

**Investigation into the circumstances surrounding the death of a prisoner at
HMP Swaleside in April 2005**

Report by the Prisons and Probation Ombudsman for England and Wales

March 2006

This is the report of an investigation into the death of a prisoner. He died in his cell at Swaleside on a Sunday morning in April 2005, ten days after he had transferred from HMP Lewes.

My office investigates the deaths of all prisoners in custody, including those due to natural causes. In this case, the investigation and clinical review of the man's care were carried out by two members of my office.

I offer my sincere sympathy and my condolences to the man's family for their loss. The loss of a loved one, particularly whilst in prison is distressing for all. I wish to offer my condolences to his family and friends at this time and trust this report answers some of the questions they have about his clinical care.

I am grateful to the Governor and staff of Swaleside for their assistance during the investigation. I am also grateful to Governor of HMP Lewes and his staff for their help in my enquiries there.

Stephen Shaw
Prison and Probation Ombudsman
March 2006

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Summary

1. The man was 45 years old when he died whilst in the custody and care of HMP Swaleside. He had suffered from cardiac problems for a number of years. He had significant surgical interventions, culminating in the insertion of a pacemaker in June 2004.
2. He was afforded a high level of clinical care whilst in prison, with clear evidence of good communication between the prison and specialist healthcare providers. Despite appropriate medical advice the man did little to help himself. He discharged himself from hospital against medical advice and continued to smoke and misuse drugs, the consequences of which were clearly explained to him.
3. Shortly before his death the man was removed from his cell due to a security operation. An examination by doctors at the local hospital following this incident confirmed his pacemaker was in the correct position and functioning correctly.

The investigation process

4. The man died in April 2005, and the investigation was opened the following Thursday.
5. My investigator visited Swaleside on 21 April to speak to staff, including the acting Deputy Governor, the chaplain, the Independent Monitoring Board (IMB) chairman, the Health Care manager and both uniformed and non-uniformed staff. She spoke informally to staff and was given access to all the man's prison records, including his medical records.
6. On 20 May, the investigator and clinical reviewer visited Lewes and spoke to staff there.
7. One of my Family Liaison Officers contacted the man's next of kin, who raised several questions that I trust this report will answer.
8. The Deputy Ombudsman carried out a clinical review of the man's medical treatment. Her report is at Annex 1.

Background

The man

9. The man was born on 10 October 1959 and lived in Sussex at the time of his arrest in June 2004. The man was arrested on 21 June with regard to a number of burglaries. During his arrest he developed heart problems and was taken immediately to a local hospital. The man remained in hospital in police custody until 30 June.
10. Whilst in hospital the man gave a false name and date of birth. This meant that the clinicians responsible for his care were unable to quickly access his previous medical records from the relevant NHS Trust. The man was well known to the a local Cardiac Centre. He had undergone a triple coronary artery bypass graft in 2000 for severe triple vessel coronary artery disease. In 2002, following continued chest pain he had an angioplasty and stent to one of his coronary arteries. This is a surgical procedure to improve the blood flow by widening the artery.
11. Following his arrest and during the subsequent admission to hospital, the man underwent implantation of a permanent pacemaker due to chronic atrial fibrillation, which is when the blood is not pumped round the body effectively. The man remained subject to a police escort throughout his hospital admission. On 30 June he was considered fit to be discharged and was therefore released into the custody of the police and taken to Chichester Custody Suite.
12. The man remained in the custody of the police until 5 July, when he appeared at the local magistrates court charged with burglary of a household dwelling. The man stated in a complaint to the Sussex Police Civil Claims Unit that he was seen by a nurse and/or doctor on a daily basis. No information was forwarded to the prison about these consultations when he was remanded into their custody from the Chichester Custody Unit. Whilst I believe this omission, did not compromise the care the man received, it could have serious or even fatal consequences in another situation.
13. The man was initially received at HMP Lewes on 5 July 2004. It was not his first time in prison custody and he was well known to staff at Lewes. On reception, the man informed healthcare staff of his cardiac history and his recent admission to hospital. When asked about his drug and alcohol history, the man said he used heroin and cocaine. He said he had last used drugs two weeks prior to reception, which would have been shortly before his arrest. The man said he only drank alcohol on a social basis and smoked about ten cigarettes a day. The man did not have a mental health history, and was not considered to be at risk of suicide or deliberate self-harm.

