

**Investigation into the circumstances surrounding the
death in custody of a prisoner in hospital in December 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 prisoner in hospital in December 2004. The cause of death was given as septicaemia and disorders of the common bile duct. He was a serving prisoner at HMP Bullingdon and at the time of his death the man was 17 months into a seven-year sentence.

The investigation was carried out on my behalf by one of my colleagues. One of my family liaison officers spoke on a number of occasions by telephone with the man's sister and next-of-kin. A clinical review was carried out by one of a number of freelance medical staff working for my office.

I would like to extend my sincere condolences to the man's relatives and friends for their loss. I would also like to thank the staff at HMP Bullingdon for their help.

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Prisons and Probation Ombudsman

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Summary

The man died in December 2004, aged 73, at an outside hospital in Oxford. At the time of his death he was serving a seven-year sentence. The man died from septicaemia and disorders relating to the common bile duct.

The man who died had a number of age related clinical conditions that were managed appropriately and enabled him to lead an independent life in prison. At the time of his death he was waiting to be fitted with hearing aids. In June 2004, he had a cancerous ulcer removed from his cheek which had not recurred at the time of his death. However, as a result of the surgery he was put on 'medical hold' in early July 2004 which meant he could not be transferred to another establishment.

On 12 October, the man first started to complain of abdominal pains which were initially treated with paracetamol. However, on 29 October after some tests revealed the possibility that he may have a gallstone problem, the doctor contacted the local hospital regarding an immediate admission. The consultant did not feel this was necessary and he arranged instead for an urgent scan. This took place on 19 November. The results revealed some cysts but otherwise all was normal. In early December, the man contacted staff via his cell bell complaining of stomach pains. Healthcare staff saw him twice during the night and the doctor examined him the following morning. His discomfort was put down to a greasy meal. The next morning he was found collapsed in his cell and taken to hospital where he continued to deteriorate. He was placed on a life support machine. The following morning his life support machine was turned off.

A clinical review of the man's treatment found that he received good care and attention from medical and nursing staff, particularly during the last few weeks prior to his death.

I make five recommendations.

Background information

HMP Bullingdon

Bullingdon Community Prison is a category B local training prison for convicted and unconvicted adult male prisoners, serving courts in Oxfordshire and Berkshire. Opened in 1992, it is a 'new gallery' prison by design, with its four main houseblocks divided into three galleried units. The original houseblocks, A and D, have been supplemented by a fifth since April 1997. There are single, double and triple cells. Bullingdon has a healthcare centre that has 22 in-patient beds and provides 24-hour nursing care.

Edgott wing, where the man who died resided, operates as a vulnerable prisoner unit and houses a population generally older than the rest of the prison. Early this year the unit began operating a scheme which allowed the older (over 65) and infirm prisoners the opportunity to have additional time out of their cells, over and above association time, so that they could have access to the unit facilities during the core day. Previously there was concern that in one period of association they were in competition with younger more able-bodied prisoners for the facilities available. This is a welcome development. However, it was not in place when the man was a resident on the wing.

The man's medical history

The man died in hospital early December 2004, after his life support machine was switched off. He had been taken by ambulance from Bullingdon the afternoon before, arriving at 1:40 pm, having been discovered collapsed in his cell. The post mortem found that the cause of death was 1A) septicaemia, 1B) acute cholangitis (inflammation of the common bile duct) and 1C) gall stone in common bile duct.

During his time in Bullingdon the man saw healthcare staff on a number of occasions. In the main these were for routine age-related dental, optical and hearing appointments. He was waiting for hearing aids to be fitted at the time of his death. In June 2004 he underwent facial surgery to remove a cancerous tumour. He recovered well and his most recent follow-up review on 6 December showed no evidence of a recurrence.

On 12 October, the man first started to complain of abdominal pains. It was noted that he previously had had his gall bladder removed. The next day he was seen by a doctor who prescribed a drug for gastrointestinal disorders. On 23 and 24 October he again saw the doctor for abdominal pains and was prescribed paracetamol. On 26 October, the doctor ordered some tests, noting his previous history of gallstones. With the results of these tests the man was seen by the doctor on 29 October and told that he may have recurring gallstones or a pancreatic disorder. The doctor telephoned the local hospital and was advised that an immediate admittance to hospital was not necessary. The consultant, however, agreed to do an urgent abdominal scan and a referral to the clinic. He was seen again by the doctor on 3 November and 'no material change' was noted. The scan, which took place on 19 November, revealed some cysts in his kidneys but otherwise all was normal. The doctor informed the man of the scan results on 8 December. No medication for abdominal pain was given on this occasion.

