

**Investigation into the circumstances surrounding the death of
a prisoner at HMP & YOI Chelmsford in May 2004**

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

April 2005

This is the investigation report into the circumstances of the death of a prisoner in hospital, in Essex, in May 2004. The man was in the custody of HMP & YOI Chelmsford but had been taken to hospital on 19 May 2004 after collapsing in his cell. He had been unwell for some time and had been in hospital on several occasions since his first reception into Chelmsford.

The results of the post mortem held on 2 June 2004 indicated that the prisoner had died as a result of a brain disease. An autopsy was carried out by a Consultant Neuropathologist at Kings College Hospital, London. On 13 December 2004 he wrote to the coroner and informed her that the prisoner had died of gliomatosis cerebri. This is a malignant brain tumour and is a very rare condition. It is normally only diagnosed during post mortem procedures, as in this case.

This investigation was managed under the transitional arrangements agreed with the Prison Service. The Senior Investigating Officer nominated to complete the investigation was Governor of HMP Holloway (formerly Governor of HMP & YOI Bullwood Hall). He was assisted by my Assistant Ombudsman. The report was written by a Residential Governor at HMP & YOI Bullwood Hall and my Assistant Ombudsman. An independent review of the prisoner's clinical care in prison was commissioned from the Director of Public Health at Chelmsford PCT. Head of Healthcare at Bullwood Hall, carried out the clinical review.

The investigation team would like to thank the management and staff at HMP & YOI Chelmsford for their assistance and co-operation during the course of this investigation.

They and I would like to extend our condolences to the family of the prisoner and to those touched by his death.

This investigation has revealed both some good practice on the part of staff at Chelmsford and areas of concern that should be addressed.

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Summary

The prisoner was a 52 year old man who was on remand at HMP & YOI Chelmsford. He died in hospital on 22 May 2004 from a progressive severe brain disease. He had been taken to hospital on 19 May after having been found collapsed in his cell in the Healthcare Centre. His death was not connected to the fact that he had been in prison nor to the level of care that he received whilst in prison.

Prior to the prisoner being remanded into custody he had attended the hospital Neurology Department for investigations following two seizures. The prisoner was diagnosed as having a progressive brain disease by the hospital shortly before his death. The post mortem indicated that he was suffering from gliomatosis cerebri, a very rare form of brain tumour.

The investigation team, prison and family liaison officer at the PPO's office have been in contact with the daughter of the prisoner.

Healthcare staff worked very hard to look after the prisoner within the Healthcare Unit at Chelmsford. However, it was accepted that the most appropriate place for him was in a long term residential ward. Steps were taken by the medical team within the prison to facilitate such a move and a long term bed was subsequently offered at hospital on 17 May 2004. Unfortunately, the prisoner was not taken there due to staffing problems at the prison on that day. He was found collapsed in his cell two days later and was taken as an emergency into hospital where he died a few days after this. I am satisfied that the prisoner was cared for by the healthcare staff at HMP & YOI Chelmsford to the best of their ability and that his remaining at the prison did not hasten his death from gliomatosis cerebri on 22 May. However, this report makes several recommendations in relation to the care of those who are seriously ill within a prison healthcare setting.

Investigation process

I appointed the former Governor of HMP & YOI Bullwood Hall, now Governor of HMP Holloway to conduct the inquiry on my behalf. The Assistant Ombudsman from the Prisons and Probation Ombudsman's Office attended the initial meeting and some of the interviews conducted with staff.

The investigation team first visited Chelmsford on 15 June 2004 and met with the Governor. They were given a full briefing about the circumstances surrounding the prisoner's death and the current situation regarding family contacts and actions instigated by the establishment to deal with his death. They also met with a Prison Officers Association representative and a member of the Independent Monitoring Board.

A notice to staff and a notice to prisoners was issued by the prison, inviting anyone who might have information relating to the prisoner's death to make themselves known to the inquiry team.

An independent review of the prisoner's clinical care in prison was commissioned from Director of Public Health at Chelmsford PCT. The Head of Healthcare at Bullwood Hall carried out this clinical review on their behalf. The clinical review makes five recommendations.

The investigation team interviewed six members of staff.

On 7 August 2004 a letter was received from a prisoner from Chelmsford, indicating that he would like to speak to someone. The investigation team spoke to this inmate and he told us that he had 'looked out for' the prisoner when he had first arrived at Chelmsford (and was located on B wing). He said he felt staff had done their best for the prisoner but that he was very disorientated. He thought the prisoner should have been in hospital long term. The team thanked him for getting in touch and said that we felt his view about the best placement for the deceased was shared by both wing and healthcare staff at Chelmsford. We also spoke to another inmate following receipt of a letter from him in early July.