HMP Swaleside

14. Swaleside opened in 1988 as a Category B Training Prison. It accepts category B prisoners who are serving four years or more or have at least 18 months of their sentence left. It is a main centre prison for prisoners in the first stage of their life sentence and accepts prisoners in the second stage of their life sentence, giving a total of 460 places for life-sentenced prisoners. It has a high minority ethnic population of between 30-40%, and a similar number of foreign national prisoners.
15. Swaleside has an active regime with a clear resettlement focus and it provides a range of accredited offending behaviour courses. It also provides a range of non-accredited courses, including victim awareness and anger management.
16. There is a Drugs Therapy Unit and a supportive voluntary testing unit. The education programme covers a curriculum from basic education to Open University courses, with the full-time equivalent of 120 places. In 2004, new classrooms and courses opened in the industries complex, offering additional part-time educational opportunities to those in work. The prison offers a variety of employment activities from industrial cleaning to engineering, including work in commercially run industries paying higher wages than the prison service averages.
17. From 1 April 2004, the provision of healthcare within the prison became the responsibility of Swale Primary Care Trust as part of the transfer of commissioning responsibility for prison health from the Prison Service to the NHS.

HMP Lewes

18. Built in 1853, this Victorian local prison houses men awaiting trial, on remand and sentenced. There are also a small number of Young Offenders committed from local courts in the East and West Sussex area. Throughout the 1940s and 1950s Lewes was used as a centre for Young Offenders and in 1963 a Borstal experiment was successfully started. In the early seventies it became a training prison, with one wing devoted to lifer prisoners, whilst retaining its remand function for the Sussex courts. This function continued until 1990, when the prison once more became a local establishment, housing mainly short-term and remand prisoners.
19. A full range of education classes is available. Prisoners are employed in three workshops, the gardens and various orderly jobs. A job club and a comprehensive physical education Programme is available, and a listener scheme for those prisoners who may be at risk from suicide or self-harm.
20. Lewes has a healthcare centre with a full time senior medical officer. Health care is provided on a 24 hour basis and the prison makes use of specialist National Health Service facilities when needed.

Key Findings

21. On 21 June 2004, the man was arrested and taken straight to hospital in for treatment for cardiac problems. He was diagnosed with slow atrial fibrillation, and the following day had a temporary pacemaker fitted. On 29 June, a permanent pacemaker was inserted and the following day he was taken to the Chichester Custody Centre. On 1 July, he was examined by a police doctor who said he was not fit to be interviewed, but the next day, the doctor said that he was now fit. He was taken to court in a car and remanded in police custody for three days, during which time the police doctor continued to monitor him. On 4 July, the man said he was not well and refused to be interviewed, but asked for some exercise and cigarettes.
22. On 5 July, the man was taken to the magistrates court, but this time he was taken in a cellular police vehicle. In a statement written at a later date, he described how he refused to get into the van, saying that he was claustrophobic. Furthermore, he had recently had a pacemaker fitted, and the doctors had told him that he should not be put under any stress. The police then put him into one of the cells in the van. The man claimed that they used force to do so. He later made an official complaint to the Sussex Police and they began an investigation. At court, he was remanded in custody to Lewes.
23. During his induction at the prison, it was noted that the man had recently had a pacemaker fitted. On the following day the medical officer wrote to the senior officer on G wing to say that he was to be located on the ground floor because of his cardiac surgery. The same day, healthcare staff contacted the hospital to check his medication and obtain his discharge summary. Hospital staff agreed to fax through the discharge summary which was eventually received on 14 July. They also advised that they would be transferring his care back to another hospital who would arrange the six week, post surgical out patient appointment. Later that day the man's wound suture was removed. The man's medication was confirmed and dispensed by the pharmacy.
24. On 13 July 2004, arrangements were made for the man to attend healthcare to have his blood clotting time checked. The man refused to wait for the test, despite advice from healthcare manager. When advised that he might have to wait before he could be returned to the residential unit, he became rude and abusive.
25. On 21 July, the man requested to an appointment with healthcare, but did not attend. The man stated he did not know about the appointment. However, he again became very abusive and began banging the door. Later he calmed down and so an appointment was made for him to see the doctor that afternoon. When the man saw the doctor he was re-prescribed dihydrocodeine, a pain killer, for 28 days and advised to stop smoking. The man also discussed his problems of travelling in a cellular vehicle. The doctor requested that other modes of transport be used if possible.