Events prior to the man's death

The man's history sheets (2052A) are very limited and the last entry was written on 19 November 2004. The sequence of events prior to his death has been pieced together through written entries on the wing observation sheet and his Medical Record.

On 11 December, at 7:50 pm, an officer responded to the man ringing his cell bell. He was complaining of stomach pains and the officer contacted healthcare. He was told that the man was down to see the doctor in the morning. At 9:10 pm, the man again pressed his cell bell and on this occasion healthcare staff attended at 9:40 pm. The medical record indicates that he was given paracetamol and reassured by a nurse.

Later that night, at 2:42 am the man again pressed his cell bell. When told that healthcare had said that he would see the doctor in the morning he became very upset and an Officer Support Grade (OSG) contacted the night

orderly officer (NOO). There is no record of the NOO seeing the man in either the wing observation log, the NOO log, or his history sheets. However, during a telephone interview with the NOO, he confirmed that he and two other officers had gone to see the man and had been accompanied by a nurse. The NOO stated both an officer and a nurse stayed with the man for some time and settled him down. The nurse had not written up her visit with the man in the medical record. However, his prescription chart indicates that Gaviscon was given at 3:30 am for stomach pain.

The man was seen by the doctor during the morning of the 12th who attributed the abdominal pain to a greasy meal that had been eaten the day before. He deemed the man fit. This is the last record of the man who died being seen alive. According to a neighbouring prisoner he was very poorly, did not eat anything all day and had been distressed on the 12th. It is not known whether any staff checked him during the afternoon and evening.

Death of the man

There is no record of anyone seeing the man the morning before he died. At 11:50 am an officer was unlocking prisoners for lunch. He discovered the man lying on the floor of his cell, half underneath the bed. He was conscious. The officer called to the wing Senior Officer (SO) for help. The SO ran to the cell and spoke to the man. The SO radioed a 'level one' response and two nurses responded from healthcare.

One nurse examined the man and records indicate that he was responsive but slow. She states that he was dehydrated and had not eaten since the Saturday. He was taken by ambulance to an outside hospital where he arrived at 1:40 pm and was taken into the A & E department. At 2:15 pm The nurse took a phone call from the A & E Department saying that the man was in a poor condition. At 3:10 pm, the man's sister phoned the hospital to find out how her brother was. At 5:15 pm, the man was moved to the ICU. That evening he had a CT scan and remained in the ICU. The following morning the department decided to withdraw the man's life support. His sister was informed of this development by the nurse on the telephone. The man was pronounced dead at 8:54 am. The prison officer on bedwatch had stayed with him throughout. The nurse contacted the man's sister at 9:02 am.

Issues considered during the investigation

Record keeping

The man's history sheet has very infrequent entries and the last one was written on the 19 November. In one case nearly three months lapse between entries. It would not have been possible for any objective assessment to have been made about the man given the scarcity of entries.

The NOO and the officers who saw him at 2:42 am on the night of the 12th made no record of their visit in the wing observation book, his history sheet or the night orderly officer book.

The nurse did not complete an entry in the man's medical record about seeing him at that time or her diagnosis.

The Incentives and Earned Privileges Scheme (IEPS)

At the time of his death the man was on standard level of the IEPS. Examination of the paperwork indicates that he applied for enhanced level but was not successful in his application. This is clearly an issue about quality of life rather than one seen to have a direct impact on his death. However, given that he was an elderly man on a long sentence, it was important to explore the issue and his lack of progress to enhanced level is of concern. Furthermore the HMIP report (2004) noted that the prison had recognised that the scheme required a thorough review which it had started to develop. However, it noted that *'there was no consistency across the wings in the standards required from prisoners or how suitability to be upgraded was decided'*. They also found *'evidence that IEPS reviews were not held regularly'*.

