

**Investigation into the circumstances surrounding the
death of a man at Frenchay Hospital, Bristol, in June 2006,
whilst a prisoner at HMP Bristol**

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

February 2007

This is the report of an investigation into the circumstances surrounding the death of a man who died from peritonitis, secondary to bowel cancer, in June 2006. He was being cared for at Frenchay Hospital, Bristol, but was in the custody of HMP Bristol. He was 64 years of age.

I would like to extend my personal condolences to the man's family and to all those touched by his death.

The investigation has been undertaken by my colleague. I would like to thank the Governor of Bristol prison and her staff for their co-operation during this investigation. Similarly, I must thank the Governor of HMP Shepton Mallet and his staff for their co-operation. Although he was in the custody of HMP Bristol when he died, the man received care and support from staff at Shepton Mallet during the difficult early stages of his illness before his bowel cancer was fully diagnosed.

Bristol North Primary Care Trust carried out a clinical review of the care the man received during his time in custody, for which I am also grateful.

Unfortunately, the man had not enjoyed good health since early 2005 when he began displaying early signs of bowel cancer. The symptoms of his condition became increasingly unpleasant both for himself and for others. An earlier diagnosis of his cancer might have been possible had he more readily accepted both the extent of his illness and the need for healthcare intervention. However, when he agreed to treatment he received prompt and appropriate medical care both within prison healthcare facilities and in outside hospitals.

I have judged there to have been good practice at both Bristol and Shepton Mallet, and have made a recommendation to both prisons in recognition of the work of healthcare and uniformed staff.

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Prisons and Probation Ombudsman

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SUMMARY

The man was sentenced to life imprisonment for murder in 1963. He was released on life licence in 1989, but returned to prison in 1990 following a conviction for other offences. He had remained in prison since.

The man first complained of bowel problems in January 2005 whilst at HMP Risley. He was treated by a nurse and given medication to settle his stomach. No further health complaints were raised until April 2005 when he was transferred to HMP Shepton Mallet. He began to experience a lack of control over his bowel movements and constipation. He was prescribed Fybogel to ease his symptoms. As his condition worsened, the nature of his illness affected others on the wing. Discipline staff sought advice from healthcare, but little could be done unless the man was willing to see the doctor. Unfortunately, he chose not to co-operate with healthcare nor address his worsening health and hygiene problems.

In mid June 2005, it came to light that the man had stopped taking his Fybogel. He began experiencing abdominal pain, dehydration and asked for laxatives (despite saying he was not constipated). He was reminded of the importance of taking his medicine, but continued to suffer with occasional stomach pains during June and July.

Nothing further was reported until December, when his problems worsened. A case conference was held between discipline and healthcare staff to discuss a possible course of action. Healthcare made it clear that nothing could be done unless the man sought help or consented to it. He continued to deny that he had a serious medical problem. His health deteriorated and he suffered from frequent bouts of faecal incontinence. Discipline and medical staff acquired a wipe clean hospital mattress, incontinence pads and pants, as well as soluble bags for handling his dirty laundry. Although staff persisted in encouraging the man to allow them to help him, he was uncooperative and continued to decline.

It was not until late March 2006, when he became increasingly frail, that he agreed to a doctor's appointment. However, he did not attend the first appointment. A health and safety assessment was undertaken to develop a plan to best manage the hygiene risks to staff and fellow prisoners. When the man was seen by the doctor on 29 March, he was having difficulty walking, had sores around his mouth, was slightly jaundiced and in some pain. Blood samples were taken for testing. These revealed that he was anaemic. He was given iron supplements and ointment for his sores.

On the evening of 2 April, the man was very weak and displayed bizarre behaviour. He tied himself to his chair and refused to shower. A nurse assessed that he was dehydrated and anaemic. He was admitted to the Royal United Hospital in Bath, where he was diagnosed with advanced bowel cancer. It was decided that the cancer was currently inoperable and he would need either radiotherapy or chemotherapy to reduce the size of the tumour before surgery could be considered. Discussions were held between Shepton Mallet and the hospital regarding discharging him to an establishment with 24 hour healthcare whilst he received treatment before surgery. HMP Bristol was suggested as the most practical option due to its close proximity to the hospital.

