# Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Bullingdon, in hospital in October 2009

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

**February 2011**

This is the report of an investigation into the death of a man at hospital, whilst a prisoner at HMP Bullingdon. He was 45 years old. He died in October 2009, after a severe stroke. He previously had a stroke in August 2007, which had left him with a loss of mobility in his right arm and hand as well as loss of speech.

I extend my condolences and those of my colleagues to the man's family. I hope that my report goes some way to answering their questions about his care at Bullingdon and apologise for the delay in completing this report.

The investigation was carried out by two investigators. I would like to thank Governor and staff at HMP Bullingdon for their co-operation and assistance with my investigation. A clinical reviewer undertook a clinical review of the man's healthcare at Bullingdon, on behalf of the local Primary Care Trust (PCT).

It is evident from my investigation that the man found it difficult to come to terms with his disability. Furthermore, although staff made every effort to assist him, the physical barriers of a prison establishment and the absence of a multidisciplinary care plan impaired his experience at Bullingdon. The clinical reviewer considers a number of points around the care and rehabilitation services available to him following his stroke. He concludes that it is unlikely that he would have received very different treatment, had he been living in the community.

I make six recommendations in regard to clinical and discipline matters. Healthcare staff should follow up possible pre-existing medical conditions revealed during healthscreens, the management of prisoners with disabilities should be reviewed with a view to providing multidisciplinary care plans and those prisoners should be enabled to take part in activities to aid their progression through prison. The prison should also review procedures for responding to emergency calls and escort officers must complete records clearly. I understand that a potentially offensive nickname was in common usage and staff should be reminded that this is inappropriate.

I am pleased to note the care and support to the man given by both officers and prisoners. The Governor might wish to write to the prisoners to formally recognise their contribution to his wellbeing before his death.

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.

**Jane Webb**
**Acting Prison and Probation Ombudsman** **February 2011**

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**SUMMARY**

The man suffered from a serious stroke in July 2007, whilst a prisoner in HMP Whitemoor. He was left without the ability to speak and right sided weakness causing mobility problems. This caused him to become frustrated at his physical limitations and, on occasion, he refused food and medical treatment, which resulted in him being made subject to suicide and self-harm procedures

He transferred to Bullingdon on 5 November 2008, where he refused to be accommodated in the healthcare department. He therefore lived on a residential wing. Staff completed a disability support action plan and he was provided with some aids, such as specially designed cutlery and later a large single cell.

Staff arranged for him to have a buddy. (A buddy is another prisoner who helps with day to day tasks.) Other prisoners also helped with personal care and staff made telephone calls to his sister, on his behalf. Although the investigation found some procedural shortcomings in respect of his care, there is also evidence that staff and prisoners did their best to make his situation more bearable.

On 3 October 2009, the man became ill on the wing and healthcare staff were called. There are varying accounts of the events following this call. The investigation found that whilst there was some delay in healthcare staff going to the cell because of ambiguity about the level of the emergency call and which staff should attend, this did not affect the outcome. After assessment by the first nurse on call, staff believed him to be having another stroke and an ambulance was called which took him to hospital. No handcuffs or restraints were used during the journey or his time at hospital and one of the escorting officers knew him very well and could assist with communication.

During the night of 5/6 October, he deteriorated and nursing staff contacted his sister at 3.00am. The hospital chaplain was called at 4.10am and said prayers at his bedside. He died later that morning. The escort staff were offered support by the staff care team. A memorial service was subsequently held on his wing and this was well attended.

I make a number of recommendations, the most significant of which stem from the findings of the clinical reviewer's clinical review. These are the need for multidisciplinary care plans and training for Disability Liaison Officers and the provision of appropriate resources for prisoners with disabilities. In addition, there should be a clear system of emergency response and an explicit rota of staff to respond to calls.

I also draw attention to record keeping, clarification and action on serious pre-existing medical conditions, evacuation of prisoners and the provision of meaningful activities for those with disabilities. The man's family mentioned the use of an inappropriate nickname and I have made a recommendation in this regard.

I am pleased to note the efforts by two officers in providing for his disabilities and the discretion in not using restraints when he was taken to hospital.

## THE INVESTIGATION PROCESS

1. The investigation into the man's death was carried out by two of my investigators. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at HMP Bullingdon. The notices were displayed around the prison and invited staff and prisoners to contact the investigators should they wish to do so. Three prisoners and one member of staff contacted my investigators and were subsequently interviewed. They obtained documentation relating to the time that the man spent at HMP Bullingdon and visited the prison on three occasions to conduct interviews with both staff and prisoners. Two clinical staff members were interviewed at a neutral venue. The investigators also contacted the policy lead for disability issues.

2. A clinical review was commissioned from the local Primary Care Trust (PCT), and the clinical reviewer has kindly completed this on their behalf.

3. One of my family liaison officers contacted the man's family to discuss the purpose and scope of the investigation and to give them the opportunity to raise any questions or concerns they had about his death. Having met with the family liaison officer, another of my family liaison officers and an investigator, the family raised a number of questions. They were concerned at the level of care given to their brother whilst he was at Bullingdon. They would like to know if their brother had been prescribed warfarin after his stroke and a gel to rub onto his painful joints. (Warfarin is a drug used to thin the blood to prevent blood clots forming.)

