INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP BRISTOL ON 15 NOVEMBER 2004

Report by the Prisons and Probation Ombudsman for England and Wales

February 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Bristol on 15 November 2004. The man died from natural causes at the age of 49. He had been in custody continuously since the age of 17.

I would like to extend my condolences to his family and to those touched by his death. I am grateful to the family, and to the management and staff at HMP Bristol, for their assistance and co-operation during the course of this investigation. I very much regret the severe delay in completing this report.

I judge that the man's death could not have been predicted. Indeed, it could be said that his life raises far more questions than his death. However, there are lessons that can be learned, particularly in the healthcare management of those suffering from hypertension. I am also concerned by the way that the news of his death was communicated to his family, and the initial contact they had with the prison.

I make four recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2006**

Contents

Summary

The man was just 17 years old when he was sentenced for murder in 1972. He was 49 at the time of his death in HMP Bristol and had spent all of the intervening 32 years of his life in prison.

He suffered from hepatitis, hypertension and osteoarthritis. He was also a long-term heavy smoker. Over the years, he had been a prolific self harmer and had taken many drugs, both prescription and non prescription. All together, these had taken their toll on his body.

On 15 November 2004, at about 7.15pm, he was found lying in his cell during routine checks. Despite resuscitation attempts, he was pronounced dead at 7.35pm. The post mortem report states the cause of death as:

1a Acute Myocardial insufficiency
1b Coronary artery atheroma

His tariff had been set at 14 years. Much of his time in prison was characterised by self harming, drug taking and disruptive behaviour. To some degree this may have been due to his youth and immaturity at the time of his sentence, coupled with the intense guilt he clearly felt about his offence. He also did not appear to cope well in prisons with a lower security status, although 'progressive' moves to lower category prisons were attempted on several occasions.

In the main, his medical care was appropriate to his needs. However, there did not appear to be systematic monitoring of his hypertension.

The initial contact with his family, and that in the day following his death was unacceptable. The family were contacted by the police but not left details of who to speak to in the prison. After they then contacted the police again, the family were given the name and number of someone in the prison but were told they would not be available until 8am, some 6 hours away. When they phoned the prison at 8am, they were informed that the identified person was not on duty.

The man died as a result of diseased arteries to the heart. His death could not have been predicted. However, there are lessons that can be learned regarding how prisons liaise with bereaved families and the monitoring of health conditions.

Investigation process

I appointed one of my colleagues to investigate on my behalf. The investigator and her manager visited HMP Bristol and met with the Deputy Governor. They were given a full briefing about the circumstances surrounding the man's death. They visited the wing where the man had died and spoke to staff and prisoners.

They then met with representatives of the Prison Officers' Association and of the prison's Independent Monitoring Board. A notice to staff and a notice to prisoners were issued, inviting anyone who might have information relating to the man's death to make themselves known to the inquiry team. No-one came forward as a result of these notices.

The investigator took away with her all of the files and records relating to the man and commissioned a clinical review from the Clinical Governance Lead for Bristol North Primary Care Trust.

One of my family liaison officers contacted the man's sister. The investigator and the family liaison officer visited his mother and one of his sisters. They raised a number of questions. These largely related to the healthcare that the man had received. Some of these questions are answered in the main body of this report and others have been addressed separately in a letter direct to the family. I repeat here my indebtedness to the family for their assistance and patience.

Events of 15 November 2004

On 15 November 2004, staff and prisoners did not notice anything unusual in the man's behaviour or mood during the day. He took his meals and medication as usual and spent time playing on his PlayStation.

At about 5.30pm, after the man had got a drink, the wing officer locked the door to his cell. The man did not press his cell bell to call for staff after this time. Some other prisoners were out on association that evening, but the man was not.

At 7.10pm, the wing officer was conducting a roll check. This is where the officer counts and checks that all prisoners are in their cells. When he came to the man's cell at about 7.15pm, he looked through the observation panel and saw the man lying on the floor with his head resting on the bed. He knocked on the door and shouted the man's name. As there was no answer, the wing officer entered the cell, touched the man's shoulder, and asked him if he was okay. Again, there was no response. The wing officer reported that the man looked pale, and was cold to touch. The wing officer felt unsuccessfully for a pulse.