There was a delay in transferring the man until healthcare staff at Shepton Mallet established with Bristol North Primary Care Trust that the cost of his care would be covered. HMP Bristol then agreed to accommodate the man on their healthcare wing and he was discharged from hospital to Bristol prison on 13 April.

The following week, he developed swelling and bruising to his right leg. He was admitted to Frenchay Hospital on 21 April for tests. He was advised that he needed an operation to insert a filter into his vein to support his kidney which was being pressured by the tumour. On 11 May, the man had a laparoscopic assessment of his tumour and a loop ileostomy at Southmead Hospital. He also had a colostomy bag fitted. The operation to support his kidney was scheduled for 23 May.

The man was discharged from hospital back to Bristol prison on 26 May with a schedule for chemotherapy appointments. On return, he refused to engage properly with healthcare staff and he was taken back to hospital on 31 May when his condition deteriorated after he had refused all treatment. He was transferred to Frenchay Hospital the same day and admitted to the Macmillan hospice ward where he was treated for dehydration. The man was very weak, frail and unable to walk. The prison was told that he was terminally ill and that they should obtain his next of kin's details. However, the man did not want his family to be contacted.

Although Bristol prison was responsible for the man's security, Shepton Mallet still maintained custodial responsibility. The lifer unit at Shepton Mallet began preparing paperwork for his early release on compassionate grounds. During the first week of June, doctors advised Shepton Mallet that the man did not have long left to live. It was agreed that he would remain at hospital for palliative care and that the application for compassionate release should be continued. Sadly, the man passed away before release could be finalised.

THE INVESTIGATION PROCESS

The investigation was opened at HMP Bristol on 29 June 2006 by my investigator. She visited the prison and met with the Governor. All paperwork relating to the man, including the post mortem report, was made available for my investigator. Unfortunately, the post mortem report gives an incorrect date of death.

On examining the man's medical record, my investigator noted that HMP Shepton Mallet had provided the majority of his medical care during 2005 and 2006. She spoke with the Governor at Shepton Mallet to inform him that her investigation would consider the care the man received at both Bristol and Shepton Mallet prisons.

My investigator asked both Governors to display notices of the investigation at the prisons inviting anyone with information or concerns about the man's death to contact her. No one from either prison came forward with information.

A clinical review of the man's care was undertaken by Bristol North Primary Care Trust. The clinical reviewer provided a brief review which can be found at Annex 3. More detailed information obtained by my investigator about the man's medical history and treatment is contained within what I have written in this report.

Both my investigator and the clinical reviewer concluded that it was not necessary to interview staff at either Bristol or Shepton Mallet as there was sufficient comprehensive paperwork to complete the investigation.

The man's family was contacted by one of my family liaison officers. She spoke with the man's niece, who was listed as his next of kin. She said that she would inform the rest of the family of my involvement and that they were grateful for contact being made. She said that they would not want a visit from my office. The family raised no issues or concerns to be addressed during the investigation.

HMP BRISTOL and HMP SHEPTON MALLET

HMP Bristol

HMP Bristol is an inner city Victorian prison located in the Horfield area. It first opened in 1883. Bristol is a category B prison with an operational capacity of 606. Accommodation is a mixture of Victorian galleried landings, with B and C wings being a t-shaped closed landing. There are seven wings in total:

- A wing – Induction, detoxification, first night centre
- B wing – Lifer unit
- C wing – Voluntary drug testing unit
- D wing – Safer custody/vulnerable prisoner unit
- E wing – Segregation unit
- F wing – Prisoners' drug intervention programme
- G wing – General wing

There is also a healthcare unit with 20 inpatient beds. The healthcare centre was refurbished and reopened in June 2004. It is situated in a block shared with the segregation unit. Although the area is clean, well furnished and provides a therapeutic environment, there is limited disabled access as it is reliant on stairs.