A Family Liaison Officer from the PPO's office got in touch with the prisoner's daughter and told her about the investigation that the Ombudsman would be carrying out. She did not wish to meet the investigation team at that time. My Family Liaison Officer has spoken to her on the telephone on several occasions during the course of this investigation.

The incidents and events leading up the prisoner's death

Upon arrival at HMP & YOI Chelmsford on 19 January 2004, the prisoner was assessed in the reception area by a nurse and was seen by a doctor the following day. The nurse ascertained medical details as well as assessing his current medical condition. The investigation team found that the assessment form (First Reception Health Screen) was incomplete and several questions relating to the mental health section were unanswered. There is no mention at all of a past history of epilepsy.

The prisoner was located on to a normal residential wing and was identified as suitable to share a cell. He was not assessed as needing to be located on the ground floor.

On 23 January 2004, the prisoner was produced at Crown Court to attend a preliminary trial hearing. He also appeared at the Magistrates Court on 5 February 2004. The medical records (IMR) for the prisoner document evidence of a "seizure" on 9 February 2004. He was not located in the healthcare unit at that time, but had a further seizure on 15 February 2004 and was taken to hospital where he remained until 17 February 2004. Upon his return to the establishment he was located back onto B wing.

On 8 March 2004, whilst still on B Wing, the prisoner was noted to be disorientated and confused. It is recorded in the IMR that healthcare staff were preparing to admit him to the healthcare centre due to concerns about him not taking his medication. However, because there was a lack of available beds, he remained on B Wing, and was placed on a "see to take" restriction when issued with medication by nursing staff. On 10 March 2004, it was documented in the IMR that he was in urgent need of admittance to healthcare, wing staff reporting that he kept collapsing. He was seen by a doctor in his cell on the same day. The doctor advised that he should be located on the ground floor, but he was not admitted to the healthcare centre.

A doctor wrote to the Clerk of the Court on 22 March and informed him that the prisoner was unfit to attend court that day. This letter reflects that the prisoner had some abnormality in the brain and possibly epilepsy. He attended a scheduled appointment at hospital on 25 March 2004 and was admitted. He remained at hospital until 15 April 2004, a period of some three weeks. The prisoner returned to Chelmsford prison with an outpatient's appointment for four weeks time. On his return, the prison followed the treatment prescribed by the hospital, and he was admitted to the healthcare centre.

On 26 April 2004 a Consultant Forensic Psychiatrist, enquired of the Home Office if, whether the prisoner was sectioned, a place be obtained in a rehabilitation ward. The investigation team found other evidence in his

medical records that several efforts had been made by the doctor at Chelmsford to have the prisoner transferred to hospital on a long term basis. A referral by the doctor at Chelmsford was made on 4 May to I/C of High Dependency Unit at hospital. This followed discussions with the Consultant Forensic Psychiatrist who had visited the prison and another doctor at the hospital.

On 7 May 2004, the prisoner was produced at Crown Court, and was again remanded back into custody. The prisoner's solicitor told the investigation team that the court was sympathetic to a bail application, as they were aware of how unwell he was, but that they would only timetable a hearing once a long term bed in hospital had been confirmed. On 9 May 2004, the prisoner was found collapsed on his cell floor and the recommendation by the doctor who saw him was that he be observed more closely. Later that day a nurse observed him having an epileptic fit and he was taken to hospital. The hospital sent him back to the prison later that night.

On 17 May 2004, healthcare were contacted by the bed manager at the hospital informing them that a bed had become available for the prisoner. Discussions were held between the healthcare senior officer and the detail manager about arranging for the prisoner to be taken to hospital. There were some staffing issues about arranging the escort as there were already other escorts out of the prison. Staffing another escort would have meant cutting the regime within the prison. The healthcare senior officer (HSO) did not think it 'urgent' that the prisoner be taken to hospital that day and he agreed with the detail manager that the escort would not go ahead but would be looked at again on the following day. There was no referral to either a doctor or the duty governor when this decision was taken. This was contrary to a Governor's Order that had been re-issued on 29 April 2004. This stated that any decision regarding the cancellation of hospital appointments could only be made by the duty governor who would liaise with healthcare management or a doctor. The HSO spoke with the bed manager at hospital on this day and made attempts to reserve the bed. The hospital was not able to do this. The HSO then made an attempt to contact the prisoner's solicitor in order to see whether it would be possible for him to be released on bail in order to take the hospital bed. He was not able to get in touch with the solicitor on that day and the HSO was not in work on the following day (18 May).

On 18 May, a case review about the prisoner was held within the healthcare centre. This review indicated that he should be transferred to hospital as soon as escorting staff could be arranged and as soon as it was confirmed that a bed was still available. However, no transfer to hospital took place on this day.