4. The family also asked why he transferred to Bullingdon from Whitemoor. They had been told that he would receive treatment and rehabilitation at Bullingdon that was not available at Whitemoor. However, Bullingdon was unable to provide the offending behaviour programmes that would lead to progression in his sentence. Furthermore, they said that he was not given any physiotherapy and that prisoners were helping with his every day needs, such as bathing. They felt that this was demeaning and embarrassing for him.

5. Since his stroke at Whitemoor, the man had lost the ability to use speech and the only sound he could make was [Nickname]. His sister said that staff and prisoners referred to him as [Nickname], using this term instead of his name and that this was very upsetting for her.

6. He also had mobility problems and he was late to arrive for family visits because it took him so long to walk to the visits venue. This reduced the length of time the family were able to spend with him. They asked why he wasn't brought to visits earlier so that he could spend the full time with them. They also commented on his appearance at visits, saying that he often looked distressed with food down his clothes. They felt he had a right to be cared for and kept clean.

7. His sisters said that they were not informed that he had been admitted to hospital until two days after his admission. They believed this deprived them of valuable time with him and they were not there when he died.

8. When his property was returned to his sisters there was part of a letter of complaint. Some of the document was missing. They wanted to know what happened to the rest of the document and whether the complaint had been addressed. I hope that this report helps clarify the family's concerns, helping them to better understand what happened to him in the time leading to his death.

## HMP BULLINGDON

9. HMP Bullingdon is a category C training prison which also holds category B local prisoners. Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. Category C are prisoners who cannot be trusted in open conditions but who would not have the ability or resources to make a determined escape. Bullingdon serves the courts in Oxfordshire, Berkshire and the London area, holding both convicted prisoners and those on remand.

10. The prison was opened in 1992 and can currently hold 1114 prisoners. It is a new 'gallery style' prison which consists of six wings, made up of both single and double cell accommodation.

### Healthcare

11. There is an inpatient unit with twenty four beds where all cells have integral sanitation. This unit is staffed by both discipline (prison) and clinical staff from the Primary Care Trust. There is a service for prisoners with mental health needs and those with physical illness.

12. The healthcare unit is staffed twenty four hours a day, with two clinically qualified nurses on duty at night and weekends. Further overnight and weekend cover is made available by local general practitioners who are on call. Medication is administered on a weekly and/or monthly basis to those prisoners who have been assessed as capable of holding it in their own possession. For others who are considered to be at risk, or where the medication is deemed unsuitable to be held in their possession, daily administration is provided.

### Independent Monitoring Board (IMB)

13. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are volunteers who are wholly independent of the prison service and the prison's management team. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and any areas of concern.

14. The most recent annual report of Bullingdon IMB in 2007/2008, said that despite pressures caused by high population, the positive improvements made to the treatment of prisoners and to the regime at the prison had continued. The medical and administrative staff in healthcare transferred to the Primary Care Trust (PCT) in August 2008. This resulted in healthcare staff feeling uneasy and insecure about their futures. Consequently, the IMB was concerned that recruitment and retention of staff had been poor. It also noted that there was a sound Assessment, Care in Custody and Teamwork (ACCT) procedure in place. However, the ACCT co-ordinator was stretched at times. (The ACCT procedure

provides additional monitoring and personalised support for prisoners considered to be at risk of harming themselves or suicide.)

## Report by HM Chief Inspector of Prisons

15. The former Chief Inspector of Prisons carried out an announced inspection of HMP Bullingdon in January 2008. She reported that despite considerable change over recent years, overall the prison was performing relatively well. She said that it was to the prison's credit that it had risen to many of the challenges posed by the complex and diverse demands placed on it. However, she made it clear that there was still more to do. She added that this should not obscure the progress made, and that it had been sustained at a time of considerable pressure.

16. She noted that relationships between staff and prisoners were mixed, and although the interactions that she observed were good, personal officer work was underdeveloped. She said entries in personal files were mostly about behaviour and displayed little awareness of prisoners' personal and individual circumstances, or their re-settlement objectives, "Until recently there had been long gaps in entries in some files".

## Emergency radio codes

22. Most prisons have a system which alerts staff to attend an emergency. At Bullingdon, a level one call means there is a life threatening incident. Level two is where someone has injured themselves and requires treatment on site.

23. Hotel one is the radio which is held in healthcare outpatients by a rostered general nurse. Hotel two is the radio which is held by a member of the nursing team in the inpatients department who would attend to back up hotel one.

## KEY FINDINGS

24. The man was remanded into custody on 11 September 2006. He was sentenced to an indeterminate sentence of imprisonment for public protection (IPP), with a tariff of nine years. He transferred to HMP Whitemoor on 24 April 2007.

25. During his first healthscreen at Whitemoor, he said he was suffering from depression. He attributed this to the death of his partner in 2003 and the loss of two friends in 2006. He was prescribed an antidepressant, mirtazapine. There is also information from another prison that he had previously suffered from a mild stroke. However, my investigator and the clinical reviewer could not confirm from the details of this or whether there was any follow up because some of the documents are undated and it is not clear by whom or where they were written.

26. On 15 July 2007, he suffered a serious stroke, which left him with mobility problems on his right side and loss of speech. He was also found to have a deep vein thrombosis of his leg. He was treated in hospital and discharged back to HMP Whitemoor, on 20 August, where he was accommodated in the healthcare centre. The clinical reviewer commented, "This was clearly a very major stroke and the degree of recovery expected would have been limited". He also commented that on his return to prison no multidisciplinary care plan was provided by either the hospital or the prison, but this omission was also common in the community.