Her Majesty's Chief Inspector of Prisons (HMCIP) carried out a full announced inspection of the prison in January 2005. At the time of this inspection, it was noted that healthcare at Bristol had improved considerably. However, the healthcare service was fragile and there continued to be management and staffing issues which adversely impacted upon the delivery of care.

There have been nine deaths in custody at Bristol in the last two years. None of the issues or recommendations raised during investigations into these deaths are relevant to this report.

HMP Shepton Mallet

HMP Shepton Mallet is the oldest prison in continuous use in England and Wales. In August 2001, it became the first dedicated category C prison for life-sentence prisoners and has an operational capacity of 189.

The 2005 HMCIP report recorded that prisoners were very positive about all aspects of healthcare at Shepton Mallet. Healthcare staff were described as well qualified, professional and caring. They had responded well to the healthcare needs of the lifer population, many of whom were older with long-term chronic conditions.

The healthcare unit is very small and has no inpatient facilities. However, there is good access to primary care and an appropriate range of visiting specialists. The healthcare unit is well integrated with Mendip Primary Care Trust (PCT), with evidence of an effective joint working at both strategic and operational levels.

Shepton Mallet has had three deaths in custody during the last two years. Investigations undertaken by the Ombudsman's office have not raised any issues or recommendations relevant to this report.

KEY EVENTS

Events leading up to the man's death

In the man's earlier years in custody there were no significant medical problems noted in his record, apart from loss of hearing in his left ear and asthma. He had no ongoing prescribed medicines. The first mention of problems with bowel movements was on 28 January 2005 when he complained of stomach and abdominal pains with frequent, sudden bowel movements. On this occasion, he was seen by a nurse and given paracetamol and magnesium trisilicate to settle his stomach.

On 26 April 2005, the man was transferred from HMP Risley to HMP Shepton Mallet. His first health screen check raised no medical concerns. Two days later, he was seen by healthcare staff due to excessive bowel movements over which he had little control. He was not prescribed any medication, but a doctor's appointment was made for the following day.

The man was seen by the prison doctor on 29 April. A stool sample was taken and sent away for tests. A follow-up appointment was made for 4 May. The medical notes for this day say that the doctor was still awaiting the test results.

The man's problem started to worsen. An entry in a F2052A (record of events) by his personal officer on 21 May notes that the man was having difficulty sharing a cell. The nature of his apparent illness was "[making] life hard for anyone who goes in with him". Wing staff reported to healthcare on 26 May that he was using two toilet rolls per day and asked whether a doctor could visit him in his cell to assess the situation. The nurse advised that this was not appropriate action and he would have to be seen in the healthcare centre. An appointment was made for that day. On seeing a nurse, the man explained that he needed to use the toilet very frequently and that his bowel movements were watery in consistency and had an offensive smell. His previous stool sample showed no infection, so it was suggested that he had constipation. The prison doctor was consulted and the man was prescribed with Fybogel to be taken 2-3 times a day. A follow-up appointment was made with the doctor for 1 June. However, the man did not attend on 1 June, but did have an appointment on 7 June where he reported that his problem had improved after omitting dairy products from his diet.

On 15 June, the man experienced severe abdominal pain. He was seen by healthcare and it was noted that he was dehydrated but had good bowel sounds. The man asked for laxatives, although said he was not constipated. It emerged that he had not been taking his Fybogel as prescribed. He was reminded of the process for applying for repeat prescriptions. A month later on 15 July, and again on 23 July, he went to healthcare complaining of stomach ache and suspected food poisoning. On the first occasion, he was prescribed Gaviscon and on the second a stool sample was taken. There is no reference in his medical record to the results of this sample.

The man did not attend the healthcare centre between July and December. He missed three asthma clinic appointments and declined a flu vaccine. There are no entries in his record of events book (F2052A) relating to his illness until 3 December when an entry by his personal officer suggests that the man had recently soiled

himself in front of other prisoners. This entry also alludes to his bowel problem causing an offensive smell which affected the wing as a whole. The man was asked to keep his cell window open to minimise the discomfort to others.