26. The following day at 12.25pm healthcare staff attended the man's cell as he was complaining of chest pain. The man's blood pressure and pulse were checked on four occasions and nitrolingual spray (used to relieve acute attacks of angina) administered to no effect. The staff nurse requested that an ambulance be called whilst on the wing with the man. However, they were advised to transfer him to healthcare and an ambulance would be called at 2:00pm. The man was taken to healthcare at 1:00pm. By 1.25pm his health had deteriorated and an emergency ambulance was requested via the communications room. On contacting the communications room, the requesting member of healthcare was asked make the request through the Oscar 1 (the duty officer). An ambulance finally was called and arrived at Lewes at 1.32pm. There was then a further delay whilst the escorting staff for the man returned from an earlier escort. The ambulance finally left at 2pm. In the case of the man the delay had no adverse effects on his clinical condition and he had returned to the prison by 4:00pm. However, in another situation, time could be critical. Furthermore delaying the ambulance by half an hour takes essential emergency paramedics off the road for an unacceptable length of time, precluding them from responding to other emergencies.
27. On visiting the man on the wing, following his return from hospital, healthcare staff found that he had discharged himself against medical advice after a blood test. The hospital staff were contacted later that evening for the results of the blood tests. The results were not available and staff were advised to call back on Monday.
28. On 2 August, the man refused to attend court. The man was examined by healthcare staff and identified as fit to attend court. He was subsequently seen by the medical officer and by then he was complaining of a headache and angina. The medical officer decided that in light of his refusal to attend and the need for three officers to escort him he should be classified as unfit to go to court. Two days later, a governor issued an instruction that the man was to be transported by a people carrier, from then on.
29. Once again on 9 August, the man complained of chest pain and dizziness. A prompt and thorough examination resulted in a decision for him to be referred to Accident and Emergency for an assessment. The man remained in hospital for two days. On his discharge, the man was required to attend healthcare for daily blood tests until his blood clotting was within the prescribed parameters. By 18 August, despite relatively high doses of prescribed Warfarin, the man's clotting time did not change. It was felt that he was not complying with his treatment.
30. During the evening of 19 August, the man again complained of chest pain. Healthcare staff contacted the hospital for advice. A decision was taken to readmit the man for observation and assessment. The man remained in hospital until 6 September, during which time he had his pacemaker leads replaced and his pacemaker re-inserted.

31. Over the next two months the man appeared settled and had regular blood pressure checks and blood samples taken for clotting times.
32. On 7 November, healthcare staff attended the wing as the man complained of shortness of breath. Paramedics were called and arrived at Lewes shortly after 5.30pm. The man was taken to hospital. Nothing significant was found and the man was advised to reduce his cholesterol and stop smoking. The man was discharged that evening and returned to Lewes with his medication and a follow up appointment for three months.
33. On 9 November, the man was sentenced to eight years imprisonment at a London court. He travelled from the court to HMP Wandsworth by car. On reception he was seen and examined by the duty doctor and was allocated a ground floor cell as he was unable to climb stairs.
34. On 19 November, the man attended healthcare and demanded dihydrocodeine. It was agreed that he should be put on a reducing dose. The man was not happy with this and returned to see the doctor. He became argumentative and abusive. The man subsequently refused to attend for a blood test.
35. The man returned to Lewes on 3 December. By mid-December he was refusing to attend healthcare for his blood tests. On 22 December, the man consented to a blood test, but refused again on 29 and 30 December.
36. On 10 January 2005, night staff saw the man for another episode of chest pain. Following clinical examination, it was not felt necessary to transfer him to hospital and so an appointment was made for him to see the doctor the following morning. The man subsequently refused to attend the appointment.
37. In April, the man was one of several prisoners who were moved from the wing to the segregation unit as part of an on-going security operation. The man did not fully co-operate with orders from staff, however full control and restraint (C&R) techniques were not used. Staff were fully aware of his clinical condition and the risks associated with using approved C&R techniques. On location into the segregation unit the man complained of chest pain and so was seen by healthcare staff. He was later transferred to the local hospital's Accident and Emergency unit for a check up. The chest x-ray showed his pacemaker was in the correct position and the electrocardiogram (ECG), a test that measures the rate and regularity of heartbeats, revealed the pacemaker was working correctly. The man returned to Lewes later that evening.
38. Two days later, arrangements were made for the man's transfer to Swaleside on grounds of security. The man had an out-standing out patients appointment the following week, but arrangements were made for him to attend this appointment from Swaleside. The man was transferred the following day. On reception he was admitted to the in-patients unit for a period of assessment in the light of his medical history.

39. Shortly afterwards, the man complained that his pacemaker had “popped out” when he had been restrained at Lewes. Healthcare staff reassured him that there were no problems; this had been confirmed by examination at hospital. The man was considered fit to be re-located on the main residential unit. The cell sharing risk assessment form noted that the man told staff that he had recently had an operation and so could not get into the top bunk bed. He was given sole occupancy of a two-man cell until a single cell became available, and staff supplied him with an easy chair so that he could sit in comfort.
40. Two days later, the man was referred to the local Accident and Emergency department. The following evening he returned to Swaleside, having once again discharged himself against medical advice. On his return to prison, the head of healthcare discussed the man's decision with him. The man told him that he preferred to wait for his consultant's appointment at Swaleside where he had the company of other prisoners. The man returned to his cell on the wing. Later that week, he attended morning surgery, and once again refused to wait. Later that day, he moved to a single cell that had become available.
41. The following Sunday at 11.45am, a prisoner reported to staff that the man appeared to be unconscious in bed. On Sunday mornings, staff unlock the cell doors and check on the prisoners but they do not wake them up. Wing staff immediately raised the alarm and healthcare staff were called to the wing. On arrival, healthcare staff could not find a pulse, and the man was not breathing. Attempts were made to commence cardio-pulmonary resuscitation but rigor mortis had set in. An ambulance was called and arrived at 12:10pm. The paramedics could not resuscitate the man. Death was later certified by the medical officer.
42. When the man was first remanded to prison, his address was recorded on the personal summary sheet of his core record as "no fixed abode". The sections for his next of kin and anyone else to be contacted in an emergency have the entry "Nil". After the man's death, police gave the news to a friend, who passed it on to another friend, who then informed the family. They then made contact with staff at Swaleside.

