Investigation into the circumstances surrounding the death of a man in a hospice whilst a prisoner at HMP Chelmsford, in September 2005

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

February 2006

This is the report of an investigation into the death of a man who died in a hospice at the age of 83, whilst on remand at HMP Chelmsford.

I offer my sincere sympathy and my condolences to his family for their loss.

My office investigates the deaths of all prisoners in custody, including those due to natural causes. In this case, the investigation was carried out by two of my investigatorsThey asked the chief executive of the local Primary Care Trust (PCT) to commission an independent clinical review. The clinical reviewer's assistance is much appreciated. I am also grateful to the Governor and clinical nurse manager of Chelmsford for their assistance during the investigation.

I note the clinical review identifies a number of learning opportunities for Chelmsford and hope that the healthcare manager and PCT will see these as such, and use them to further develop and improve their healthcare services for prisoners.

During his time at Chelmsford, the man who died was well cared for. Staff in the healthcare centre liaised with other healthcare agencies to ensure he received appropriate, sensitive and timely treatment. I commend the Governor and his team for the sensitive care and management of the man in the final stages of his illness.

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

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Summary

1. The man was born on 10 November 1921 and died at the age of 83 in September 2005. He spent the last 11 months of his life on remand at HMP Chelmsford. During this time, he suffered a decline in his physical and mental health and spent many weeks in hospital. Five days before his death, he was transferred to a local hospice where he lapsed into unconsciousness and died.

2. On 9 October 2004, he was remanded into custody having been charged with attempting to murder his wife. He had made two attempts to take his own life after the attack on his wife. When he arrived at HMP Chelmsford, a number of the documents that had been sent with him flagged up his suicide attempts.

3. This was the man's first time in prison and he was initially very distressed. In spite of this, he told staff that he did not intend to harm himself. However, staff decided to open a 'self harm at risk' document that meant he would be carefully watched and supported. This remained in place until four weeks before his death, by which time he was physically very frail and receiving 24-hour nursing care.

4. When he arrived at Chelmsford, the man had a number of health problems, mostly associated with his age and these were treated appropriately and in a timely manner. However, in March 2005, his health deteriorated very markedly. Over the next three months, he spent many weeks in hospital where his symptoms were investigated and treated. In June, he was diagnosed as having a fistula (a hole) between his bowel and bladder. The surgeons decided not to operate to repair the fistula because the man was so frail and weak. Also, the man did not want to have the surgery.

5. He returned to prison where the medical and nursing staff did what they could to make him comfortable and keep him pain free. On 3 September, he was admitted to a hospice where he died five days later.

6. The clinical review makes four recommendations and highlights an example of good practice, all of which I thoroughly endorse.

The investigation process

7. My investigators opened the investigation by letter and then visited HMP Chelmsford on 5 October. They met the Head of Healthcare, a member of the Independent Monitoring Board and the chairman of the local branch of the Prison Officers' Association. The clinical nurse manager showed them around the healthcare centre. They also received copies of the man‘s prison and medical records.

8. One of my Family Liaison Officers contacted the man’s family to ask if they wanted to raise any issues about the man’s time in prison. No issues were highlighted.

9. A clinical review of the health care the man received was carried out by a member of the local PCT. Her report is at Annex 1.

Background

The man who died

10. The man died at the age of 83, from bronchopneumonia (inflammation of the lungs) in a hospice whilst on remand at HMP Chelmsford. He had been arrested on 7 October 2004 and charged with attempting to murder his wife. After the alleged offence, he attempted to take his own life. His only child, a daughter, had died a number of years previously, but his son-in-law kept in touch as did his grandchildren.

11. The man spent most of his time in prison in the healthcare centre. His needs were very different from many of the other patients, most of whom had mental health problems. Staff allowed him to be out of his cell as much as possible, and he spent a lot of his time in the day room reading his newspaper and drinking tea.

12. Staff explored the possibility of transferring him to the Older Persons Unit at HMP Norwich, but this was not possible as it only accepts convicted prisoners and has limited capacity.

HMP Chelmsford

13. Chelmsford is a category B local and Young Offender Institution. Built from 1830 onwards as the county jail, it has been used as a long term category B prison, a young person's prison and, since 1987, as a local prison. Two new house blocks were opened in 1996 to relieve overcrowding.