A case conference was held on 9 December between a Principal Officer, an Officer and a Nurse to discuss the implications of the man's ill health on staff and fellow prisoners. The man was in denial regarding his condition and insisted that it was not a medical problem. He had not been collecting or taking his prescribed medication and could not see the value in complying with the suggested course of treatment. During the meeting it was agreed that an officer would collect the man's Fybogel and encourage him to start taking responsibility for his health and personal hygiene. The man began retaking his medicine on a daily basis from 19 December. On 22 December, he soiled his bedding. His condition was not improving. Despite this, he did not attend healthcare.

On 10 January 2006, a governor requested a further case conference be held to discuss the man's ongoing health and hygiene problem. A conference was provisionally booked for the following day; however this was adjourned on news of the man's mother's death. He was informed and offered support (which he declined). Shortly afterwards, he told wing staff that he was not going to take his medication any more. He felt it was a "waste of time". My investigator found no follow up on this comment by wing staff or healthcare at this stage in any of the man's records.

The following week, the man asked a wing officer for another pair of jeans. He was wearing only an overcoat as he had soiled his last pair of trousers. It was noted that he was spending increased amounts of time on the toilet and frequently soiled himself. The atmosphere around his cell area continued to affect others on the wing. Two days later, an Officer spoke to the Head of Healthcare regarding the man's worsening situation. Again, it was stressed that he needed to make an appointment with the doctor and could not be forced to have treatment.

Following a complaint made to healthcare by wing staff on 27 January, the Head of Healthcare sent a letter to the man inviting him to make an appointment with the doctor. The letter also explained to him that staff were concerned about his personal hygiene. She suggested that his current treatment did not appear to be alleviating the problem and that he should not try to manage his problem without help. It was recommended that he see the doctor and perhaps a specialist to determine a different course of action. The Head of Healthcare said that healthcare staff would look out for his appointment request and ensure that it was dealt with urgently. The man did not accept this offer.

On 4 February, a new system was put in place for managing the man's laundry. Soluble bags were acquired for transferring his soiled clothes to be washed. This was to stop him from washing clothes in his cell and drying them on the radiator. He was told that this was an unacceptable way to clean his clothes as it caused a smell. He accepted this without complaint.

The Director of Operations at Mendip Primary Care Trust was asked to speak with the man when she was at the prison on 6 February. Unfortunately, he refused. (My

investigator spoke with the Head of Healthcare about this incident. She explained that the man remained firm in not engaging with any healthcare person and was often very abusive to staff when they tried to talk to him.)

Wing staff became increasingly concerned about the man's level of personal hygiene and began to raise questions about the health and safety implications. Again, staff spoke to healthcare about what measures could be taken. The message remained consistent that nothing could be done without the man's willingness to engage. On 19 March, the situation was brought to the attention of the Governor. Officers from the wing stressed that living conditions were difficult for both staff and fellow prisoners whilst the man refused to address his ill health. The Governor was told that staff had done everything they could to encourage him to help himself, but the situation continued to escalate. It was suggested to the Governor that the man's allocation to Shepton Mallet was "totally unsuitable". My investigator found no reference in the man's records to suggest that any consideration was given at this point to transferring him to another jail.

The man's health deteriorated further. On 23 March, he was incontinent of faeces in the wing kitchen. Fellow prisoners cleared up the mess. A governor reported what had happened to healthcare, and a nurse noted in the man's medical record that fellow prisoners should not have been required to deal with the matter. A further letter was sent to the man inviting him to make an appointment with the doctor to address his ill health. The following morning, he fell and grazed his head. This was reported to healthcare by an officer. The doctor came to see the man on the wing that afternoon and found him to be dehydrated, weak and frail. He encouraged the man to take fluids, have his urine tested and take bed rest.