On 19 May 2004, the prisoner seemed to be confused in his cell. He was drinking large amounts of water and then accidentally flooded his cell by repeatedly washing his tracksuit bottoms in his sink. Staff went into the cell and mopped up the water before sitting down with him on his bed and giving him his medication. Later on in the morning, around 11:30, staff found the prisoner lying on the floor by his bed. He did not respond to staff talking to

him nor to their touch. They immediately summoned the doctor who examined the prisoner and asked that an ambulance be requested as an emergency. The doctor put him into the recovery position and gave him oxygen until the ambulance arrived. He was admitted to the Intensive Care Unit at hospital with assisted breathing.

On 21 May, the hospital informed the prison that the prisoner was unlikely to make a recovery. The prison priest went to visit him in hospital and conducted his last rites. A new risk assessment was carried out to explore the possibility of reducing the staff cover on the bed watch due to the deterioration in the prisoner's condition. The staffing level was reduced to one officer, without handcuffs or restraint, at 15:40 on that day. The bed watch log records that he was visited by his son and daughter.

The Duty Governor who was working on the weekend of 22 and 23 May had been fully briefed by the Deputy Governor about the prisoner's condition before he went off duty on the Friday. She was aware that the hospital did not expect him to recover.

The prisoner died around 16:45 on 22 May 2004 at hospital. The escorting officer rang the duty governor at the prison at 17:00 and told her the news. The duty governor then spoke to the prisoner's daughter to inform her of her father's death. She also offered her the support of the chaplaincy team at the prison and the opportunity to visit the prison.

The response after the prisoner's death

The prisoner died in hospital on 22 May 2004 around 16:45. The PESO informed the duty governor at HMP & YOI Chelmsford at 17:00. As he was alone at the hospital, a member of the prison care team drove to the hospital to offer support to the escorting officer.

The duty governor contacted the Governing Governor of Chelmsford, to inform him of the prisoner's death.

The establishment contingency plans were activated and all the necessary agencies were informed of his death.

The duty governor made contact with the prisoner's daughter and was assisted by the prison chaplain. Later, a letter was sent to both the prisoner's daughter and son, inviting them to visit the prison to discuss or answer any questions and to collect their father's belongings.

At 20.00 on 22 May, staff were collected from hospital and were taken back to the establishment for a hot debrief. The hot debrief gave staff an opportunity to ask questions and to recount their experience. They were also offered support. The duty governor took several steps to ensure that the officer who was with the prisoner at the time of his death was okay. She remained with him and his family until late into the evening.

The following day, a notice to staff was published and letters were sent to the staff who had been involved. The prison care team contacted staff directly to offer their support. A notice to prisoners was also issued and a memorial service was held the following day during church. The Minister offered support to those prisoners who felt they needed it.

Level of compliance with authorised procedures

Reception into custody

Prisoners on Induction are normally located on to D Wing, which is used as an induction wing. In this prisoner's case, he was located onto B Wing.

All prisoners arriving at Chelmsford are subject to a cell sharing risk assessment. On arrival, the prisoner was assessed as suitable to share a cell. However, the investigation team could not find any evidence of this risk assessment being completed in the files we were given.

Standards of Health Services

Medical screening assessments (First Reception Health Screen) are routinely conducted on all new receptions at Chelmsford. In the prisoner's case, this assessment was found to be incomplete with several boxes left unmarked.

The evidence in the medical record of the prisoner suggests that, due to the number of reports of bizarre behaviour and confusion, he should have been located in the healthcare centre of the prison much sooner than he actually was. By 15 February, the prisoner had had two seizures and by 8 March there is a note in his medical record that staff were preparing to admit him to the healthcare centre. However, it was not until 15 April, after a three week period in outside hospital, that he was actually admitted to the Healthcare Unit. He would have been able to be observed much more closely and received more appropriate care if he had been in the healthcare centre.

Recognised standards for clinical record keeping were not met. It was sometimes difficult to tell where the prisoner was located within the prison.

There did not appear to be any record keeping in relation to the fluid / diet intake of the prisoner within the healthcare centre.

There appeared to be a lack of knowledge within the healthcare staff team about the prisoner's serious condition, when a bed became available at the hospital, resulting in an unnecessary delay in him accessing appropriate secondary care services.

Procedures for arranging a medical escort

On 17 May 2004, a bed became available for the prisoner at hospital. It is recorded in the IMR that for staffing reasons this could not be facilitated. The investigation team found that this decision was taken by the healthcare senior officer after talking to the detail manager. The healthcare senior officer was not fully aware of the reason why the hospital had offered him a bed and took the decision that it was not an urgent move and could therefore be revisited

when staffing would permit. No discussions took place regarding this decision with either the duty governor or a medically qualified member of the healthcare team. The investigation team were told that decisions about whether an escort will go ahead are ultimately the responsibility of the duty governor, who would consult with healthcare about the need for a particular patient to be taken to outside hospital on a particular day. Although he was already very unwell by the time the offer of a long term bed was made by the hospital, it is disappointing that correct procedures were not followed by the prison in assessing the need for the prisoner to be escorted to hospital on this day. The negotiations for a long term bed had been going on for some months.