14. The regime includes provision of education and domestic work in the gardens, laundry and workshops. There is a Samaritans supported Listener scheme in place for prisoners who are in distress or who need to talk in confidence. There is also an Insiders scheme to assist prisoners through the first few days in prison.

15. The healthcare centre is housed in a purpose-built, two storey building that was opened in June 2004. It has 12 in-patient beds and a number of treatment rooms, including a dental surgery and pharmacy. Part of the ground floor houses a mental health day care centre where occupational therapy and psychiatric services are provided. The day care staff are employed by North Essex Mental Health Partnership Trust.

Key findings

16. The man appeared at Chelmsford Magistrates' Court on 9 October 2004, charged with attempting to murder his wife. Whilst there, his solicitor asked that he be assessed by a member of the Community Justice Mental Health Team. The team leader spoke to the man. He informed her that, after the alleged attack on his wife, he tried to hang himself but the rope broke and he fell to the ground. He denied that he had any current intention of harming himself. He said that he was an outpatient of a consultant psychiatrist for older people, but that he was not on any medication. He listed his physical health problems as arthritis of the spine and knees (for which he was prescribed pain killers), high blood pressure and thyroid problems. The team leader concluded that, at that time, the man was not showing signs of mental illness. However, his solicitor later informed her that the man had taken a drugs overdose approximately two weeks earlier. The team leader recommended that a suicide/self-harm warning notice should be opened, and, if he was remanded in custody, he should be admitted to the prison's healthcare wing.

17. The man was remanded in custody until 15 October, and taken to Chelmsford prison. The warrant sending him to Crown Court for trial had a note written at the top highlighting his suicide attempt and then adding, "suicide watch". In spite of the team leader's recommendation, the man was not moved directly to the healthcare centre, as no beds were available. Instead, he was accommodated on D Wing.

18. The continuous clinical record notes that when the man was in reception he spoke at length about his home life. He denied having any thoughts of harming himself. When the process of being put on a suicide and self-harm watch was explained to him, he said that he did not want this as such thoughts were furthest from his mind. He was referred to a doctor to have his medication prescribed.

19. However, a further entry at 11:30pm that evening described the man as extremely upset and wanting to stay on the landing outside his cell all night. The officer who made the entry attributed this to the fact the man could not cope because it was his first time in prison. The member of healthcare who attended D wing contacted the doctor who prescribed a sleeping pill for the man. Soon after taking this medication, he settled down and slept through the night.

20. The following day, a first reception health screen form was partially completed as part of the induction process. It was noted that the team leader's report and police custody medical and medication forms had been received by the prison. Also noted was the fact that the man had recently been treated by his general practitioner for depression. He also told the member of healthcare staff that he suffered from arthritis

of the spine and right knee. It was recorded that the man had a dressing on his forehead, a bandage on his left arm and a bruise on the back of his head. The question, "Do you think there is any reason why you might need to see a doctor?" was given a positive answer, but no reason for this was recorded. Indeed, the remainder of the form was not completed. Therefore, the sections on planned action and fitness for normal location and work appear not to have been considered. Finally, the form has not been signed or dated. These issues are addressed by recommendations in the clinical review, with which I agree.

21. The continuous clinical record recorded his current state of health, and highlighted depression and high blood pressure as problems. The man was referred to the healthcare centre for crisis intervention with a review scheduled for 48 hours later, preferably with a psychiatrist. His current medication was recorded and a review by the doctor was scheduled for later on that week.

22. At this point a F2052SH self-harm at risk form was opened. This document is opened when a prisoner has harmed himself or is thought to be at risk of doing so. There were still no beds available in the healthcare centre and the Governor was informed. Until a bed became available in the healthcare centre, the man was moved to a cell on E wing where vulnerable prisoners are accommodated. A review of the case should be held within 72 hours of the F2052SH document being opened and at least every two weeks thereafter. The man 's first review was held on 11 October, well within the guidelines. The man attended and told staff at the meeting that he was upset at not getting bail, but was more concerned about his wife. The support plan that was drawn up included phone calls to the hospital to check on the condition of man’s wife and to his son-in-law. It also included referrals to the healthcare centre and to day care. Staff in the day care centre provide occupational health and psychiatric services.

23. However, there was still no available bed in the healthcare centre for the man. The clinical nurse manager liaised with the wing staff to emphasise the importance of closely monitoring him overnight. The man was also assessed by staff in the day care centre.