A doctor's appointment was scheduled for 27 March, but the man did not attend. A nurse went to visit him in his cell later that afternoon. The record gives no indication why the man did not attend. However, a further appointment was made for 29 March with the doctor and another one for the Well Man Clinic on 30 March. The man told the nurse that he was managing to collect own his meals, despite wing staff's concerns that he was generally unsteady on his feet. He preferred to do this as he did not trust staff to bring them to him. (This comment was not elaborated on.) The nurse noted that, although the man's cell smelled, it was clean and tidy.

During the morning of 28 March, the man was incontinent of faeces on a chair whilst having his hair cut by a fellow prisoner. A governor phoned healthcare at the request of wing staff. They wanted a case conference to discuss how best to deal with the man's health problem. The man was also spoken to by an officer regarding his personal hygiene. He told the officer that he slept in his clothes to prevent soiling his bed during the night. The man was told that a wipe clean hospital mattress had been ordered for him.

Later that day, a health and safety risk assessment was conducted for staff and prisoners who came into contact with the man. The evaluation focussed on the following:

- physical contact
- dealing with contaminated clothing

- dealing with contaminated showers and other communal areas
- the man's mental state and age
- risk of hepatitis A, B and C.

It was recommended that contaminated clothing should be placed in biohazard disposal bags and that the man be provided with incontinence pads and pants. This plan was to be reviewed after one month with a view to discussing a possible relocation to another prison better equipped to provide the level of care he needed. (This assessment was not signed.)

The following morning (29 March), the man was seen by the doctor. It was noted that he had a pale pallor and mouth ulcers. The doctor recommended that he have further blood tests. Blood samples were taken by a nurse. Whilst she was with him, the man became incontinent of faeces. She examined him and found that he was slightly jaundiced and had sores around his mouth. He was weak, in pain and was having difficulty walking. The nurse discussed her examination with the doctor who was content to wait for the blood test results before suggesting treatment. The man was supplied with a walking stick. Later that afternoon, a principal officer from the wing rang healthcare for an update on the man's situation. He was told that healthcare could not discuss anything in detail due to patient confidentiality. However, he was advised that a hospital referral had been sent and that blood test results would be known later that week.

The blood test results were made available on 30 March. The man was anaemic. He was given iron supplements (ferrous sulphate) and prescribed fucidin ointment for the sores on his lips. During that morning, a nurse was called to see the man in his cell after another bout of faecal incontinence. The man agreed that it would be a good idea for him to wear incontinence pads. He also consented to healthcare contacting an incontinence advisor. The nurse explained to him that his iron levels were low and that was why he was feeling weak. She assured him that the supplements would make him feel better. Officers on the wing were also informed that the man was weak and that he would need help collecting his meals. He was registered with Frome Hospital's incontinence service for a supply of pads and pants. He was supplied with a wipe clean hospital mattress on 1 April.

On the evening of 2 April, the duty nurse was contacted three times between 5pm and 7:30pm for advice on how to deal with the man's incontinence. On the last occasion, he had refused to leave his cell for a shower and had tied himself to a chair. The nurse went to the man's cell and found him to be frail, weak and displaying bizarre behaviour. She felt that he needed to be admitted to hospital as he was probably dehydrated and anaemic. The doctor was contacted for advice. He concurred with the nurse and the man was admitted to the Royal United Hospital in Bath. There he was quickly diagnosed as having bowel cancer and would need to remain in hospital for the foreseeable future. The nurse telephoned the hospital for an update and was told that he was receiving intravenous fluids and had constant uncontrollable diarrhoea. He was to have a MRI scan of his rectum, an ultrasound of his liver and a biopsy of a tumour. The nurse began making enquiries for organising palliative care should he return to Shepton Mallet. The Head of Healthcare asked prison senior staff to look into early release from prison on compassionate grounds.

On 6 April, healthcare staff were updated at length by the man's consultant. A malignant ulcer had been found in his lower rectum and discussions were being held to see if it was operable. It was thought that he would need radiotherapy prior to any surgery, and either radiotherapy or chemotherapy afterwards. The consultant did not think palliative care was needed at this stage.