The wing officer then left the cell and shouted to another officer, the prison officer that there was a code blue in cell D4 15. (A code blue means that someone is not breathing.) the prison officer then used his radio to call for urgent assistance, whilst the wing officer returned to the cell. He moved furniture out of the way to make some room, and began to move the man so that his body was flat on the floor. At this point, the wing officer found that the man was cold and quite rigid. As the wing officer was trying to put the man into the recovery position, he was joined by other officers, the unit manager - Principal Officer (PO) - and by nursing staff.

The staff nurse checked for a pulse, but could not find one. She then commenced cardio pulmonary resuscitation (CPR) with the help of the PO. A second nurse arrived shortly afterwards with an automated defibrillator machine. The second nurse placed the necessary pads on the man for the defibrillator machine. The defibrillator instructed not to shock. The paramedics from Avon Ambulance Service arrived quickly. They found no signs of life and pronounced death at 7.35pm.

The prison's response following the death

Bristol has a comprehensive 'Death in Custody' booklet that is completed by the orderly officer, investigating governor and the doctor in the event of a prisoner's death. It provides detailed information including prisoner details, when and how the death occurred, Coroner information and post mortem arrangements. My investigator found that most sections of this booklet had been completed thoroughly and that the documentation was very useful.

Following the man's death, the prison's contingency plans for a death in custody were implemented. A hot debrief took place, and staff and prisoners on the wing informed and offered support. Statements from all those staff who had been involved were taken. My investigator found that these contained appropriate and relevant detail.

The post mortem was conducted on 17 November. This confirmed the cause of death to be acute myocardial insufficiency, and coronary artery atheroma.

Contacting the man's family

HMP Bristol asked the police to break the news to the man's family as they live in Berkshire. For reasons I have been unable to ascertain, the police did not attend the man's family's home till 2am some six and half hours after his death.

When the police arrived at the family home, they did not have the correct family name which caused the man's mother some distress. Nor did the police leave a contact name or number for someone the family could call at the prison for more details. They had to phone the police station to obtain one. The police gave a name but said that person would not be available till 8am. The man's family then had to wait six long hours not knowing really what had happened other than that the man had died.

The man's family phoned at 8am, but were told that the named contact they had been given was not in the prison that day. The man's family reported that they had to make a number of calls to try and find out the circumstances surrounding the man's death.

Bristol subsequently offered the man's family the opportunity to visit the prison which they accepted. During the visit, they met with the deputy governor who attempted to answer the family's questions.

Findings and Conclusions

The man died of natural causes. His death could not have been predicted. However, there are issues that warrant further consideration and explanation.

Medical care

The man was only 49 when he died. I have little doubt that 32 years continuously in prison had an effect on his general health. It is known that the man had abused drugs, smoked and self harmed over the years.

In 2000, the man was diagnosed as having hepatitis C. As the tests revealed there was no active hepatitis C infection, it did not require medication but was regularly monitored. In December 2003, the man was diagnosed with hypertension. Hypertension is a major but modifiable contributory factor in coronary heart disease. The National Institute of Clinical Excellence (NICE) states that to identify hypertension the patient must have high blood pressure (above 140/90mmHg) on at least two occasions. The clinical reviewer found no evidence in the medical record that these recordings had been taken.

There was also no clear evidence of systematic monitoring or management of the man's hypertension. This was compounded by the fact that the records were not in date order and sometimes difficult to follow. The NICE provides a clear flowchart for the management of hypertension in adults within a primary care setting.

I therefore make the following recommendations:

I recommend the PCT in partnership with the prison develop a local policy for the diagnosis, care and the management of hypertension in accordance with the guidelines laid down by the National Institute of Clinical Excellence.

I recommend that healthcare professionals should be reminded of their responsibilities for appropriate standards of records and record keeping in accordance with professional standards and a clinical audit system introduced to ensure compliance.

The management of the man's hypertension had greatly upset his family.

Medication

The man was on appropriate medication for his conditions. The man had once been prescribed with Rofecoxib otherwise known as Vioxx. He started taking this on 17 March 2004 for the pain and inflammation related to osteoarthritis. However, on 30 September 2004, the drug was withdrawn on the advice of the Committee on Safety of Medicines. It was withdrawn as it was discovered that there was an increase of **three thrombotic events per**

400 patient years of treatment?. This difference in event rates was only apparent after 18 months of treatment. The medication was stopped at an appropriate time and there is no evidence that the Rofecoxib contributed to his death as he had stopped taking the medication on 3 October 2004, and had only been taking it for seven months.

On 4 October 2004, the man was assessed fit as suitable to have some in possession medication. This was after several months of not having this allowed due to a previous overdose. On 3 November, he was permitted to have all his medication in possession. This was a positive forward step for him.

