Investigation into the circumstances surrounding the death of a man at HMP & YOI Bristol in June 2008

Report by the Prisons and Probation Ombudsman for England and Wales

May 2009

This is the report of an investigation into the death of a man. He was a prisoner at HMP & YOI Bristol and died in June 2008. He had been suffering from diabetes, heart disease and schizophrenia for a number of years, and was 70 years of age when he died.

The loss of a loved one is always distressing and I extend my condolences to the man's family. I know that his son has raised concerns that he was not made aware of the seriousness of his father's illnesses. I trust that my report addresses this issue

The investigation into the man's death was carried out by one of my investigators. A clinical review was commissioned from the local NHS Primary Care Trust and completed by a clinical reviewer. I thank him for his observations and the recommendations drawn from his findings. I would also like to thank the Governor of Bristol and his staff for their co-operation and assistance. I am particularly grateful to the Healthcare Manager and the prison liaison officer.

The man had a history of significant heart disease and ill health. Unfortunately, he was also becoming more physically frail. My investigation concludes that there was little that could have been done to prevent his death. However, I make five recommendations for procedural improvements.

I must apologise for the delay in issuing this report and any additional distress this may have caused.

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 **May 2009**

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SUMMARY

The man was received into custody at HMP & YOI Bristol on 28 April 2006. He was 68 years old at the time. He was a diabetic, suffered from significant heart disease and had been diagnosed with schizophrenia in the past. As a result of his medical history he was closely monitored by wing based healthcare staff. He regularly attended the diabetic clinic and received routine care for his heart condition. He was also regularly reviewed and monitored by the Mental Health In Reach team.

In January 2007, the man complained of upper body tremors and had difficulty walking. He was assessed by a specialist from the local Mental Health Partnership Trust, who diagnosed a movement disorder, possibly Parkinson's Disease, although the diagnosis was never confirmed. A scan of his head was arranged in April which showed a degree of cerebral atrophy that could have been caused by cerebral vascular disease and smoking. (Cerebral atrophy is when part of the brain dies or becomes non-effective. In his case, it was attributed either to a stroke - that is, cerebral vascular disease - or his smoking.)

The man had been complaining of being breathless and, after a heart scan (ECG) in September 2007, he was diagnosed with heart failure. Over the following months he started to experience further problems with his mobility and became incontinent. This resulted in admission to the Royal Infirmary on 12 February 2008 where he remained until mid March.

The man continued to have problems with his mobility and was physically deteriorating. He was readmitted into the healthcare centre at Bristol prison on 12 May. He had been provided with a Zimmer walking frame and was being given assistance with his personal care.

A full review of the man's health took place on 28 May. His diabetes and heart condition were recorded as stable on medication, and his incontinence problems had been resolved. However, he was confused and still had significant problems with mobility. Healthcare staff referred him to the Mental Health In Reach team and a specialist physiotherapist.

On 4 June, it was recorded in the medical notes that there was a further deterioration in the man's mental state. He was confused and had become incontinent again. It was decided to refer him for a psychiatric assessment which was planned for 12 June. In the meantime, urine tests could be completed and a course of antibiotics (if he was found to have a urine infection) completed prior to the psychiatric assessment. The urine tests proved negative for infection.

Three days later, on the morning of 7 June 2008, the man had breakfast and was assisted to shower. A healthcare officer noticed a slight deterioration and in the afternoon he asked a visiting doctor to see him. In interview, the healthcare officer said that the doctor saw the man and was not concerned about him. (This examination is recorded in the medical record but the entry

is not signed.) He spent most of the rest of the day in his room lying on his bed, which was not unusual. He was given his medication and a cup of tea in the evening. The evening duty staff, the healthcare officer and a nurse, helped him into bed and thought that he was comfortable when they went off duty. The nurse said that she asked the night staff, a second nurse and a senior officer (who was acting as a Healthcare Assistant), to observe him through the night but there is no record of this actually happening.

In interview, the second nurse said that she checked the man several times throughout the night as he had got out of bed on previous nights that week and had to be helped back into bed. The records for the night state that he appeared “to have slept through the night” and was still in bed at approximately 5.15am when the early roll check was completed by the senior officer.

An hour and a half later, at 6.50am, the man was found during a routine check by a third nurse. He was kneeling on pillows on the floor with his head resting on the bed. He had no pulse and his body was cold. His death was pronounced at 7.20am.

The post mortem report carried out on 12 June 2008 concluded that the cause of the man’s death was ischemic heart disease.

THE INVESTIGATION PROCESS

1. An investigator carried out the investigation into the man's death on my behalf. Notices were issued to staff and prisoners informing them of the investigation and its terms of reference, and inviting them to contact the investigator should they wish to do so. In the event no one came forward.