The man was not happy with the prospect of surgery. Healthcare staff at Shepton Mallet were reassured by the hospital that they would try and encourage him to consent to treatment. On 7 April, the hospital contacted Shepton Mallet to discuss discharging the man to an establishment with 24-hour healthcare inpatient facilities whilst he prepared for surgery. He would need to return to the hospital for regular chemotherapy appointments. Although the man was able to manage reasonably independently at this time, he still needed assistance in washing at least every two hours. The most suitable prison was thought to be HMP Bristol as it was closest to the hospital, has 24-hour healthcare and in-patient beds. The suggestion was discussed with the Duty Governor at Shepton Mallet who agreed to speak with the healthcare centre.

Shepton Mallet spoke with Bristol's healthcare manager the same evening. However, Bristol was unable to take the man at this time, as the prison was subject to a nightly lock-down between 5pm-8am. As a consequence, he would not have received 24-hour care. As the man could need blood transfusions during these hours, it was decided that transfer to Bristol prison would not be suitable. Instead, nursing staff at the Royal United Hospital agreed to continue monitoring him and to develop a care plan in order to revisit the suggestion with Bristol prison at a later date. The discussion between the Royal United Hospital, Shepton Mallet and Bristol continued over the next few days. Bristol remained uncertain and was concerned whether there was funding available from the Primary Care Trust (PCT) to provide the man's care. A GP at Shepton Mallet, agreed to look into the funding situation with the PCT.

The man's condition remained the same. On 11 April, he was seen by an oncology team to discuss whether he would receive radiotherapy or chemotherapy. Surgery was now imperative. He was made aware of the urgency and told that he would need a colostomy bag after the operation. The oncology team wanted him to convalesce for up to a fortnight before treatment began. Attempts were made to find him a bed in a community hospital, as the issue of PCT funding for Bristol prison was still unresolved.

On 12 April, a nurse at Shepton Mallet received an update on the man's condition from the hospital. Although he was a little more independent (mobile, yet unsteady, and he could use the commode and maintain hygiene to a certain degree), he still needed some nursing intervention. He would become weaker during the course of treatment. The hospital agreed with the nurse that an establishment with 24-hour healthcare facilities would be required. A GP at Shepton Mallet then telephoned Bristol North PCT who confirmed that there would be no funding problem if the man was accepted at Bristol prison. She passed this information to the healthcare manager at Bristol, who then agreed to take the man. The next day, he was discharged from hospital and transferred to Bristol where he was located within the

healthcare unit. He settled in quickly and was on the whole calm and co-operative in his new environment.

Over the next week, the man developed a swelling and some bruising on his right leg. He was to keep his legs elevated, but also walk when possible.

Healthcare staff began to make enquiries with St Peter's Hospice in Brentry about palliative care for the man. A referral form was completed and faxed on 21 April. On the same day, he was admitted to Frenchay Hospital in Bristol with possible deep vein thrombosis. He was taken to hospital with escorting officers who would remain with him on bedwatch duty. The man was required to wear cuffs and restraints as he was relatively mobile and there was a need to comply with normal security measures. On 22 April, healthcare staff rang the hospital for an update on the man's condition. They were advised that doctors were trying to determine whether the swelling was a result of the cancer or a deep vein thrombosis. He was to remain in hospital for the foreseeable future.

The man was seen by the colorectal surgical team on 24 April. He was told that he would need an x-ray and a scan before they could make a decision to operate. Both were done that afternoon and the results were available on 27 April. The decision was taken to operate. On 2 May, the consultant surgeon advised the man that they would be performing two operations. One would be to insert a filter into his vein to support his kidney which had come under pressure as a result of the tumour. A second would be to insert a loop ileostomy. This would remove part of the large bowel. He would need a colostomy bag afterwards. These procedures would be carried out at Southmead Hospital. Post-operation, he would receive six weeks of chemotherapy to reduce the tumour in preparation for further surgery. The prison was informed and he was escorted to Southmead the following day.