24. On 12 October, the man was assessed by a psychiatrist. He noted that the man was alert and aware of his surroundings but was very upset about his wife. He concluded that the man remained at risk of suicide, should be admitted to the healthcare centre as soon as possible, and should be watched closely. The man was admitted to the healthcare centre later that day. Over the next two days, he slept for long periods, but when awake he chatted easily with the staff. He then returned briefly to E wing, before being re-admitted to the healthcare centre on 15 October. He returned to court that day and was again remanded in custody. He told staff that he was tired after being in court all day and upset at being returned to prison.

25. On 17 October, the man was told of his wife's death and was then put on constant watch. Staff spoke at length with him and continued to watch him closely. Although he showed signs of distress, he did not talk about suicide. A note on the record stated that he had spoken about his wife's death to a member of staff in the day care unit and he felt that doing so had helped him.

26. On 18 October, probation staff in a local probation office sent a Prisoner Warning Notice to the prison highlighting three matters of concern about the man. Firstly, that his wife had died on 16 October. Secondly, that his late daughter's birthday fell on a date shortly afterwards. Thirdly, that the anniversary of her death was in March. Receipt of the letter was noted in the continuous medical record.

27. On 27 October, due to pressure on healthcare centre accommodation, the man was temporarily returned to E wing. However, a week later he was re-admitted to the healthcare centre where he remained for the rest of his time in the prison. Staff noted that he had crying spells and looked disturbed, and they drew up a care plan for him at that point. Over the next few weeks, he began to have a more positive outlook. Staff ensured that the man was out of his cell as much as possible. He spent a lot of time watching television and reading the paper. The prisoners who worked as cleaners in the healthcare centre kept him supplied with cups of tea. He was treated by a doctor for a number of illnesses, including a urinary tract infection.

28. As the date of his wife's funeral approached, staff noted in his records that the man would need lots of emotional support before and afterwards. The funeral passed without incident. On 13 December, the man attended court where he was again remanded in custody to Chelmsford. By this time, he was facing a charge of murder as a result of his wife's death.

29. On 10 January 2005, the doctor treated him for a bowel problem and then on 14 March he was prescribed medication for a urinary tract infection.

30. In the early hours of 22 March, the man rang his cell bell after discovering that he was bleeding from his rectum. By the time staff opened the door, he was lying on the floor. He was helped onto the bed, given oxygen and an ambulance was called. He was taken to a local hospital, where he was admitted and reviewed by the surgical team. He continued to bleed and was given a blood transfusion. The following day, surgeons attempted a colonoscopy, which is an internal examination of the intestines by means of a fibre optic cable. However, they had to stop the process because the man was losing too much blood. He remained in hospital for further tests which showed that he had diverticulitis, inflammation of the wall of the intestine.

31. He was discharged from hospital and returned to the prison on 4 April. Over the next few days, his medical notes recorded that he was very tired. On 15 April, he told staff it was painful to pass urine, and again two days later. Staff recorded that he was sleeping for longer periods and that he was lethargic. On 19 April, a blood test revealed that his haemoglobin was low, indicating that his body was not making enough red blood cells. The man was taken to hospital for a blood transfusion. Six days later, the hospital doctor informed the prison doctor that the man was anaemic, had an enlarged prostate and possibly acute renal failure. He also probably had an obstructed urinary system and was waiting to be assessed by a urology specialist.

32. The man remained in hospital until 13 May when, against medical advice, he discharged himself. He returned to the healthcare centre at the prison and an outpatient appointment was made for him for 1 August at the hospital. However, by 16 May the man was again unable to use the toilet without pain and on the following day he was re-admitted to the hospital. Over the next two weeks, he had two small operations and other investigations, but the results were not available until 17 June. While waiting for the results, healthcare staff regularly contacted the hospital for information on the man's condition. The clinical nurse manager visited him three times with different colleagues. On the first visit she conducted a 2052SH review along with the prison doctor and the two prison officers who were supervising the man. They noted that the man's mood was low and tearful.

33. On 17 June, healthcare staff were informed that the man had a fistula between his bladder and bowel and that there was a non-malignant tumour in the area. The surgeons discussed the possibility of an operation with the man. However, they were not sure that he was strong enough to have the surgery and the man refused to agree to it. He also refused to have blood tests done that would allow doctors to assess his overall health.