When the man completed his first sentence planning document in HMP Nottingham in November 2003 he was set the target of gaining enhanced level by December 2003. His core records indicate that on 25 March 2004 he had applied for enhanced but was not successful. The entry written on his application by his personal officer states *'Although his behaviour is acceptable and he gets on with his peer group I need to know him for a bit longer before I can recommend him for enhanced'*. The entry in his wing sheet says *'enhanced paperwork done, not at this time'*. The man had been introduced to his personal officer on 3 January 2004. According to Bullingdon's policy *'all prisoners will receive a regime review every four weeks'*. There is no evidence to suggest that he was subject to any reviews. He had additionally been excused from attending any offending behaviour courses until his hearing aids had been fitted.

The cell

It is not known for how long the man lay on the floor of his cell before he was discovered. If the cell had been fitted with a floor level cord for the cell bell he may have been able to draw attention to himself earlier. Bullingdon commendably continues to develop facilities and systems specific to the needs of an ageing and infirm population. This physical alteration may be something to give consideration to in some of the cells.

Family contact

The man's next of kin spoke with my family liaison colleague on 12 January 2005. At this stage, one month after he had died she stated that she had had no contact from the prison. She had not been aware that her brother was in prison as the man had been estranged from his family. According to the man's sister she was informed by the police that her brother was in hospital a few hours before he died. She then had contact with the hospital and described them as extremely helpful.

Our liaison governor informed my investigator that an offer was made via the hospital for the man's sister to visit before the life support machine was turned off. An incident report by the duty governor indicates that he spoke to her although this does not concur with her account. The reason for the discrepancy is not clear. Given that the man was the responsibility of the prison it would be expected that they would take the initial lead in contacting the next of kin rather than delegating this task to the hospital or the police.

When my investigator asked about contact with the next of kin she was told that the prisoner had no next of kin listed but they had made enquiries and discovered he had a sister. This is surprising given that the man's sister's details appear in his core records and are present on the LIDS system. She was also told that a governor was acting as the family liaison person and she contacted him. However, he told my investigator that he did not know anything about this. When she again contacted the duty governor on 6 January he stated that he would 'act as liaison person'. My investigator informed the prison on 14 January that the man's sister had said that she had no contact with the prison. This does not appear to have prompted any contact from the prison to the next-of-kin.

The man's sister said that she tried to contact the prison by telephone on a number of occasions without success. She was concerned about her brother's possessions and whether financial assistance was available for the funeral. She was advised by my family liaison worker to contact the Governor by letter.

On April 15, she confirmed that she had eventually made contact with the prison and had received the funeral costs. She had also had her brother's bank card and watch sent to her.

Notice to prisoners

The notice put out to prisoners informing them of the man's death indicates that he was found unconscious in his cell. A neighbouring prisoner contacted my investigator to say that he had heard him talking to staff whilst being treated. Examination of the medical record reveals that he did indeed respond to staff when treated in his cell. This was an unfortunate error.

Findings and conclusions

There are very few entries on the man's history sheets including no evidence of regime reviews.

The governor should remind staff of the need to complete entries regularly in prisoners' history sheets including regime reviews in accordance with the prison's own policy. An internal audit should be undertaken to ensure compliance.

During the night that the man was seen by the night orderly officer and the nurse no record was made in either his medical records or in the various logs.

The governor should remind all staff of the need to complete the appropriate records when engaging with prisoners.

In accordance with PSO 2710 consideration should be given to communications with the deceased family. In this case contact between the prison and the man's next of kin was very poor.

The prison should have some specially trained family liaison officers to oversee and conduct all family contact to ensure compliance with PSO 2710.

Recommendations

The governor should remind staff of the need to complete entries regularly in prisoners' history sheets including regime reviews in accordance with the prison's own policy. An internal audit should be undertaken to ensure compliance.

The governor should remind all staff of the need to complete the appropriate records when engaging with prisoners.

The prison should have some specially trained family liaison officers to oversee and conduct all family contact to ensure compliance with PSO 2710.

From the clinical review:

Entries in the patient's medical records should comply with standards of record keeping of the relevant professional bodies. All changes in patient's condition, consultations, treatments and outpatient appointments should be documented in the medical record. The medical records should be audited in partnership with the PCT on a regular basis.

All relevant previous medical history should be obtained if possible from other health providers with the prisoner's consent.