The man was anxious about having surgery. He became agitated and occasionally unco-operative with nursing staff, usually by refusing to have blood samples taken. However, on 11 May he underwent a loop ileostomy and a laparoscopic assessment of his tumour. A Principal Officer visited him that afternoon. As he was still wearing restraints, the Principal Officer spoke with the Orderly Officer at the prison regarding the level of security. He was told that the restraints could be removed whilst the man was recovering, but that they should be reinstated once he became more active. The cuffs were then removed and reapplied at 9:30pm.

By 15 May, doctors were encouraging the man to become more self-sufficient in managing his colostomy bag. When he was advised that he would need to remain at Southmead for the next fortnight for a second operation, he became distressed and tearful. Whilst in the hospital, the man was visited by staff from Bristol to receive updates on his condition and to offer support. He did not ask for his family to be contacted at any time.

His second operation was scheduled for 23 May. After the surgery he was generally quiet but in some discomfort. A schedule of future chemotherapy appointments was sent to the prison to make arrangements for bringing him back to the hospital.

The man was discharged from Southmead Hospital back to Bristol on 26 May. The care plan issued by the hospital stated that he:

- had a urinary catheter
- was mobile, but unwilling to walk
- had a colostomy bag that he was capable of changing without assistance
- could manage his own hygiene needs, but was reluctant to wash
- took paracetamol, ferrous sulphate 200mg, fortijuice and warfarin
- could be verbally aggressive and did not want to leave the hospital and become more independent.

On return to prison, the man was located in cell 12 in the healthcare unit. He was not willing to positively engage with staff. On 31 May, he refused all treatment from the nurses. At this time, his condition had deteriorated. He was vomiting and suffering with abdominal pains. A nurse contacted the Orderly Officer with a view to taking the man back to hospital. He was transferred to Frenchay Hospital at 5pm and admitted to the Macmillan hospice unit where he was treated for dehydration. Due to his condition, the man was not required to wear restraints. He was weak, terminally ill and not capable of walking. He was asked whether he would like his next of kin contacted. He did not wish for this, but the prison nevertheless (and sensibly) obtained his listed next of kin's details from Shepton Mallet. The man's niece had stipulated that she wanted to be informed if his condition further deteriorated, but did not want direct contact with her uncle.

Although Bristol prison supplied escort staff and managed the man's bedwatch, Shepton Mallet still maintained responsibility for custodial issues. The lifer unit at Shepton Mallet agreed to prepare and implement any paperwork for early release on compassionate grounds should he deteriorate further. Likewise, the healthcare centre would liaise with Bristol's healthcare unit to organise palliative care should it become necessary.

The man remained weak and slept for long periods over the next few days. He continued to receive intravenous fluids for his dehydration and his pain was managed through a syringe driver. Early in June, he was assessed by doctors who told the prison that he probably had days left to live. A multidisciplinary case review was held two days later. It was agreed that he could remain at hospital but that escort arrangements should be reviewed. This was discussed with Bristol's Governor who was happy for a new bedwatch risk assessment to take place. In addition, the healthcare manager at Bristol liaised with Acting Principal Officer at Shepton Mallet to start procedures for early compassionate release. The application would need to be supported by the man's consultant.

Following the bedwatch risk assessment, the man's restraints were removed but two officers remained with him. Later that evening, he was given an injection to stop him feeling nauseous and told to remain in bed and rest.

The day after the bedwatch risk assessment, the man's consultant completed the medical section of the application for early release on compassionate grounds. This was returned to Shepton Mallet. The consultant wrote that the man was terminally ill

and unlikely to live longer than a month at the most. His condition was further deteriorating on a daily basis.

Sadly, the man died in June - before the application for compassionate was finalised.

Events following his death

Bristol prison was informed of the man's death half an hour later at 9.30pm. In accordance with the local contingency plans for a death in custody, the Governor and the Area Manager were informed by the Duty Governor at 9:45pm.

The care team and chaplain were contacted to provide support to staff and prisoners. The local police were also advised. The escort staff who had been with the man were transferred to another bedwatch in the hospital. They were consulted beforehand and were happy to do this.