34. On 21 June, he was discharged from hospital and admitted to a hospice through arrangements made by hospital staff. However, as the tumour was not cancerous, the man was unable to remain there and on 27 June he returned to the healthcare centre. The discharge letter from the hospice staff offered to give advice to the healthcare staff if they required it. The hospice staff also said that they would consider re-admitting the man when he reached the final stages of his life.

35. Staff noted that the man was doubly incontinent and a chart was begun to keep a record of his fluid intake and output. After a risk assessment was carried out, staff arranged that:
    - the man 's cell would be unlocked 24 hours a day
    - a care worker would always be present along with another member of staff

- a daily review would be held with the deputy governor and head of healthcare and, whenever possible members of staff from other departments.

The healthcare staff also arranged for the man's family to visit him.

36. On 5 July, one of the nurses on the afternoon shift noted that she had been unable to give the man full nursing care because of staff shortages. The following day, a nurse on the evening shift made the same observation. In order to meet the man's need for 24-hour care, the healthcare manager hired agency care staff to supplement her staff.

37. Over the next two weeks, staff noted that the man was not drinking enough and on 11 July the doctor recorded that he was refusing fluids. Two days later, pressure ulcers were noted. Healthcare staff liaised with the tissue viability nurse and the continence advisor from the local PCT and took advice on how to treat the man. They obtained an air-flow mattress and other equipment to improve the man's comfort. The costs were met from the prison's budget. They looked at the possibility of obtaining cot sides to improve his safety when in bed, but an assessment by an occupational therapist was needed first. The clinical nurse manager tried to arrange this, but was unable to make contact with the staff in the local NHS occupational therapy unit.

38. The man was due to return to court on 20 July. The day before, his solicitor faxed to healthcare staff a copy of a psychiatric report she had commissioned. The psychiatrist had previously seen the man on 9 December 2004, and noted a significant deterioration in his mental and physical health since then. He described the man as “physically frail and dependent” and said that he “cannot sustain his attention and concentration for any period of time”. He concluded that the man was not fit to stand trial. The medical and nursing staff at Chelmsford discussed whether the man was fit enough to attend court the following day. They agreed that he was too frail and faxed this decision to the court and solicitor.

39. In the early hours of 22 July, the man slipped out of bed onto the floor, bruising his left eye. Staff put him back into bed and checked him thoroughly. He had no other injuries. At 11:00am, the prison doctor was given the man's latest blood test results which showed that he had an infection. He contacted the hospital and at lunchtime the man was once more admitted to hospital. Healthcare staff again regularly contacted the hospital for updates on the man's condition and visited him. They kept his solicitor informed of events. On 26 July, hospital staff reported that the man was "very poorly" and was being given antibiotics because he had sepsis, a serious infection of the bloodstream. However, over the next few days, he gradually improved.

40. On 1 August, hospital staff told healthcare staff that the man was no longer on antibiotics and his treatment had been reviewed. They had

decided that he was "not for further intervention and not for any re-admissions". The following day, the ward sister at the hospital told healthcare staff that the man and his family had agreed that he should not be resuscitated if he had a heart attack. The consultant then faxed a letter to the prison confirming this information. The man returned to the healthcare centre later that day. Staff briefed prison management about the man and stressed the decision not to resuscitate. They also informed his solicitor.

41. On 4 August, a 2052SH review was held. The man was sleeping when the review team entered his room. They noted that his health had deteriorated and he now required and was receiving 24-hour nursing care. They therefore decided to close the document.

42. Three days later, the man was again found on the floor of his room. A full physical assessment was carried out, but he had no injuries. The incident occurred shortly after the healthcare assistant went for her break. Staff moved the bed to the wall to make it more secure, and advised the man not to try to get out of bed unaided. An additional note was made that staff were to encourage him to take more fluids, but not to force them on him. For the next four weeks, the man grew weaker. He spent most of his time in bed and slept for a lot of the time. He was regularly encouraged to drink, but by 2 September the doctor noted he was more confused and appeared dehydrated.

43. On 3 September, staff asked the doctor to review the man as he was becoming distressed. He appeared to be in pain - he was restless and was not sleeping. However, when asked by staff, he denied that he was in pain. Staff contacted the doctor at the hospice and he agreed that the man could be admitted at once. By mid afternoon he had been transferred by ambulance to the hospice. Staff informed his family of the transfer. Healthcare staff remained in contact with staff at the hospice and they visited the man two days later, but he was asleep. The following day they were informed that he was now unconscious.