2. The clinical reviewer of Bristol Primary Care Trust used the healthcare records to carry out a full clinical review of the man's mental and physical healthcare whilst he was in custody.

3. The investigator visited HMP Bristol on 26 June 2008. He spoke informally to staff and visited the healthcare centre where the man spent the last few months of his life. He spoke with members of the Independent Monitoring Board (IMB) and the Prison Officers' Association (POA). He reviewed the prison records for the man and arranged for copies of these and his medical record to be sent to him. He also interviewed a nurse.

4. My investigator contacted HM Coroner's office to inform him of the investigation and ask for a copy of the post mortem report. A copy of my report will be sent to the Coroner to assist in his enquiries into the man's death.

5. One of my family liaison officers contacted the man's next-of-kin, his son, to offer him and other family members the opportunity to contribute to the investigation. There was some delay in making this contact due to my office being given incorrect address details.

6. The man's son was concerned that the family were not made aware of his father's deteriorating health and that their contact details were incorrectly recorded. I have done my best to address their concerns. I hope that my report helps the family better understand what happened in the time leading up to his death.

7. On 2 December, the investigator returned to Bristol to interview three additional members of staff. The nurse on duty in the inpatient unit on the night of 7/8 June 2008, is not currently working in a prison. The investigator conducted a telephone interview with her on 18 February 2009.

HMP & YOI BRISTOL

8. HMP & YOI Bristol is a category B local prison which first opened in 1883. It has accommodation for 600 prisoners and serves the local courts in Avon, Somerset and Wiltshire.

9. The healthcare service is commissioned by the local NHS Primary Care Trust (PCT). Primary care is provided by Bristol Community Health (an arms length organisation from the PCT) and a mental health in-reach service is provided by Avon and Wiltshire Mental Health Partnership NHS Trust. The prison provides 24 hour primary healthcare, which includes nurses who treat patients within the prison's wings. There is a 20 bed inpatient facility within the healthcare centre (HCC), which is located in a two storey block shared with the segregation unit. The HCC also has association/day room facilities for inpatients, and consultation rooms where prisoners from other parts of the prison can see a doctor. An exercise yard is shared with the segregation unit.

10. Bristol received an unannounced inspection by HM Chief Inspector of Prisons in June 2008. She wrote that she was "extremely encouraged by the significant developments in all aspects of the health services". Primary care services were good, with wide range of nurse led clinics in operation. Inpatient services were also good.

11. There had been eight previous deaths from natural causes at HMP & YOI Bristol since 2004, when I was given responsibility for investigating all deaths in prison custody, before that of the man. In a report I issued in March 2005 I made a recommendation about resuscitation policies for people who are terminally ill. Resuscitation is a feature of this report too, albeit from a different perspective.

KEY FINDINGS

12. The man was received into custody at HMP & YOI Bristol on 28 April 2006 having been sentenced to 14 years imprisonment. During his initial health screening it was noted that he suffered from heart disease and diabetes and had suffered from schizophrenia in the past. He was referred to the mental health team, diabetes nurse and a chiropodist.

13. The man was located within the main prison where he was monitored regularly by wing based healthcare staff. He attended the diabetic clinic where his condition was monitored and received treatment from the visiting podiatrist. Throughout his time at Bristol his mental health was reviewed by the Mental Health In Reach team and he received regular routine care for his heart condition.

14. In January 2007, the man was assessed by a Specialist Registrar at the West of England Forensic Mental Health Service after complaining of upper body tremors and difficulty with everyday movement. The Specialist Registrar diagnosed him as having a movement disorder, which was possibly Parkinson's Disease. A head scan was carried out in April 2007 which showed a degree of premature cerebral atrophy that could be due to cerebral vascular disease and smoking, but a definitive diagnosis was not reached.

15. The man started to complain of breathlessness. On 5 September 2007, he was given a heart scan following which a doctor, from the cardiology department of Bristol Royal Infirmary, diagnosed heart failure.

16. In February 2008, the man was experiencing problems walking and controlling his bowels. He was admitted to the Royal Infirmary on 12 February. He returned to Bristol HCC on 11 March and to his wing on 29 March. While he was being looked after in the HCC, his medical notes record that on 16 March staff were asked to make contact with HMP Norwich, where there is an elderly prisoners unit, with a view to arranging a transfer. However, my investigator was unable to find out if an application was ever made.

17. Close monitoring by healthcare staff continued during April. The man was assessed for a Zimmer frame walking aid, and his hearing aid was sent for repair. He was readmitted to the HCC on 12 May as his mobility had deteriorated and he was becoming frail. He needed assistance to look after himself including washing, dressing and eating. A routine external hospital appointment was cancelled as he was not well enough to attend.