27. Whilst in the healthcare centre, the man refused to accept help or medication from one of the female nurses or to take a bath with the help of a male nurse. He also had a number of aggressive altercations with other prisoners in healthcare, because they considered he was expecting them to do too much for him. He had a speech therapy assessment but it is not clear from the records if ongoing speech therapy was provided. The clinical reviewer comments that there was a delay in him seeing a speech therapist because of a shortage of therapists. However, some advice was given to nursing staff on 17 September.

28. He was provided with picture cards and a communication chart but at this stage he refused to use them. This made communication more difficult and he became increasingly frustrated. There is evidence in the medical records that he had regular physical and occupational therapy and education visits to assist in his recuperation. These also provided meaningful and useful activities to fill his time.

29. On 7 December 2007, a hospital consultant reviewed the man's condition. He said that he was improving from the right-sided weakness but the muscles in his right upper arm were still affected. He acknowledged that he could not speak but did not suggest speech therapy or other intervention. He was using a stick to walk at this time as his right leg was still weak due to a blood clot. The consultant stopped prescribing warfarin and started aspirin, as a preventative measure against further strokes. He increased his ramipril (a drug used to lower blood pressure) and asked that staff monitor his blood pressure and kidney functions.

30. During December, the man made a number of pre-arranged visits to A wing to meet prisoners and to see how he could cope on the wing. He subsequently

moved permanently to A wing on 31 January 2008. Staff developed a care plan and a 'buddy' was established. (A buddy is a prisoner who helps with daily tasks.) This move was at his insistence as he wished to be able to smoke freely. The clinical reviewer commends staff for complying with his wishes because of the "risks and difficulties inevitable in this move."

31. He transferred to HMP Peterborough on 25 February 2008. He refused to attend for physiotherapy and healthcare on a number of occasions during March and April. It is not clear why he would not attend. He also refused to take his medication for approximately a week. It is clear from the medical records that he struggled to come to terms with his lack of mobility and his inability to speak throughout his time at Whitemoor. However, consistent support was provided, in the form of buddies, a wheeled trolley to help with transporting meals and access to gym and physiotherapy sessions.

32. In August, the man's family contacted the prison because they were concerned about his care, recovery and rehabilitation. They asked if he could be transferred to a prison nearer to them and one which could deal with his disabilities more adequately. A number of prisons were considered but refused to take him, although from records and interviews the reasons why remain unclear.

33. On 10 October, a Registered Mental Health nurse, (RMN) at the prison, completed an assessment for the man's sentence planning. He said that he did not need the services of a psychiatrist at that time. He also commented that in the past he had refused to work with the mental health inreach team but that he agreed to a re-referral. He advised that in order to progress through his sentence, he should attend regular education classes for reading and writing, or his communication would be difficult when he returned to the community.

34. In response to this on 11 October, the man attended for a mental health assessment. The only information my investigator could find was a part assessment, which stated that depression may have played a large part in his offence. It also said that he had previously needed counselling for post traumatic stress disorder. The speech therapist had also informed him that "the chance of speech returning to him now is very unlikely".

35. On 5 November, he transferred to HMP Bullingdon. Nurse A carried out the first healthscreen assessment. She told my investigators that healthcare staff had not been warned that he was coming. She therefore contacted Officer A, who had accepted his transfer, to clarify whether she was aware of the extent of his disabilities when she had accepted him and was told that she was not. The prison was not aware of his mobility problems. They were aware of his loss of speech, although the extent was not clear. After the assessment, his medication was continued as it was from Whitemoor. At that time, he had been prescribed simvastatin and aspirin, medication to reduce the potential for a further stroke, as well as mirtazapine and ramipril, medication for high blood pressure.

36. The man's sister believed that he had moved to Bullingdon because he would be more likely to receive rehabilitation and treatment for his condition. The nurse said that he had believed this to be a progressive move for him, where he would

be able to get on with his sentence and "start things afresh". She added that he wanted to be on the wing rather than in healthcare, although she did feel that "he was the type of patient that would require a 24 hour healthcare setting".

37. Nurse A told my investigators that she thought a formal care plan should have been completed for the man but she did not know whether this had been done. My investigators made enquiries with the modern matron and wing staff who said there was no multidisciplinary care plan in place for him. The modern matron said that healthcare staff should take the lead in providing a plan for someone with obvious disabilities. The plan would contain objectives around social needs, such as special accommodation, or other disability needs, such as wheelchairs.

38. At an appointment with the prison doctor on 6 November, he said he was feeling low in mood. He said he had previously harmed himself when he lived in the community, by cutting his wrists and had taken a number of overdoses of medication. His restricted speech and mobility also caused him frustration and depression. His antidepressant medication had just been increased to 45mg per day so the doctor considered he should stay on this dosage until it started to take effect. In view of his depression and low mood, Hospital Doctor A opened an ACCT document to start the suicide and self-harm monitoring procedures at 10.57am and the relevant initial assessments were duly completed.