The case review on 18 May is not well documented in the prisoner's medical record. There is some evidence to suggest that the bed space was no longer available at the hospital anyway, but there does not seem to be any clinical input into assessing the urgency of the need for him to be transferred to hospital, nor any record of discussions with the detail office about arranging staff for the escort.

Procedures after notification of the prisoner's death

HMP & YOI Chelmsford had a full and thorough contingency plan covering a death in custody. This was implemented as soon as information was received notifying the establishment of the prisoner's death.

In light of information received that indicated the prisoner's imminent death, an aide memoire was drawn up by the deputy governor in preparation for this to strengthen the existing contingency plan.

The duty governor was conversant with what was required by way of communicating the sad news to the appropriate authorities and Prison Service personnel. The prisoner's next of kin was notified as soon as possible and consideration was given to the "bed watch" staff who remained at the hospital.

Conclusions

There was a lack of communication within the healthcare unit about the referral made to hospital for a long term bed, and a subsequent lack of clinical or managerial input into the decision not to provide the escort for the prisoner on 17 May. There is evidence to suggest that some healthcare staff did not know why the hospital were offering to admit him on 17 May 2004.

The establishment staffing levels were limited and another bed watch would have necessitated a degree of curtailment to the prison regime. The decision not to facilitate the bed watch on 17 May 2004, was not a clinical decision, but was made based on staff shortages. This decision was made in spite of a Governor's Order, re-issued on 29 April 2004, that any decision regarding the cancellation of hospital appointments could only be made by the duty governor who would liaise with healthcare management or a doctor. In this case, the prisoner did not have an 'appointment' as such, but he had been awaiting the offer of a long term bed for some time. The decision not to take him to hospital on 17 May, just two days prior to him being admitted as an emergency, is unlikely to have made a difference to the time that he had left to live. However, decisions regarding escorts should always be taken by the duty governor in consultation with the appropriate clinical staff.

The reactions of the staff who discovered him lying on floor of his cell on 19 May were quick and appropriate. Entry to the cell was without delay and the doctor was on the scene rapidly. The investigation team praise the medical treatment given at the scene and are of the opinion that the assistance of the Essex Ambulance Service was summoned without delay.

The "Death In Custody" file, prepared by the deputy governor, gave clear guidance and advice to the duty governor for that weekend and complemented the existing prison contingency plans well. The post incident actions of the duty governor and the management team at the establishment were thorough, professional, and clearly took into account the feelings of the prisoner's relatives and those of all staff involved in caring for him.

Recommendations

Medical

LOCAL - The Head of Healthcare should ensure that Reception Health Screening forms are fully completed.

LOCAL - The Head of Healthcare should ensure that entries for medical records (IMR) comply with standards of record keeping.

LOCAL - The Head of Healthcare should ensure that efforts are made to locate patients who are exhibiting behaviour which is out of character, both mental and physical, into the healthcare centre as quickly as possible. Completion of a risk assessment, endorsed by the Medical Officer, should be made a priority, enabling correct nursing assessments to be made. This will permit referrals to secondary care specialists to take place without delay.

LOCAL - The Head of Healthcare should ensure that following a referral to an outside agency for medical treatment, staff working within the unit are fully aware of why this referral has been made. The urgency or importance of a referral can be communicated to staff using a “traffic light” system and appropriate entries in the medical record. Healthcare staff would then be able to see at a glance whether admission to hospital is seen as a priority or if it can be delayed.

General

LOCAL - The Governor should ensure that all Cell Sharing Risk Assessments are completed on arrival and that a copy of this assessment and subsequent changes are kept on file in the F2050 record.

LOCAL - The Governor should ensure that all decisions not to proceed with a hospital admission are made following a clinical risk assessment, signed by the medical officer and the duty governor. The principle should be that hospital visits take place irrespective of staffing levels whenever possible.

Staffing

LOCAL - The investigation finds no reason to criticise any individual members of staff. The investigation has already pointed out that there was a lack of consultation about the bed watch of 17 May 2004, but this appears to have been custom and practice rather than the deliberate actions of an individual.

LOCAL - The actions taken by the duty governor and HMP & YOI Chelmsford after the prisoner had died should be commended. During a stressful period, they responded professionally and effectively and ensured that the prisoner's next of kin, and all the appropriate authorities, were made aware of his death.

Recommendations: Good Practice

NATIONAL - The Investigation team found the “Death In Custody” file, prepared by the deputy governor, in readiness for the inevitable and imminent death of the prisoner, to be extremely useful to the duty governor and a positive re-enforcement of the existing contingency plan. The value of preparation of this kind should be shared with the remainder of the prison estate.