18. The man's health was reviewed on 28 May when he was referred to the Mental Health in Reach team for a review of his symptoms of schizophrenia. He was also having problems with mobility and was referred to an outside hospital's physiotherapy department. His

diabetes and heart condition were stable due to the medication he was taking, and his incontinence problems had been resolved. He was experiencing pain in his feet for which he was prescribed additional medication. He had an optometry assessment on 2 June and new glasses were ordered.

19. By 4 June, there was deterioration in the man's memory, he was confused and also experienced further incontinence. Urine tests were taken and an appointment for a psychiatric assessment was planned for 12 June, once the results of the urine tests were received and any infection had been treated. (The test results showed that he did not have an infection.) Healthcare staff noted that he was slightly brighter and more mobile the following day.

20. Two days later, on the morning of 7 June 2008, the man had his breakfast and the staff assisted him to shower. The healthcare officer noticed a slight deterioration and asked a visiting doctor from Brisdoc, the out of hours service, to see him. The doctor examined him and, according to the healthcare officer, was not concerned about his condition. My investigator could not find the identity of the visiting doctor in the written, unsigned, record of this examination.

21. The evening duty staff on 7 June were a nurse and the healthcare officer. The man spent most of the evening on his bed, which was not unusual. He was given his evening medication by the nurse. The healthcare officer and the nurse then gave him a cup of tea and helped him into bed, ensuring he was comfortable for the night.

22. Talking to my investigator, the nurse recalled asking the night staff to keep an eye on the man as he had been "slow" during the evening. My investigator could not find any written record of the discussion nor any evidence to suggest that the request was acted on.

23. The night staff on 7 June were a senior officer (SO), who was acting in the capacity of a Healthcare Assistant, and a second nurse. The segregation officer also patrolled the HCC regularly during the night. My investigator interviewed the SO and conducted a telephone interview with the nurse. The SO remembered the man having a settled night on 7 June. He said he checked on him periodically through the night and had no cause for concern.

24. The nurse said that at approximately 10.30pm the man was talking to himself and waving his hands in front of his face. She spoke to him and gave him a cup of tea through the hatch in the door. She remembered that he was slow to collect his cup of tea from the hatch, and she left him to make his way there at his own pace. She returned to her other duties, but recalled seeing him use his Zimmer frame. She noticed that the cup of tea was gone when she next looked in and that he was back in bed. A short time later she remembered waving to him as she left the inpatient area, and that he waved back.

25. The nurse also remembered checking on the man several times throughout the night. He had got up during preceding nights and needed help to get back into bed, which necessitated calling for the night orderly officer (the person in charge of the prison at night) in order to unlock his cell. She did not think that he got out of bed during the rest of the night of 7/8 June, as he did not require help to get back into bed.

26. The SO conducted a roll check at approximately 5.15am on 8 June and checked on all the inpatients in the HCC. At 6.00am, 45 minutes later, he reported by telephone to the Control Room that all the inpatients were accounted.

27. The SO and nurse handed over to the day staff, a third nurse, who is a Registered General and Registered Mental Nurse, at 6.40am. The handover was verbal and no problems were reported. The man was reported to have had a quiet night.

28. The nurse opened the observation hatch on the door of the man's cell to check on him at 6.50am. He saw him kneeling on pillows on the floor by his bed, with his head on the bed. He went into the cell and examined him. As he had no pulse and was cold to the touch, the nurse decided not to attempt resuscitation. An ambulance and Brisdoc (the out of hours doctors service) were called. The man was pronounced dead by the paramedics at 7.20am.

29. The prison's Family Liaison Officer and Duty Governor attempted to visit the man's next of kin, his son, at the documented address later that day. Unfortunately, the address recorded was wrong. The prison's Family Liaison Officer eventually made contact with the man's son at 4.40pm and arranged to visit the following day.

30. The post mortem conducted by a pathologist on 12 June concluded that the cause of the man's death was ischemic heart disease.

ISSUES

Clinical care

31. In his clinical review, the clinical reviewer concludes that the man's chronic conditions of diabetes, heart disease and schizophrenia were appropriately cared for by staff at HMP Bristol. He was regularly reviewed and appropriate consultant assessments were carried out. The clinical reviewer is satisfied that best practice was followed in regard to prescribing for heart failure, diabetes and ischaemic heart disease.

Record keeping

32. There are a number of discrepancies between the documentation and evidence given at interview for this investigation. It was often difficult to establish who was responsible for entering comments on the records and who was the named nurse responsible for care at any particular time.

