The death in custody of a prisoner

HMP Lewes – June 2004

Report by the Prisons and Probation Ombudsman for England and Wales

September 2004

This is the report of an investigation into the circumstances of the death of A prisoner in the Royal Sussex County Hospital in June 2004. The prisoner was in the custody of HM Prison Lewes but had been taken to hospital a few days earlier. He died after surgery to remove an obstruction in the bowel.

All deaths of prisoners in custody are investigated, including those due to natural causes. Until recently, the responsibility for carrying out these investigations fell to the Prison Service, but it has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task.

In this case, two of my investigators carried out the investigation. An independent review of The prisoner' clinical care in prison has been commissioned from the Sussex Downs and Weald Primary Care Trust.

My colleagues and I would like to extend our condolences to those touched by the prisoner's death. Whatever, the family circumstances, the death of a close relative is always likely to be bring strong emotions to the surface, perhaps the more so when there has been a distressing history.

I would like to thank the Governor of HMP Lewes, and his colleagues for their assistance with the investigation.

Stephen Shaw
Prisons and Probation Ombudsman
September 2004

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The investigation

My practice in cases of apparent natural cause deaths is to conduct an initial review to determine the extent of investigation required.

My investigators visited HMP Lewes in June 2004 to examine documentary records and to speak informally with staff to outline the facts relating to The prisoner' death. They issued notices announcing the investigation and invited information from staff and prisoners. On a second visit on 9 July 2004 one of my investigators met individual members of staff to verify key facts.

One of my investigators and a family liaison officer have spoken several times to members of the prisoner' family and also visited family members.

With the consent of the Coroner, a copy of this report was sent in draft was sent to the Prison Service and to members of the prisoner' family. I have taken account of their comments in this final version of the report.

Summary of findings

The investigation focuses on three issues: the care of the prisoner by the prison on the day he went to hospital; the use of security restraints; the prison's liaison with family members.

I am satisfied that the prisoner received proper and sympathetic care and that the limited use of restraints was appropriate. There are lessons to be learned about communications with family members and about record keeping after a death.

The prisoner' medical history

The head of healthcare at HMP Lewes, formerly practised as a nurse but he is now a prison governor and no longer retains his nursing registration. He knew the prisoner because of his extensive contact with healthcare for longstanding chronic illness. The head of healthcare had read the prisoner' medical record and gave my investigators the following summary of his medical history.

While the prisoner was at Maidstone he was under the care of St Thomas's Hospital, London. He had two cardiac catheterisations to investigate potential unblocking of cardiac arteries and shortness of breath. Consideration was given to a triple bypass but instead it was decided to treat the condition conservatively by angioplasty. The prisoner became breathless again and had chest pain and was referred back to St Thomas's for numerous out patient appointments.

When the prisoner was transferred to Lewes, a locum doctor immediately referred him for cardiac consultation at Royal Sussex County Hospital and to orthopaedic and ENT clinics. He was subsequently seen by the cardiac department.

The prisoner was admitted to the Sussex County Hospital from Lewes Prison early in June. He was suffering from a bowel obstruction that required emergency surgery. However, his overall poor health meant he never recovered from the anaesthetic. Despite the efforts of the surgical and intensive care teams he died three days later.

The prisoner' admission to hospital

The prisoner's cellmate had shared with him for about six weeks. He told my investigators that, during the night before he was taken to hospital, the prisoner was ill with "sickness and diarrhoea". The cellmate said he knew the prisoner had a weak heart and lungs but the illness in the night had nothing to do with that. The prisoner did not seek any help from staff and he and his cellmate discussed what he had eaten that might have caused it. In the morning, the prisoner saw the nurse on F wing at about 0800 and in the afternoon he was taken to the healthcare centre. The cellmate arrived back from work at 1600 on that afternoon and the prisoner had gone. The cellmate heard first from another prisoner that his cellmate had died, and then asked an officer, who confirmed it.

A nurse saw the prisoner when she was giving out treatments on F wing between about 0800 and 0830. When the prisoner came to the hatch he said he had been suffering from abdominal pain since the previous evening and felt unwell. He did not look acutely unwell but, because of his age and chronic illness, the nurse thought it appropriate he should see the doctor that day. The healthcare centre called the wing to ask for the prisoner to be brought over that afternoon and he was escorted to healthcare by an officer. When

the prisoner came to the healthcare centre that afternoon he still did not appear acutely ill, but was sufficiently unwell to warrant cause for concern.

The system is that registered nurses exercise their professional judgment to decide whether a patient needs to see a doctor that day or can wait for an appointment. The doctors hold surgeries in the mornings, the lists are generally filled in advance by appointments. In the afternoons the doctors come back to see anyone else who needs to see them.