39. At 3.50 pm, the man was again interviewed at a case review as part of the ACCT procedures. He communicated that he was frustrated at his condition but denied that he was suicidal. He used his communication tools to explain this to the officer completing the summary of the case review. Staff introduced him to a buddy who agreed to help him on the wing and to other prisoners. They also explained the wing regime. The ACCT document was closed after this interview and a post-closure interview arranged for 26 November. At the review, he told the officer that he was now feeling a lot happier. He was happy on F wing and was enjoying taking part in an art course. Other prisoners supported him, helping him to complete day-to-day tasks and write letters to his family.

40. A number of prisoners came forward to be interviewed. They all said that they took care of his personal needs and although they had no training, they tried to help with his speech and mobility. Some felt that the personal care was difficult and that they should not have had to do it because of their own personal experiences. Nevertheless, they completed these tasks because they believed that if they did not do so, no one else would assist him.

41. Prison Doctor A ordered some blood tests and arrangements were made for the man to attend the general practitioner (GP) clinic on 10 November. Unfortunately, he refused to have the blood taken and then refused to attend for a further review on 16 November.

42. As part of his induction, Officer B, the disability liaison officer (DLO) assessed him on 7 November and made a number of recommendations in the disability support plan for reasonable adjustments to be made. When his disability support plan review took place on 23 February, there were still a number of

outstanding recommendations. In particular, he was still waiting to be moved to a larger, single cell and for a trolley to help when he collected his food.

43. In March, the man's sister wrote to the prison. She was concerned that his condition had worsened over the past few weeks. She thought he was distressed and depressed due to his communication problems and was still suffering from very high blood pressure. She also said that when she telephoned the prison she did not get a lot of information. She was under the impression that he would remain in the healthcare centre at Bullingdon and she asked for a reassessment. The Governor replied that he was receiving suitable care from the local Primary Care Trust (PCT) and his condition was being monitored regularly. He also said that the PCT was responsible for his clinical care and as such, "I am not in a position to dictate to them where he is located or what level of treatment he receives …" It is clear from the medical records that it was his preference to be accommodated on the wing.

44. My investigators were told that around this time there was a fire drill on the wing and the man had been allocated an "evacuation buddy". This was another prisoner on the wing who had the responsibility for walking him to a safe area. The prisoner told my investigators that when the fire alarm sounded he went to the man's cell and put a jacket on him because it was winter and was icy. He said that it took him a long time to walk with him to evacuate the wing. He said if there had been a real fire, "Forget it." By this he meant that they would have had little chance of escaping. Staff confirmed that he was provided with a wheelchair as it took him longer to evacuate the premises during the drill than was deemed safe. The wheelchair was provided to help staff transport him around the prison easily and in case of emergencies.

45. A prisoner said that the man had a number of falls in the prison:

> "Every now and again, he would fall and you didn't know whether it was a genuine fall or whether he was crying wolf. Because he did that a few times, you know, where he would just lie on the floor. (…) He did pull that stunt a few times and then he'd even done it on the landing, you know. Where he'd make out that he couldn't move and he'd start shaking his leg and things like that, so we didn't know whether it was a genuine fall."

46. After one fall on 15 March, he was referred to hospital for an x-ray on his right leg. The hospital doctor said he had a soft tissue injury and prescribed painkillers and gave advice, both verbally and in written form.

47. According to prisoners, his time was generally spent watching television in his cell. There were occasions when staff from the education department went to his cell to do art work and crosswords, which he enjoyed. However this seems to have been haphazard and irregular, despite the ongoing input from Officer B and the man's personal officer.

48. From 24 April, the man started to refuse his meals occasionally and he also refused to go to the gym. He told Officer C that staff in the education department had not been coming to see him and he wanted to do some offending behaviour

work. From the prison records, it seems that at this time there was little in the way of structured activities for him to take part in and he often had arguments with his buddies on the wing. He started to use the wheelchair more often and stopped walking around the wing. According to prisoners interviewed, at around this time prisoners who were helping him told him that he needed to do more for himself. They said that he was playing prisoners off against each other and manipulating them. He alleged that prisoners were stealing from him. Staff investigated and found no evidence to support the allegation. He subsequently retracted.

49. Officers B and C reviewed the man's disability support plan on 20 May. He was still waiting for a larger cell and a trolley for his food. They assessed that he needed various items of day to day equipment which were subsequently provided and that he should be reminded to go to the gym. They also made enquiries about speech therapy. Officer C told my investigators that they had been "fighting" for him to have speech and physical therapy for some time but they "didn't get far with it at all". When she attempted to make arrangements, no one took responsibility for taking them forward. Staff from occupational therapy did not make contact until after he had died. However, he was referred and assisted to go to the gym on occasions. Officer B said she often visited him, as part of her role as disability liaison officer (DLO) and made regular telephone calls to his sister on his behalf, as did his personal officer.

50. On 21 May, the man asked Officer D to make enquiries with his solicitors about a move to HMP Kirkham, where he believed there was a special unit for people affected by a stroke. His solicitors said they were in the process of getting a specialist to assess his suitability for a move to Kirkham. There is no indication as to whether this assessment took place.

51. Staff put in place monitoring under the ACCT procedures on 24 May, because he had not eaten for two days and would not come out of his cell for association. He was still using the wheelchair instead of walking and his buddies said that he was expecting too much of them and was becoming lazy. During the ACCT assessment, he communicated that he would harm himself, by pointing to a razor and making slashing movements across his throat, with his hand. He told Officer E that he wanted to move to C wing but this was not possible as there was no appropriate larger single cell accommodation for him there.