44. On 8 September, the man's family visited him and later that evening, at 9:15pm, he passed away. On 6 October, the prison chaplain conducted his funeral and members of healthcare staff attended the service.

Issues considered during the investigation

The care the man received

45. The man's care during his time in custody began at the police station where he was examined and given medication by a police doctor. At Chelmsford Crown Court, he was assessed by the Community Justice Mental Health Team leader. She highlighted the man's recent suicide attempts and recommended that, if remanded in custody, he should be accommodated in the healthcare centre. After his arrival at the prison, local probation staff alerted prison staff to dates when he might need extra support. I commend these actions as an example of good communication between agencies resulting in good care of a vulnerable person.

46. When the man arrived at Chelmsford, there were no beds available in the healthcare centre. However, the staff on the wing were alert to his distress and worked with healthcare staff to ensure that his first night passed relatively comfortably. For the next month, the man spent as much time as possible in the healthcare centre, until a permanent bed was available for him. Staff acknowledged that his needs were different to many of the other patients and they arranged for him to spend as much time as possible out of his cell.

47. For almost all his time in custody, the man was on a 2052SH document, to give him closer supervision and support to prevent him attempting to harm himself. The review meetings were carried out regularly and according to the guidelines. The staff who attended the reviews were drawn from the team that conducts the reviews in the prison. This provided continuity of care over the months that the document was open. The suicide prevention co-ordinator took part in well over half the meetings and chaired the review when it was decided to close the 2052SH.

Healthcare

48. The man's illnesses were treated efficiently and healthcare staff liaised with a number of agencies to ensure that he received prompt and appropriate care. Once it was agreed that there should be no further surgical interventions, he received constant nursing care. Agency staff were hired to help provide 24-hour nursing, and staff arranged that his cell would always be unlocked. They obtained a specialised mattress to make him more comfortable and sought advice from specialist nurses and hospice staff. However, it is unfortunate that cot sides for his bed could not be obtained as they might have prevented him twice falling out of bed.

49. When the man's condition worsened, staff contacted a local hospice to arrange for him to go there. The speed with which the transfer was accomplished was commendable. The relationship and communication with the hospice was appropriate and timely in the man's case. However, the development of a formal multi-agency policy for the management of terminally ill prisoners would assist in identifying pathways of care and treatment options for future patients.

    The healthcare manager and Primary Care Trust should develop a multi-disciplinary policy for the management of terminally ill patients within the custodial environment.

50. The man received a high level of medical and nursing care from healthcare staff at Chelmsford who ensured that his treatment was prompt and appropriate. But other members of the prison staff also contributed to his care. He was also cared for by the staff on the wings where he spent his first month. The prison's management contributed to caring for him by making special arrangements to allow him to be unlocked for longer periods than usual. The suicide prevention co-ordinator and his team regularly met with the man and discussed how his needs could be met.

    I commend the Governor and his staff for the excellent care they gave the man. The ways in which they met his individual needs are examples of good practice.

51. The clinical review identifies a number of learning points for the healthcare manager and PCT. These should be seen as an opportunity to further improve and develop healthcare services for prisoners.

Records and record keeping

52. Whilst on remand, the man spent approximately 12 weeks in hospital and the hospice. During these times, he was accompanied by uniformed prison officers who were responsible for his security. As part of their duties, they made written observations in two documents:
    - The hospital bedwatch occurrence log
    - The daily supervision and support record.

53. The front cover of the Bedwatch Log reminds officers of the need to ensure that the entries they write are factual and respectful. Most of the entries were well written, and some were very sensitive and caring. However, I was disappointed to read a number of comments by different officers that did not reach this high standard. To make comments of a personal nature is unwarranted and I consider such entries disrespectful and lacking in common humanity. I have separately provided the Governor with a list of the inappropriate comments.

54. The entries in the clinical records did not on occasions meet the standards required by the professional bodies for nurses and doctors. Specifically, they were not always legible, the entry time was not recorded and the name of the author was not printed next to the signature. Healthcare staff should be reminded of the expected standards for clinical record keeping.

    I recommend that staff should be reminded of the need to ensure that entries in prisoner records are accurate, factual, sensitive and respectful.

Recommendations

The healthcare manager and Primary Care Trust should develop a multi-disciplinary policy for the management of terminally ill patients within the custodial environment.

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Good practice

I commend the Governor and his staff for the excellent care they gave the man. The ways in which they met his individual needs are examples of good practice.