A Doctor saw the prisoner on the examination couch in the health care centre in the afternoon of a day in early June. He had thought he was suffering from an adhesion or other obstruction in the bowel and arranged for an emergency admission to the Royal Sussex County Hospital. There is no time of day entered for the record on that day; the doctor usually arrives at the prison at 2 pm on Thursdays.

The Prisoner Escort Record indicates that the prisoner was taken from the healthcare centre to an ambulance at 1600 and left the prison at 1610. He was accompanied by two members of prison staff and arrived at the Royal Sussex County Hospital in Brighton at 1640 where he was admitted for an acute obstruction to the bowel.

Subsequent entries in the medical record indicate that at 0100 on the day after he entered hospital, a message was received to say the prisoner' handcuffs were removed as he was undergoing invasive investigations.

On Friday morning, healthcare staff telephoned the hospital and were told that the prisoner would be going to the operating theatre for removal of a bowel obstruction and was expected to go straight to the Intensive Therapy Unit (ITU). The hospital considered the prognosis poor because the prisoner had a 'bad chest'. They requested that the prisoner' next of kin be informed. However, at 1210, the medical record says that Security had received a call to say the prisoner did not want friends or family informed of his condition or the fact he was in custody.

On Saturday morning, the healthcare staff telephoned the hospital and were told the prisoner was now on the ITU. He had been sedated and was being ventilated. His condition was considered to be critical

On Sunday morning the hospital reported that the prisoner had been unstable overnight and oxygen use increased. He had gone into renal failure and the doctors would review his condition. Later, the hospital telephoned to say the decision had been made to withdraw treatment. The prisoner died peacefully at lunch time on a day in June.

The post mortem records the cause of death as being ischaemic heart disease subsequent to major surgery for a small bowel abscess and perforation. The surgery itself is not thought to have contributed to his death.

Security procedures while the prisoner was in hospital

The prison remained responsible for the prisoner while he was in hospital. Two officers accompanied him to hospital and remained there as escorts.

A risk assessment prepared by a Senior Officer says that the prisoner was handcuffed to an escort chain when he went out in the ambulance because of the nature of the medical emergency. This meant he would have worn a handcuff on one wrist attached to a chain about two metres long which was attached to a single handcuff worn by an escorting officer.

The prisoner was seen by members of the hospital staff in Accident and Emergency and then he was transferred to a ward later that evening.

The officer in charge of the overnight bedwatch on Thursday night, said that hospital staff were attending the prisoner continuously conducting various interventions. It was evident to him from the prisoner' frailty and his medical condition that he posed no risk of escape. To facilitate his medical treatment, the officer removed the restraint, probably at about 2200. This was later confirmed to the prison at 0135 when the House Officer formally requested that the prisoner not be restrained. Officers have confirmed that the restraints were not reinstated. It was necessary to balance the requirements of security with the need for sensitivity and common sense. The prisoner was a Category B prisoner serving a long sentence for a serious offence, but his medical condition was such as to allow restraint not to be used.

Communications with the prisoner' family

The prisoner's inmate medical record (IMR) states that at 10:10 on the morning after he entered the hospital, hospital staff asked the prison to inform his next of kin of his condition. However, a later entry at 12:10 that day says that Security had received a call to say the prisoner did not want friends or family informed of his condition or the fact he was in custody.

Hospital staff contacted the prison on Saturday to say the prisoner was dying and had requested the prison to contact a Prison Visitor who was known to him. The Prison Visitor was not an authorised visitor for Lewes Prison but prison staff identified her telephone number on the prisoner' list of authorised phone numbers. The communications staff tried to telephone but were unable to get through to her.

Having been unable to contact the Prison Visitor, staff identified a name and address for next of kin in the prisoner' local records. This was his former wife. They contacted the local police in his former wife's area who found that she had moved twice since that address. However, they were able to locate her and told her that her ex husband was dying. A Principal Officer understood from the police that the prisoner's former wife indicated that she no longer had any interest in the prisoner and did not wanted to make any contact.

When the prison was told that the prisoner had died, communications staff again contacted the police. Staff had not dealt with any particular individual in the police, and gave no contact details of the prison, as they understood the family was not interested.

A few days after the man's death, the Prison Visitor telephoned my office on behalf of one of the prisoner' daughters. The daughter had received her father's property from the prison and amongst this she had found a letter addressed to the Prison Visitor. She had contacted her to find out more about her father's recent life, the circumstances of his death and what would happen about the funeral and to his estate.