52. During an ACCT assessment interview at 4.35pm on 25 May, the man indicated that he was not suicidal and did not want to harm himself. He explained that he was not eating because he was not hungry. He also told staff he was not sure whether he wanted to leave F wing for another. Staff concluded in the ACCT document that he was "frustrated because of the confines of his disability". He transferred to the healthcare centre on 26 May because of his food refusal and was assessed by medical staff. He was discharged and returned to F wing the following day.

53. As part of the ACCT procedures, staff completed a caremap where they set objectives to encourage him to use his communication charts to explain his

needs, to use his locker for his property, to see education staff more regularly and to continue doing crosswords.

54. The ACCT was closed on 1 June, when staff said he:

> " … was in good spirits with no thoughts of self-harm. Will get locker for him to use. He is taking part in activities and integrating into the regime. [teacher] from education attending and doing crosswords with him/painting pictures of cats, taking 2 baths week and being assisted by HCC staff to do so. Attending gym. Still no speech therapy – not clear whether this appropriate - Has larger cell."

55. It is clear from the document that staff spent time with the man, to make sure he was able to communicate his feelings and needs with them effectively and from 1 June there he seems to have more organised activities. (The post-closure review took place on 9 June and staff said he was feeling better, "he was happy to be on F wing but upset that he has to wear glasses. Staff telephoned his sister from time to time and she visits now and again".)

56. Officer C reviewed the man's disability plan on 1 June. He had been moved to a larger cell and was using the specially designed fork and the plate with sides on it. He was attending healthcare, where staff assisted him with bathing. A prisoner told the investigator that for much of his time on the wing he was bathed and shaved by his peers. Prisoners also said that they helped him out with his canteen. (Prisoners can buy goods such as tobacco, sweets, soap, toothpaste etc via a process known as 'canteen'. However, canteen is also the term used for those goods once they have been purchased and are in a prisoner's possession.) SO A said that he didn't know if he was in receipt of any wages or benefits but clarified that prisoners on the enhanced level of the Incentives and Earned Privileges (IEP) scheme earned an extra £1 per week as a privilege. (IEP is a scheme to encourage and reward good behaviour. It has three level basic, standard and enhanced and prisoner move between the three levels according to their behaviour and performance.)

57. As he was not working he was not entitled to wages, so he had little money to buy things like snacks. He told his personal officer that he wanted to do some form of work to earn some money. He also said that he would do in cell work on alcohol issues and that he was excited about doing some paintings of tigers for the art department. They discussed his sentence progress as he was a category B prisoner.

58. Staff from the Alcohol and Drug Treatment Programme, (ADTP) assessed the man's ability to take part in the group programme to work on his alcohol issues but decided that he was unsuitable because of his disability. However, it is recorded in wing history records that the ADTP department would try and provide some materials and feelings sheets for him to work on in his cell with one of their supporters. It is not clear from the records whether this work ever took place.

59. Records show that for the next two months he used his time effectively. He started to use the gym from Monday to Thursday, after an assessment on 18

June and records state that he was gaining confidence on the cardio vascular and hand bike machines. He was unable to attend the education department as it was upstairs and, and in any case, they did not have an EVAC chair in case of emergency. However, there were occasions, recorded on the wing history sheets, when education staff went to work with him in his cell.

60. On 13 September, he fell over in his cell. He slipped and banged his head when he was about to use the toilet and was unable to get back up. Healthcare staff went to the cell and noted bruising to both his knees and a bump to the right side of his head. They examined him and advised him to rest on his bed. They recorded that PO A should be notified that he would benefit from having an SOS neck chain in case of further falls when he might be unable to call for help. (An SOS neck chain is a chain with a fob, which has information about a person's illness and what to do in case of an emergency.) It is not clear whether he was ever provided with the neck chain.

61. On 3 October, the man was in his friend's cell when he became ill. Staff and prisoners said that he fell over and at first was in a vacant state, staring and then he became very agitated. His breathing was shallow and he was salivating heavily and thrashing his arms about. Officers B and F moved him to his own cell and placed him on his bed.

62. Officer G said that he was on duty in the healthcare centre at about 3.20pm when he answered a telephone call from Officer F, who told him that the man was not well and asked for healthcare assistance. He said that he was in a room with Nurse B, her husband, Nurse C and Healthcare Assistant (HCA) A. He then turned to Nurse B, told her what the call was about and she said, "Well I finish at 4 o'clock because (sic) I am not going, can you phone downstairs and ask downstairs to attend?" He said that he then rang the inpatients department downstairs and was told that they could not attend because there were only two nurses. He said that Nurse B then took the phone and spoke to the inpatients nurses. Whilst this was going on, Officer F tried to telephone the healthcare centre again but the phone was engaged. He therefore told Officer D, who was with the man, to call a level 2 over the radio.

63. Nurse B remembers things differently. She said the first that she knew about the situation was when a call came over the radio. She said she remembers it clearly as "hotel 1, hotel 1, level 2". She said that as Nurse D had just returned to the office in outpatients, she handed him the hotel 1 radio, for him to attend the call. She told him "It's a level 2 call, if you need back up, I'll be there".

