

INVESTIGATION INTO THE DEATH IN CUSTODY OF A MAN
WHO
DIED AT THE QUEEN ELIZABETH HOSPITAL, GREENWICH
WHILST A PRISONER AT HMP BELMARSH ON 29 OCTOBER 2004

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES

November 2005

This is the report of an investigation into the circumstances of the death a man who died aged 73 on 29 October 2004 at the Queen Elizabeth Hospital, Greenwich. At the time of his death, he was on remand at HMP Belmarsh awaiting trial at the Central Criminal Court. At the Post Mortem, the pathologist gave the prisoner's cause of death as natural causes.

The investigation was carried out by one of my colleagues. Greenwich Primary Care Trust carried out a clinical audit of the prisoner's clinical care and treatment.

We would like to extend our condolences to the prisoner's family for their loss. I would like to thank the Governor of Belmarsh, and his staff for their help.

Stephen Shaw
Prisons and Probation Ombudsman

November 2005

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SUMMARY

1. The prisoner was born on 11 May 1931 and was 73 years-old when he died on 29 October 2004. He died at the Queen Elizabeth Hospital, Greenwich. A post-mortem was held the following day and the cause of death was found to be natural causes through:
 - 1a Left ventricular failure
 - 1b Myocardial failure
 - 1c Coronary atheroma
2. At the time of his death, the prisoner was on remand at Belmarsh awaiting trial for murder at the Central Criminal Court. A trial earlier in the year had been abandoned because of his deteriorating health.
3. The prisoner had been in poor health for a number of years. It is known he had diabetes and a heart condition. It is also documented in his prison medical records that he had refused in-patient treatment for a heart condition in July and October 2004. The consequences of his refusal were made known to him by staff within the Health Care Centre at Belmarsh.
4. The news of the prisoner's death was broken to his wife by the chaplain at Belmarsh on the evening of 11 May. The Prisons and Probation Ombudsman's Family Liaison Officer spoke to his family who commented that they had anticipated his death as he was in poor health.
5. The family had no concerns with the treatment of the prisoner, whilst at Belmarsh. The PCT review makes seven recommendations, which I accept. Once agreed the implementation of recommendations will be monitored by the Clinical Governance Sub-Committee of Greenwich Teaching PCT.

The Investigation Process

6. My practice in apparent deaths from natural causes is to conduct an initial review to determine the extent of investigation required. My investigator visited Belmarsh on 12 November 2004 when he spoke informally with the Head of Residence, who outlined the facts relating to the prisoner's custody at Belmarsh, and his transfer to hospital. The investigator was given access to the prisoner's records, including his medical records.
7. The investigator subsequently spoke to a representative of the local Prison Officers' Association (POA) and to a representative of the Independent Monitoring Board (IMB). Neither had any issues which they wished to draw to the Ombudsman's attention.
8. One of my office's family liaison officers spoke with the prisoner's family who were aware that he was in poor health. The process of the PPO investigation was explained. The family did not have any concerns regarding the prisoner's treatment at Belmarsh.
9. Greenwich Primary Care Trust (PCT) commenced a clinical review of the prisoner's healthcare needs. The report of the review of the events leading up to his death, were approved and agreed by Greenwich multi-agency panel on 7 October 2005. HMP Belmarsh has been asked to lead the development of action plans. Once agreed the implementation of these plans will be monitored by the Clinical Governance Sub-Committee of Greenwich PCT.
10. A Post Mortem was carried out on 30 October 2004.
11. No formal interviews with staff were conducted. This report is based upon a review of all relevant paperwork, including the prisoner's clinical records.

The Prisoner

12. The man suffered from a number of physical ailments including diabetes and a heart condition. Whilst at Belmarsh he was described by staff as compliant, polite, and a gentleman who kept himself and his cell immaculate. It is known that the only visits he received were from his legal representatives. He did however, have telephone contact with his wife.
13. The last entry on the prisoner's prison history sheet prior to his death dated 26 September 2004 stated that he *remains settled at present although declines exercise and association, but always polite and helpful to staff, no management problems at this time.*

HMP Belmarsh

14. Belmarsh became operational on 2nd April 1991, and is a category A local prison.
15. The Health Care Centre offers facilities for inpatients, and outpatient clinics, primary care services and has a purpose built therapy unit. Medical primary care and psychiatric services are contracted in from local NHS providers on a full-time basis. The Inpatient Unit has 38 beds mainly used for psychiatric care. All cells have integral sanitation. There is also an Intensive Care Suite and a Special Observation room, both single occupancy. An inpatient clinical manager heads the staff complement comprising nursing grades, healthcare officers, discipline officers and nursing assistants in conjunction with the psychiatric team.