The prisoner's daughter told my investigators that the police went to a neighbour's house who directed them to her address and was given a message to ask her mother, to phone the police. This message was passed onto her mother who indeed, did phone the police. They gave her the phone number of the hospital. The daughter then phoned the hospital and they discussed her father's condition. It was the hospital who then phoned her on the Sunday to inform her of her father's death. Although the daughter felt very torn in her feelings towards her father, she felt a need to know what had happened. One of my investigators spoke to the prison and was given the name of an officer who would act as liaison for the family and with my investigation.

Two members of my staff visited the prisoner's ex wife and daughter. They gave a more detailed account of their contacts with the police and the prison. The police had come to the house next door to the prisoner's daughter in search of her mother and had spoken to her neighbour. An unclear message was passed to the daughter who asked her mother to call the police. When she did so and was told that the prisoner was dying and which hospital he was in. The prisoner's daughter phoned directory enquiries to obtain the hospital number and rang the hospital, who asked her how she felt about turning off the life support machine.

The prisoner's daughter wanted to contact the prison. She did not know her father was in Lewes. She rang HMP Maidstone as she knew he had been there and they informed her of the move to Lewes.

She then phoned HMP Lewes and asked to speak with the Governor. The prison does not have a dedicated switchboard but uses a telephone switching centre. The person who answered the telephone asked her the nature of her call and she explained her father had been in Lewes and had died. She told my colleagues that the telephonist replied, "Do you want to inform the governor?" and that she did not get put through. The prisoner's ex wife says that when she tried later, she was told she would have to write to the Governor.

The prisoner's family felt they had received mixed messages from the prison and this had caused distress. They felt prison staff had been hesitant to provide information on the basis that they were uncertain who was next of kin.

The prison had sent the prisoner's property in two Parcelforce boxes with no accompanying letter; they had not sent the prisoner' bank-books but had not explained why. The Governor informed my investigators that the prisoner's accounts contained substantial sums and the prison wanted to be sure that the bank-books were released to the appropriate representative of the prisoner's estate. The family have now instructed solicitors to deal with the estate and they are in correspondence with the prison.

The victims of the prisoner's offences were family members. The prisoner's daughter was struggling with the fact that her father had never acknowledged or apologised for what he had done, and was hoping to find someone that he might have spoken to about his offence. To this end she had contacted the Prison Visitor. She also contacted the prison Chaplain. She spoke to one Chaplain who said an officer knew about the case and he would get them to call her but she does not know who the officer is and has not heard from them.

My investigator spoke to the Victims Unit of the National Probation Service in the area where the family live. A Senior Probation Officer, said that the field probation officer was aware that the prisoner was ill but it was his daughter who contacted the Victims Unit to say that he had died. The Senior Probation officer considered that there might properly be a role for NPS in communicating with the family in these circumstances.

Compliance with Prison Service requirements

Clinical care

Standards of healthcare in the prison are intended to mirror those available in the outside community. I am satisfied that this was achieved.

Communications with the family

PSO 2710, which is currently being revised, advises prisons about what actions must be completed after a death in custody. Much of the advice is directed to the circumstances when a prisoner dies within the prison, but the PSO makes clear that it applies to the death of anyone whilst in prison custody. Although the prisoner died in hospital, he remained in the custody of the prison.

The Order recognises that it will sometimes be necessary to notify next of kin via the police, but provides as a mandatory requirement that:

> *"where the police are used it is important to gain confirmation and ensure that a member of staff is in contact with the next of kin at the first available opportunity to ascertain whether they wish to receive a visit or visit the establishment. Give next of kin as much factual information as possible at this stage and who the family can contact for outside support...A note describing the arrangements to inform the next*

of kin…should be retained by the governor for possible inclusion in reports to Headquarters. Where the police are used a note describing the follow-up contact with the next of kin should be retained." (paragraph 3.2.5)

The Order contains further detailed guidance about follow-up support for families. Notably:

"A senior member of staff should be appointed as the named point of contact for the family and a second person named as available in the first person's absence." (paragraph 6.2.3)

"The handing over of personal effects including all monies held on behalf of the deceased needs to be done with care and sensitivity." (paragraph 6.2.10)

The sequence of events in this case as relayed by the family show the wisdom of the guidance. It seems that reliance was placed on conversations with the police, and a fixed impression of the family's feelings was formed prematurely on the basis what was said to have been their reaction to the sudden news of the prisoner' illness and death. Some of the family's confusion and distress might have been averted if the prison had made contact directly to offer information and named contact points.