64. Nurse C was interviewed as part of the investigation as Officer G had said he was in the room at the time of the original call. However, he said that he was not there at the time and was more likely in the inpatients department as he had been scheduled to work there from 3.00pm. He first heard about the incident from his wife later that evening. There are no further references to Nurse C in the body of this report.

65. Nurse D told the investigator that he was told that there had been a hotel 2 call, which would have meant that someone from inpatients should attend. When this

was clarified as a hotel 1, level 2 call, he took the green bag and went to attend to the man. (The green bag contains basic first aid equipment such as a thermometer, gloves and basic dressings. It is the bag that staff would generally take to a level 2 call.) He said it took him about two minutes to get to the cell. However, Officer G said he thought that it took about 15 minutes to get a nurse to the man's cell from the time he received the first telephone call from Officer F.

66. Nurse B, said that when Nurse D had gone to attend to the call she spoke to HCA A to find out who the call was for. When she found out it was the man, she knew that he had previously had a stroke and thought that he might be having another, so she prepared to be back up. She walked to the doctor's office and then heard a call over the radio network for hotel 1, level 1. She then rang the gate and also 999 for an ambulance because she believed him to be having a stroke. She then went to his cell with Prison Doctor A.

67. My investigator asked Nurse B if she had said that she wouldn't respond to the call because she was due to go off duty at 4.00pm. She denied having said this or any knowledge of the phone call to outpatients from Officer F. She said that Nurse D was responsible for the hotel 1 radio during that shift. However, he gave the radio to her just after 3.00pm as he had to go the visits hall temporarily for around 15 minutes and, at that point, she had reminded him that she would be off duty at 4.00pm.

68. My investigator was told that the system for emergency calls was that one healthcare staff member, who had to be a qualified as a registered nurse, would be designated, on a rota basis, as hotel 1. That person would hold the hotel 1 radio throughout their shift. The hotel 2 radio would be held by the inpatients staff and would only be used if another emergency call was made whilst hotel 1 was busy, for example on another call.

69. Nurse D said that on arriving at the wing he saw that the man was salivating excessively and he thought that there was some type of "cerebral vascular accident". By this, he meant that he thought he was having another stroke. The clinical reviewer commented that appropriate management of a suspected stroke has changed in the last two years. He said there had been a public campaign to re-brand a stroke as an "acute brain attack" so that the public would equate it with a heart attack and call '999' immediately. This is so that a relatively new treatment can be given which could minimise the damage done to the brain.

70. There are differing perceptions of what happened next. Nurse D said that he then went to the office on the wing and rang healthcare, to tell them it was a level 1 emergency. He said he used the phone rather than the radio because he believed he would get a faster response. He spoke to the healthcare assistant and told her that the man was having a stroke and that it was a level 1, not a level 2. However, Nurse B remembers the level 1 call coming over the radio.

71. The doctor and Nurse B then went to the man's cell. The nurse said that this would have taken about five minutes from the call coming over the radio. She said that he was in a very agitated state. She explained that Nurse D had tried to put a blood pressure cuff on him but it was very difficult to get a reading because

his body was jerking about a lot and he was distressed. The doctor agreed that he was having a stroke and, as an ambulance had been called, he felt there was nothing more that could be done except to reassure him, make him comfortable and ensure his safety.

72. The doctor then left the cell and went back to his office. Nurse B said that there were quite a few people in the cell and she felt he needed ventilation. As Nurse D was assisting him, she went to speak to PO B, to arrange escorts to take him to hospital and to do the paperwork. She said that she was confident that Nurse D had things under control and that he was qualified to deal with the man.

73. Nurse D said that HCA A had called an ambulance and he left the man with a prison officer before it arrived. He estimated that the ambulance took around 45 minutes. Nurse B said that she had called an ambulance and there had been a quick response. The clinical reviewer said that normally a fast response to a stroke would enable a specialist assessment to be made in order to consider the use of drugs to minimise damage to the brain. However, he considered that because of the man's pre-existing condition, this would have been unlikely to have benefited him.

74. Nurse D told the investigators that he had spoken to the clinical manager earlier that day when he had been told that he should hold the hotel 1 radio. He said that he did not feel confident attending level 1 calls because he was a mental health trained nurse and not a registered general nurse.

75. The man was subsequently taken to hospital. Officer B was one of the escorts. She knew him well, having undertaken his disability plan and reviews. She discussed the use of restraints with a governor. It was her belief he was a low risk because he could not move fast, he was clearly poorly and he might need immediate medical attention. The governor agreed to this and said that restraints were to be used at the officers' discretion.

76. Officer B told my investigator that at hospital the man's hand co-ordination was poor. He could not hold a cigarette to his mouth, or eat or drink without coughing and choking. However, he was still joking and she believed that hospital staff were going to discharge him and bring him back for tests on Monday. She told hospital staff that she knew he was not well and that she was not happy for him to return to prison because of his condition. Although not medically trained, the officer considered that he needed to be observed for a further period. He was consequently kept in hospital for further tests. She remained on escort duty with him until 11.30pm, that night. She said that she telephoned his sister on 5 October to let her know that he was in hospital.

77. Although my investigator was given bedwatch logs, they are difficult to understand. (A bedwatch log is a history, recorded by escort officers, of time and events which take place while a prisoner is out of the prison as an inpatient at hospital.) There are no dates on the top of each page and until 6 October, the ongoing record is not fully completed. However, it is clear that throughout the man's stay in hospital he was never restrained. The decision to use restraints was left at the discretion of the escort officers.