The Governors of Lewes and Swaleside should ensure that, as far as possible, all prisoners provide next-of-kin details for their records and that these are checked and updated on an annual basis.

43. The family received a letter from the prison saying that the prisoners had made a collection and a cheque was enclosed. The man's possessions were also sent to the family. The Governor agreed to help the family with the costs of the funeral. They also invited the family to visit the prison and see the man's cell.

Issues considered during the investigation

The man's health

44. The man was received into prison custody with a significant cardiac history. He had previously had a triple coronary artery bypass graft, angioplasty and stent and in 2004 a pacemaker was inserted.
45. The man's clinical care was appropriate and timely throughout his time in prison. There is clear evidence of good communication with secondary and tertiary care services and prompt referrals.
46. Prison staff were fully aware of his clinical condition and when the man refused to co-operate with a security operation, minimal force was used. Furthermore, he was subsequently referred to hospital to check on his pacemaker. The clinical examinations carried out by the hospital showed his pacemaker was in the correct position and functioning properly.
47. The man was not fully compliant with his treatment and took little personal care of his health needs. He continued to smoke, misuse drugs and have a high fat diet, despite medical advice to the contrary. Furthermore, on a number of occasions he refused to attend for medical appointments and on at least two occasions discharged himself from hospital against medical advice.
48. Whilst not directly affecting the premature death of the man, two areas of concern have been identified as a result of this investigation that could put others at risk.
49. The man spent nine days in hospital following his arrest and five days in police custody during which there was significant interaction with clinicians. On his reception into prison no information was passed on by the police. Prison staff cannot be expected to provide appropriate and comprehensive care packages for prisoners if they are not in receipt of all the available information.

I recommend that the Governor forward a copy of this report to the Chief Constable of Sussex Police with a request that medical information relating to the care of offenders should be shared in a timely manner.

50. On one occasion there was an unacceptable delay in calling an ambulance, compounded by un-necessarily complicated lines of communication. When the emergency ambulance was called there was a further thirty minute delay whilst the escort staff arrived. While I have been pleased to learn that there is a protocol in place that should ensure an ambulance gets into the prison as quickly as possible, I want to be certain that all staff are aware of its existence and importance. For that reason:

I recommend that the Governor reminds staff of the importance of the protocol covering the admission of ambulances to Lewes.

51. In conclusion, I believe the clinical care the man received was timely and appropriate for his medical needs. All prison staff were fully aware of his health problems and ensured that their actions did not compromise his cardiac condition. Conversely, the man did little to help himself and frequently went against the professional advice offered to him.

Documents used at Lewes

52. When my staff examined the man's records, they noted three forms that are in use at Lewes that I would commend for use at other establishments. Copies of these documents are at Annex 12.

53. Two documents are for use on the wings. Firstly, a personal officer log records, cell by cell, the contact that officers have with prisoners. It includes the date of contact and has space for the senior officer to countersign. The second form is on a sticker that is completed bi-weekly and added to each prisoner's core record. It provides a clear summary of the prisoner's status and behaviour. As with the first document, the officer prints his or her name as well as signing it.

54. The third form is a cellular confinement monitoring sheet that forms part of the segregation unit history booklet. Again, it shows a great deal of information in a very clear format. It also includes space for those who visit the prisoner to include their name as well as their signature. Each page sets out the checks carried out over a seven-day period.

Recommendations

Policy

I recommend that the Governor forward a copy of this report to the Chief Constable of Sussex Police with a request that medical information relating to the care of offenders should be shared in a timely manner.

Operational

I recommend that the Governor reminds staff of the importance of the protocol covering the admission of ambulances to Lewes.

The Governors of Lewes and Swaleside should ensure that, as far as possible, all prisoners provide next-of-kin details for their records and that these are checked and updated on an annual basis.

Good Practice

The personal officer contact log, the bi-weekly summary sticker and the segregation monitoring sheet are well laid out documents that present a lot of information in a very clear manner. It is also helpful that the forms require the staff member's name to be printed as well as a signature. I would commend these documents for use at other establishments.