Events leading up to the prisoner's death

16. The prisoner stood trial at the beginning of July 2004. However the case was adjourned because of his ill health. He was admitted as an in patient to the Queen Elizabeth Hospital, Greenwich on 5 July following an episode of cardiac sounding chest pain. He was discharged on 15 July 2004. It was recommended that he should undergo an in patient transfer to St Thomas' Hospital, London for angioplasty. The risks and benefits were discussed in detail by medical staff. The prisoner decided that he would not undertake any interventions.
17. On 19 October 2004, the prisoner signed a disclaimer refusing to attend an outside hospital after complaining of being breathless. Medical staff explained the consequences of not receiving treatment at outside hospital to him. He had previously signed disclaimers refusing treatment for a hearing aid, and follow up outpatient treatment.
18. He continued to be monitored and treated within the Health Care Centre daily. On 29 October 2004 at 4.30pm, the prisoner was found unconscious in his cell. It appeared that he had hit the back of his head upon collapsing. Action was taken promptly. He was placed on his back and healthcare staff and subsequently paramedics carried out Cardio Pulmonary Resuscitation. He was taken to the Queen Elizabeth Hospital where he died at 5:30pm.

Events after the prisoner's death

19. The prisoner died at 5:30pm on the evening of 29 October 2004. The Chaplain from Belmarsh informed the prisoner's wife later that evening. of her husband's death.
20. A Post Mortem examination at Greenwich Public Mortuary on 30 October concluded that death was due to natural causes:
 - 1a Left ventricular failure
 - 1b Myocardial infarction
 - 1c Coronary atheroma

Level of Compliance

21. Standards of clinical care in prison are intended to mirror those available in the outside community. .
22. The post incident response by staff at Belmarsh was fully compliant with Prison Service instructions and policies on managing a death in custody.

Conclusions

23. Quite clearly, the prisoner was a man who was in poor health. He clearly had a good relationship with those caring for him whilst at Belmarsh. He was described as a polite and tidy man. It would appear that his mental state was such that he was aware of the consequences of his actions in allowing himself not to be treated.

Recommendations

24. The Primary Care Trust has made seven recommendations, which I endorse.

- 1 Access policies for Category A ambulances are reviewed to optimise access times and ensure that undue delays are avoided.
- 2 A computerised record system is introduced as soon as possible to the prison.
- 3 A review of the risk assessment procedures in relation to cuffing is undertaken to ensure that security policies are appropriate to the risk involved and the duty to provide health care.
- 4 A policy is needed to:
 - regularly check healthcare equipment
 - remove faulty equipment
 - ensure that all equipment is calibrated at regular intervals.
- 5 Communication
 - A programme of training is introduced alongside a regular audit of record keeping against agreed standards to ensure that staff are aware of the implications of where communications are not sufficiently clear with relation to the need for observations and management
 - A significant event process involving all clinical staff involved with recommendations and action planning for improvement introduced. This will require a clear policy of what constitutes a significant event. A no blame culture relating to significant events reporting needs to be fostered to create an environment where staff can learn positively from incidents without fear of reprisal.
 - Staffing levels for nurses and doctors should take into account the extra time needed for high quality communication both verbal and written.
- 6 A clear ethical framework is established which defines a system whereby the duty of care and its limits for each prisoner who refuses a particular treatment are identified and documented. See website: www.ethicsnetwork.org.uk In addition training of all

staff in how to use this framework needs to occur following its development

7 Clinical Governance

- Activities need to continue to be high priority to build on the good work already undertaken in improving quality and acting on recommendations. These activities need to be informed by the prison health's commissioning organisation (Greenwich Teaching Primary Care Trust) and given the appropriate high priority at board level.
- Clinical governance and audit expectations should be written into staff job descriptions including the expectations on staff and management to give appropriate time for these activities within rostering and staff procurement.

Good Practice

25. I commend the healthcare staff for their prompt action upon finding the prisoner unconscious.