but the main findings are reproduced below:

Key Findings and Conclusions

1. The man had several risk factors for development of an acute cerebrovascular or cardiac event, namely long term, poorly controlled hypertension; clinical obesity; smoking; raised cholesterol with a very high Total/HDL ratio and a family history of hypertension and stroke. His overall risk of cardio- or cerebro-vascular event in December 2006 would have been assessed as > 20% using a CVD risk calculator.

2. The standard of documentation in the North Sea Camp prison medical records was excellent and there is a robust system within the healthcare service for monitoring patients with chronic conditions such as hypertension and coronary heart disease.

3. All contacts to healthcare were recorded and there was repeated reference to the man’s hypertension during individual consultations with nursing staff. Appropriate investigations were arranged by the healthcare staff and referral to the duty GP was made on several occasions. He did not attend some of the appointments that were made for him. Responsibility for attending follow-up appointments lies with the patient and there is no formal recall system in place for patients that do not attend.

4. The man did not receive optimal treatment for hypertension despite regular readings that were outside the recommended treatment targets. He was taking enalapril for most of his period in custody. He received a month’s supply of amlodipine at Nottingham prison, but this was not continued following his return to North Sea Camp. He appeared to be reasonably compliant with his treatment as evidenced by regular collection of his medication and regular attendance for BP measurement. There was, however, no trace of enalapril or simvastatin found on analysis of his post mortem blood sample.

5. There were several possible reasons for poor BP control, including reduced patient compliance with medication, co-prescription of a NSAID, which can elevate BP, and lack of optimisation of anti-hypertensive medication. The recommended treatment regime would have included the addition of a calcium channel blocker to the enalapril with consideration to use of a beta or alpha-blocker if further reduction was required.

6. The man was prescribed simvastatin 10mg daily to lower his cholesterol. This is lower than the recommended dose of 40mg for primary prevention and there were no follow up measurements to check the efficiency of this dose in lowering the Total/HDL ratio.

7. The man was seen and assessed for his knee problem and he was appropriately referred for an orthopaedic opinion. It is likely that the Orthopaedic Surgeon would have requested anaesthetic assessment of his BP, which was 152/96 at the time of referral.

8. The man died of a massive haemorrhagic stroke, likely to have been caused by hypertension, with additional contribution from his smoking, obesity, an adverse lipid profile and family history.

Recommendations

1. **The GPs who have been commissioned by the PCT to provide general medical services to the prisoners at North Sea Camp should review current guidelines on management of chronic diseases such as hypertension, coronary heart disease and diabetes. There should be consistency in their treatment targets.**

2. **There is a clear need for management protocols, based on National Guidelines, to be introduced so that the GPs and Healthcare staff are working to recognised minimum standards of care for all chronic conditions.**

3. **Transfer of prisoners is always a risk in terms of continuity of healthcare and there should be a robust system which outlines the patient's current, recent and past health problems, ongoing treatment and monitoring arrangements, and continuation of therapy as planned following transfer. There should be a formal clinical handover at the time of transfer with full documentation of ongoing treatment and monitoring requirements.**

4. **A Clinical Governance Policy and Plan should be established for North Sea Camp to ensure that clinical protocols are regularly reviewed and performance is monitored. Critical incidents should be reviewed in a "no blame" culture and used as a learning process. The Clinical Governance process should receive input from the GPs, healthcare staff and nurses, the PCT, and relevant Chronic Disease Groups to ensure that prisoners with chronic medical and mental health problems receive appropriate management.**

RECOMMENDATIONS

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GOOD PRACTICE

The Governor and staff involved at North Sea Camp should be commended for their quick response and the compassionate way in which they dealt with the next of kin following the man's death. In particular, the prison FLO should be recognised for his wholly professional approach in carrying out the role.

ANNEXES

1. Clinical review

2. Medical record

3. Wing record (page 16)

4. Statements of staff

5. Roll check report
   Incident log
   Minutes of debrief