His last hospital appointment had been on 28 October for investigations into a cyst on his left scrotum.

The length of time the man had been in prison

His tariff was set at 14 years. At the time of his death he had served 32 years and was still far from release.

The reasons for this were complex. He had been disruptive for a number of years. He was involved in drug taking, and would often declare himself a vulnerable prisoner due to debts he owed. He seemed to punish himself repeatedly for his crime, either by his reckless behaviour or by self harming. At times during his years in prison, his self harming was prolific including several suicide attempts.

In 2003, he had eight adjudications (prison disciplinary hearings). Two of these for were for unlawful use of controlled drug, and one was for possession of drugs. In 2004, he had three adjudications the last of which was in August.

His life sentence plan was, in the main, regularly reviewed. Over the years, he had completed several GCSEs, drugs awareness courses and an enhanced thinking skills course. He also had three periods in the therapeutic community at Grendon prison. He found it very hard to talk about his feelings in front of others in that environment. He had to leave Grendon due to returning to drugs. He was often assessed as being a risk to himself more than to other people.

The man moved to four lower category prisons at various points during his sentence. On each occasion, he found it difficult to cope and was returned to a higher category prison.

On other occasions, he was in the process of being moved to lower security prisons but would jeopardise the move. For example, he refused to move to Highpoint in 2003, the day before he was due to move. He said that, if he was made to move, he would threaten to escape thereby making the move impossible.

At his last Parole Board review in 2002, it was felt he needed to undertake more drug and alcohol related work before a move to open conditions could be considered. His move to Ashwell was in order complete this work. However, he was unable to cope well in the conditions and was returned to Bristol.

Staff reported that he had been more settled in the last few months before his death. He had been complying with the regime and was friendly towards staff. Some felt that, although he wanted to be released, he was afraid of what it might mean. Thus, when he got close, or a progressive move came up, he did not seem able to cope with it.

Family contact

HMP Bristol asked the police to break the news to the man's family as they did not live locally to the prison. For some reason, the police did not attend his family home till 2am. Breaking the news of a death in custody is both sensitive and demanding. The way in which it is carried out may well colour a bereaved family's whole relationship with the Prison Service. The two main objectives should be to break the news speedily and to do so in a way that emphasises the Prison Service's accountability, sense of shared loss, and commitment to the family as members of the public that the Service serves. I appreciate that speed and personal involvement of the Prison Service may sometimes be in conflict.

If at all possible, the governor or other member of senior management in the prison where the prisoner has died should personally break the news. Where this is not possible, I do not think that the Prison Service should routinely rely on the police:

Where it is not possible for the governor or a senior manager from the prison where there has been a death to break the news personally, a governor at the prison closest to where the deceased's next of kin lives should normally be asked to do so on behalf of the Prison Service as a whole.

I recommend that the Governor of Bristol reviews his contingency plans for a death in custody in light of this report.

The man's family were not provided with a contact point they could call immediately. They had to phone the police to request this information. They were further told no-one would be available to speak with them till 8am. When they phoned at 8am, the person whose name they had been given was not on duty that day. This was most upsetting for his family. If, as a last resort, the police are needed to inform the family, the prison should ensure a contact number of a suitable member of staff is provided. The prison should seek confirmation that the police have made the visit and provided the relevant information.

I recommend that if, as a last resort, the police are needed to inform the family of a death in custody, the prison should provide information of an

immediately available contact point and seek confirmation that the police have made the visit and provided the information.

Furthermore, his family encountered some difficulty in receiving his property. To date, they still believe that they are missing some of his property.

The post mortem found that the man died of acute myocardial insufficiency and coronary artery atheroma. In layman's terms, there were fatty deposits in his coronary arteries which obstructed the blood flow to his heart. His death could not have been predicted, and every effort was made to save him when he was found by staff.

List of Recommendations

Local

I recommend that the Governor of Bristol reviews his contingency plans for a death in custody in light of this report.

I recommend that if, as a last resort, the police are needed to inform the family of a death in custody, the prison should provide information of an immediately available contact point and seek confirmation that the police have made the visit and provided the information.

Healthcare

I recommend the PCT in partnership with the prison develop a local policy for the diagnosis, care and the management of hypertension in accordance with the guidelines laid down by the National Institute of Clinical Excellence.

I recommend that healthcare professionals should be reminded of their responsibilities for appropriate standards of records and record keeping in accordance with professional standards and a clinical audit system introduced to ensure compliance.