I recommend that all staff be required to print their names next to any entry on official documents and that all staff are reminded of the need to document all significant contact with prisoners.

Resuscitation

33. The man's body was cold when he was found at 6.50am. Whilst no precise time of death is known, it is probable that he had been dead for some time before he was discovered, the previous check having taken place at 5.15am. The current roll check procedures do not require a check to be made by the oncoming day staff prior to the departure of night staff. Whilst this would not have prevented the man's death, it might have resulted in him being found earlier.

I recommend that the Governor review the roll check procedures within the inpatient unit of the healthcare centre.

34. There may be some who read this report and question why no attempt was made to resuscitate the man. To answer this issue, Annex C of Prison Service Order (PSO) 2700 clearly states that resuscitation should not be attempted when rigor mortis has set in. The clinical reviewer in his clinical review concludes that the nurse's decision not to resuscitate was appropriately taken. I agree. It is respectful neither to the person conducting resuscitation nor to the memory of the deceased to attempt to revive someone when their body is already cold.

35. There is no documentation to evidence that regular nursing checks were carried out throughout the night of 7/8 June on those prisoners who did not require special observations. Again, this would not have

prevented the man's death, but it would ensure that all prisoners are regularly monitored and any problems quickly identified**.**

I recommend that the Governor review the night patrol procedures for the inpatient unit of the healthcare centre.

Contact with the family

36. When a prisoner dies, PSO 2710 states that prison managers must:

> "Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened."

PSO 0500 further states that, on reception into the prison, staff must ensure that the next of kin is accurately recorded. The address recorded for the man's next of kin was out of date which resulted in an unnecessary delay in informing his son. The Duty Governor and prison's Family Liaison Officer did attempt to visit the family to break the news face to face but had the wrong address. This resulted in the family being advised by telephone. The incorrect contact details were also passed to my own Family Liaison Officer which again led to delays in initiating contact.

I recommend that the Governor ensures the accuracy of every prisoner's next of kin details and puts in place an annual check of these details.

37. The man's son has expressed concern that the family were not kept informed about his father's deteriorating health. There is no direct requirement on prison staff to keep next of kin updated on the health of prisoners. However, in the light of the man's increasing frailty, such contact would have been good practice.

I recommend that the Prison Service reminds Governors of the need to communicate with the next of kin when a prisoner's health deteriorates significantly, subject to consent being given.

The Prison Service responded to the following recommendations with an Action Plan, the detail of which I have incorporated into this report.

RECOMMENDATIONS

1. I recommend that the Governor reviews the roll check procedures within the inpatient unit of the healthcare centre.

   Accepted: The staff are aware that the roll check must be a full roll check where each prisoner must give a response to staff when checks are made.

2. I recommend that the Governor reviews the night patrol procedures for the In Patient unit of the healthcare centre.

   Accepted: A full review of the night patrol procedures will be reviewed [sic] to ascertain if any best practices can be adapted to ensure that [sic] safety of all patients located in the healthcare centre (target date for completion is November 2009).

3. I recommend that all staff be required to print their names next to any entry on official documents and that all staff are reminded of the need to document all significant contact with prisoners.

   Accepted: A notice to staff will be issued to inform all staff when they make entries in the prisoner/patients documents i.e. wing file, ACCT documents, IMR etc that they must print their name so it is legible (target date end April 2009).

4. I recommend that the Governor ensures the accuracy of every prisoner's next of kin details and puts in place an annual check of these details.

   Accepted: All prisoners are asked for next of kin details in reception when they first enter the prison; on Induction which is within the next 24 hours of reception; and when an ACCT document is opened. A prisoner may also request to change their next of kin details. A notice to staff will be issued to remind staff to ensure that they ask the prisoner for this information. An annual check will be completed by the Safer Custody Team on ACCT documents. First night and Induction staff will inform Safer Custody of those prisoners who have refused to give this information out (target date for completion is February 2010).

5. I recommend that the Prison Service reminds Governors of the need to communicate with the next of kin when a prisoner's health deteriorates significantly, subject to consent being given.

Accepted: National response – There is no mandatory requirement for Governors to keep next of kin updated on the health of prisoners. However, it is good practice to appoint a Family Liaison Officer (FLO) where a terminal illness is diagnosed. This enables the prison to develop a relationship with the family and provide support at this difficult time. A recent edition of Safer Custody News reminded Governors of this and consideration will be given to including it in the review of PSO 2710.

Local response – With regards to HMP Bristol, they will ensure that the next of kin details will be used to contact those family members when health of a prisoner deteriorates. A working party will be set up to look into the safe provision of older prisoners whose health may deteriorate whilst in prison, and this recommendation will be included in this group (target date for completion is February 2010).