78. During the night of 5/6 October, the man deteriorated and records show that at 3.00am, staff contacted his sister. At 4.10am the hospital chaplain said final prayers at his bedside. At 7.20am, one of the escort officers became concerned that he had stopped breathing. Nurses checked but could not find a pulse. A doctor was called and confirmed he had died. Prison officers stayed with the body until the police arrived. He was then moved to the bereavement centre where staff telephoned his next of kin. The duty staff care team contacted the escort officers to offer support.

79. The prison chaplain held a memorial service on the wing where the man lived. This was well attended and prisoners told my investigators that they found it very helpful. Some prisoners said a few words at the service and were able to meet his sister. The prison family liaison officer liaised with the next of kin regarding arrangements for the funeral and paid the costs.

## ISSUES

### Recordkeeping

80. The man's medical records contained a secondary healthscreen completed at HMP Belmarsh in February 2007. It is recorded that he had a "mild stroke" at some point prior to his reception there, but there is no follow up or information as to who made this diagnosis. The clinical reviewer comments that "this highlights the discontinuity between medical records in general practice, and those maintained in the prison system, and may have had an impact on his future health". He makes a recommendation relating to this which I endorse and slightly amend.

    **The Head of Healthcare should remind staff that where a serious past medical history is suggested at a healthscreen assessment, it is imperative that this is highlighted to a responsible person for clarification. This should be recorded and if confirmed, assessed by a doctor for any implications for the care and treatment of the prisoner.**

81. Both the clinical reviewer and my investigator found the man's medical and bedwatch notes to be chaotic and haphazard. This has affected the timeliness of this report and has left some questions relating to his medical history unanswered. The introduction of electronic medical records has generally improved the organisation and legibility of notes, but if manuscript records are also kept, staff should be mindful that entries should be legible, clearly signed and dated.

    **The Governor should remind staff who act as escort officers of the importance of clearly legible, dated and signed bedwatch records. Each sheet should be dated at the top, signed and the name of the officer who made the entry should be recorded.**

82. No multidisciplinary care plan was completed when the man left hospital and returned to Whitemoor, nor when he transferred to Bullingdon. The clinical reviewer commented:

    > "On return to prison, his care, including medication, was appropriate but not formally structured. Every reasonable effort appears to have been made by the Prison Service to meet his needs and encourage his rehabilitation, but there appear to be issues around the co-ordination of his care and the absence of a Care Plan that would support his rehabilitation. The care and concern of a whole range of staff and fellow prisoners is quite apparent, and should be highlighted and commended. There does not appear, however, to have been any member of staff with the appropriate training, skills, or dedicated time to ensure the best care could be provided to a patient such as the man, with such complex needs. It appears he was very keen to live on a wing rather than in healthcare. It is commendable his view was accommodated although this clearly complicated the ability for the service to meet his particular needs. However, the presence of a structured care plan that could be shared

between healthcare and the wing, that could be updated regularly, and that was co-ordinated by a trained and dedicated person, would have ensured maximum comfort and possible further recovery for him. Whilst it is apparent his own mental state did appear at times to have made his care more difficult that is something the care plan would have recognised and accommodated. It should be said I do not think the care he received at this juncture was very different from that which he would have received in the community."

83. The clinical reviewer makes a recommendation relating to the policy and training of staff who work with prisoners with disabilities in which he suggests that a formal multidisciplinary care plan should be instigated and shared with relevant people. Prison Service Order (PSO) 2855 sets out the arrangements for managing prisoners with disabilities. Relevant staff are in place at Bullingdon to support prisoners with disabilities and a disability support plan was put in place by discipline staff. However, it appears from interviews with staff that resources to undertake this work might be inadequate. The policy at Bullingdon might therefore benefit from a review in respect of the coordination of care plans and providing appropriate resources.

    **The Governor should review the local policy for the management of prisoners with disabilities, with a view to ensuring that care plans for such prisoners are drawn up by a multidisciplinary team, including healthcare staff and discipline officers. The plan should be shared with the prisoner concerned. Also, the prison should provide appropriate resources, including time, training and support, to ensure that care plan is delivered.**

**Emergency call on 3 October**

84. There are differing recollections and perceptions about what happened after the call for healthcare assistance on 3 October, when the man became ill. The scheduled holder of the emergency radio had temporarily handed it to another member of staff. This led to ambiguity about who should attend the emergency call. When interviewed, staff were not entirely clear about the general procedures. The clinical reviewer makes a recommendation in this respect, which I recast and endorse.

    **The Head of healthcare should review the procedures for the response to emergency calls response to ensure immediate clarity to staff as to exactly who is responsible for responding. The rota should be written, explicit and enable an easy audit trail. Temporary responsibility for the relevant means of communication should be discouraged to facilitate this clarity and ensure clear accountability.**

**Meaningful activities and sentence progression**

85. My investigators were told that the man spent a lot of his time watching television in his cell and often was unable to take part in meaningful activities because of his disabilities. Whilst I realise that it is difficult to provide work and support to someone with complex needs, such as his, PSO 2855, states in paragraph 4, "…

we must ensure that prisoners with disabilities are able to take a full part in the regime of an establishment, that they can access offending behaviour courses, education and work, and can move through the categorisation process without restrictions because of their disability".