As noted, Prison Service guidance on action following a death in custody is at present under review. I recommend that the revised version of Prison Service guidance pays particular attention to the following lessons, which can be drawn from this case:

- The guidance on supporting families applies to all deaths of prisoners, including occasions when a prisoner dies in hospital of natural causes.

- Prisons should always ensure that the next of kin is informed how to get in touch with a named member of staff (and deputy in their absence) who will act as liaison point and who knows all aspects of the case, even if the initial response has been apparent indifference.

- The liaison person should hold all information and as far as possible be the only one to deal with the next of kin and other family members.

- Operators answering the phone should be notified of prisoners' deaths, trained in dealing with bereaved family members sensitively, and briefed as to who should deal with their calls.

- When property is sent it should be presented sensitively and the family member should be informed of when to expect to receive it.

- Where family members are also victims, consideration should be given to engaging the Probation Service's assistance in accordance with the Victims' Charter.

Notifying other prisoners

It is a mandatory requirement to notify other prisoners, especially friends or associates in the establishment. (PSO 2710 3.2.18)

The prisoner's cellmate told my investigators that he heard of the prisoner' death first from a prisoner then spoke to an officer who confirmed it.

Some cellmates will be close friends, some reluctant acquaintances. As a matter of good practice, however, I recommend:

- that staff should make a point of telling cellmates in person at the earliest opportunity when if someone with whom they have lived recently in such close proximity has died.

Record management and Incident recording

My investigators were given copies of the prisoner' Inmate Medical Record, Sentence Management, Security and Main Records. These did not include his recent history sheets in which staff record significant events. Various members of staff searched for the papers to no avail. My investigators were told that there are several boxes of unfiled records, which are generally stored alphabetically. A search as far as the 'Es' produced nothing for the prisoner.

There were no statements, special logs or debrief report, as we would usually find in the case of a prisoner's death. This is probably because what occurred was that the prisoner became ill and was admitted to outside hospital. There would have been no reason at that stage to implement the contingency plans for action following death in custody.

However, the prisoner remained in the custody of the prison even though he was in hospital. It is regrettable that his recent wing history sheets could not be found. These, with the medical and other records might have provided a sufficient contemporary record of events immediately before his admission to hospital. After The prisoner' death, I consider that it would have been good practice for those members of staff who were in contact with the prisoner on the day he became ill to have been asked to prepare brief statements of their contact with him that day. I recommend that:

- in the event of a death, it is good practice for Prison Service staff who have been involved in the episode to prepare a written statement promptly after the event. This would have been helpful to my investigation. It would also assist the inquest at which staff might be required to give evidence, as well as enabling the Prison Service to demonstrate accurately the care provided to a prisoner who has died.

Conclusion

From my enquiries it seems to me that the prisoner was treated by prison staff with care and humanity and that he received appropriate medical care at least as quickly as he would have received it in the community.

That a sick and elderly man should be taken to hospital secured by a chain for what proved to be his final illness is not a comfortable idea. But it is part of the necessary paraphernalia of security outside the prison walls. Staff used the least oppressive form of restraint and an officer took the initiative to remove it once the extent of the prisoner' illness became clear, even though medical staff had made no express request at that stage. I consider that prison staff acted properly and considerately.

I have made recommendations that I hope may help the Prison Service to respond more effectively to the needs of bereaved families, and to provide a full account of their care when a prisoner dies in custody.

In commenting on the draft of this report, the Prison Service told me that HMP Lewes is taking action to apply the lessons of this investigation. The Suicide Prevention Co-ordinator is developing a protocol for managing the follow-up process when a prisoner dies in a hospital outside the prison. I welcome this constructive response.

SUMMARY OF RECOMMENDATIONS

Communications with families

I recommend that the revised version of Prison Service guidance pays particular attention to the following lessons which can be drawn from this case:

- The guidance on supporting families applies to all deaths of prisoners, including occasions when a prisoner dies in hospital of natural causes.

- Prisons should always ensure that the next of kin is informed how to get in touch with a named member of staff (and deputy in their absence) who will act as liaison point and who knows all aspects of the case, even if the initial response has been apparent indifference.

- The liaison should hold all information and as far as possible be the only one to deal with the next of kin and other family members.

- Operators answering the phone should be notified of prisoners' deaths, trained in dealing with bereaved family members sensitively, and briefed as to who should deal with their calls.

- When property is sent it should be presented sensitively and the family member should be informed of when to expect to receive it.

- Where family members are also victims, consideration should be given to engaging the Probation Service's assistance in accordance with the Victims' Charter.

Notifying other prisoners

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- that staff should make a point of telling cellmates in person at the earliest opportunity when if someone with whom they have lived recently in such close proximity has died.

Recording incidents

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