**The Governor should ensure that in accordance with PSO 2855, prisoners with disabilities are able to take part in meaningful activities which enable their progression through the categorisation process.**

86. It is unclear why the man transferred to Bullingdon. Healthcare and discipline staff had not been forewarned or his arrival or informed fully of his disabilities and it is apparent that Bullingdon struggled to accommodate him. PSI 31/2008, paragraph 6, which sets out the policy on allocation of prisoners with disabilities states, "if it is obvious that the accommodation is not suitable for that prisoner, even after making reasonable adjustments and he/she cannot access work, education, courses etc, the prison can seek a move to an establishment which can facilitate access for that prisoner. If the establishment has problems securing a transfer, they should contact the Area Office and PMS". I make no formal recommendation on this point, but in the event of similar difficulties in the future, the Governor might wish to take steps to secure a transfer for the prisoner.

**Family concerns**

87. One of the prisoners told my investigators that on occasion some staff and prisoners referred to the man as "[Nickname]" because that was the sound that he used to communicate. Although the references were not malicious and he never raised it as an issue, his family rightly raised concerns over this practice.

**The Governor should remind staff that nicknames can be offensive and derogatory. Staff should not use them when they relate to someone's disability or a personal attribute. Prisoners should also be challenged when using such nicknames.**

**The man's general care**

88. It is apparent that Officers B and C visited and assisted the man throughout his time at Bullingdon. As DLOs they took their role seriously. Although there is currently a lack of specific DLO training and they found it difficult to obtain certain items to assist him, they continued to ensure he was well looked after and as happy as he could be under the circumstances.

89. When he became ill on 3 October and was taken to hospital by ambulance, the duty governor agreed that restraints should only be used at the discretion of the escorting officer. Throughout his stay in hospital, no restraints were used.

90. He was assisted and cared for very well by prisoners on his wing. Often, they overcame personal experiences of abuse, to help him with his personal care. Their continued help was creditable and I encourage the Governor to write to them formally, to recognise their assistance.

## CONCLUSION

91. Any death in custody is upsetting for those involved, particularly where the deterioration was as rapid as it was in the man's case. He transferred to Bullingdon after previously having a stroke which left him with disabilities. Although he often made his care more difficult by refusing treatment, the clinical reviewer comments that the completion and use of a multidisciplinary care plan might have recognised and accommodated this.

92. There are differing accounts of what happened following the call for healthcare assistance on 3 October. However, he was taken to hospital immediately and, given the gravity of his condition, remained without handcuffs throughout.

93. The report highlights areas for improvement at Bullingdon and services to prisoners with disabilities. However, overall, I am satisfied that the level of care given by staff and prisoners was appropriate and in some cases excellent.

## RECOMMENDATIONS

1. The Head of Healthcare should remind staff that where a serious past medical history is suggested at a health screen assessment, it is imperative that this is highlighted to a responsible person for clarification. This should be recorded and if confirmed, assessed by a doctor for any implications for the care and treatment of the prisoner.

   **Accepted.** The Prison Service said that a protocol is in place regarding past medical conditions. All prisoners are assessed on arrival; a secondary screen is carried out the next morning. All health screens are recorded on the EMIS system and in future, will be recorded on SYSTEM One.

2. The Governor should remind staff who act as escort officers of the importance of clearly legible, dated and signed bedwatch records. Each sheet should be dated at the top, signed and the name of the officer who made the entry should be recorded.

   **Accepted.** The Prison Service said that a notice is to be added to each bed watch pack to instruct staff of the quality of the record keeping required. This will include the need to date, sign and write their full name in capitals on each sheet.

3. The Governor should review the local policy for the management of prisoners with disabilities, with a view to ensuring that care plans for such prisoners are drawn up by a multidisciplinary team, including healthcare staff and discipline officers. The plan should be shared with the prisoner concerned. Also, the prison should provide appropriate resources, including time, training and support, to ensure that care plan is delivered.

   **Accepted.** The Prison Service said that the Disability Liaison Officer will carry out a full review of this policy which will incorporate this recommendation.

4. The Head of healthcare should review the procedures for the response to emergency calls response to ensure immediate clarity to staff as to exactly who is responsible for responding. The rota should be written, explicit and enable an easy audit trail. Temporary responsibility for the relevant means of communication should be discouraged to facilitate this clarity and ensure clear accountability.

   **Accepted.** The Prison Service said that this is now in place.

5. The Governor should ensure that in accordance with PSO 2855, prisoners with disabilities are able to take part in meaningful activities which enable their progression through the categorisation process.

   **Accepted.** The Prison Service said that this recommendation will be considered as part of the full review under recommendation 3. The Disability Liaison Officer will work in partnership with the Offender Management Unit.

6. The Governor should remind staff that nicknames can be offensive and derogatory. Staff should not use them when they relate to someone's disability or a personal attribute. Prisoners should also be challenged when using such nicknames.

   **Accepted.** The Prison Service said that staff who were working with and involved with the care of the man do not recall him being addressed in this negative way, although they can see through the transcripts from a few of the other men on Finmere that they did talk about him using an unacceptable nickname. A Notice to Staff and a Notice to Prisoners will be published regarding the use of nicknames. Anybody within the prisoner or staff community who is heard to use inappropriate nicknames will be challenged.