The Duty Governor at Shepton Mallet was told the following day. He was asked to inform the man's next of kin as Bristol only had the first name and telephone number for his niece. The Duty Governor declined as they did not have any additional information. However, he issued a notice to staff and prisoners informing them of the man's death. An Inspector from Avon and Somerset Constabulary confirmed that it was not the responsibility of the police to inform the man's next of kin as he had not died in prison.

In the event, the Duty Chaplain at Bristol telephoned the man's niece. She was grateful to be informed of his passing and offered to tell the rest of her family. Beyond this, neither she nor the rest of the family wished to be contacted by the prison or anyone else regarding the man's death or the funeral arrangements. The duty chaplain made the funeral arrangements. It was decided jointly by the Chaplain and the Governor that, as the man had not been at Bristol for very long and was not known to many prisoners there, a memorial service would not be held.

A staff debrief did not take place at Bristol prison. It was not considered necessary as man's death had taken place after long periods in an outside hospital and with little involvement from the prison.

A post mortem took place in June. The pathologist concluded that the man had died as a result of peritonitis which had been caused by the perforation of the cancerous tumour in his bowel.

CLINICAL REVIEW

The clinical review was undertaken by Bristol North Primary Care Trust (PCT). The clinical reviewer is a full time GP Principal. He is also the Clinical Governance Lead at Bristol North PCT. I summarise his findings below.

The man first presented with symptoms of bowel cancer as early as January 2005. The diagnosis was made in April 2006 during a hospital admission. By this time the cancer was inoperable.

The cancer perforated at the end of May leading to a rapid deterioration of his condition and his death.

There was a long period of time between the presentation of the initial symptoms of bowel cancer and its diagnosis. This was despite the best efforts of both discipline staff and the healthcare team to help the man.

Concerns were raised on many occasions by the discipline staff about personal hygiene and faecal incontinence. However, the man refused to engage and would not involve the healthcare team. In this situation, it was not possible to force him to do so. It was only when he became weak due to dehydration and anaemia that he was admitted to hospital and then fully diagnosed.

The delay in diagnosis was unavoidable due to the difficulty in engaging with the man. His care in Shepton Mallet, Bristol and the local health providers was of a high standard and raises no clinical concerns.

The clinical review makes no recommendations.

CONCLUSION

I agree with the clinical reviewer that it is difficult to see what more either discipline or healthcare staff could have done in their management of the man's illness. He was encouraged on a regular basis to engage with healthcare and to take better control of his health and personal hygiene. Unfortunately, in the absence of his willing co-operation, it was not possible properly to diagnose his condition and he remained on normal location at Shepton Mallet.

However, healthcare and discipline staff did make attempts to accommodate the man's needs during the later stages of his illness. I note that a health and safety risk assessment took place on 28 March 2006 after he was faecally incontinent in the kitchen area. The assessment recommended a plan for dealing with the issue of contaminated waste, minimising contact and preventing a similar situation arising. This led to more appropriate measures eventually being taken to manage the man's condition and lessen the burden on staff and prisoners.

(It is possible to argue that earlier consideration could have been given to conducting such an assessment to help alleviate the consequences of the man's illness for himself and staff and prisoners on his wing. I would also like to echo the concerns of the nurse who commented in the man's medical record regarding prisoners being asked to handle contaminated waste. This is unacceptable practice.)

Even when the man did choose to engage with staff, his willingness to comply remained erratic. He did not take his prescribed medication (Fybogel) on a regular basis and often missed healthcare appointments. This difficult behaviour continued when he was discharged from hospital to HMP Bristol on 26 May 2006. The man refused all treatment from healthcare staff and had to be readmitted back to hospital. It is clear that he did not make it easy for those attending to him, even when his condition was becoming increasingly fragile.

Nevertheless, I wonder whether more could have been done between the two prison healthcare centres to ensure a smoother and quicker transfer when the man needed to be discharged from hospital during April 2006. It took several telephone calls over the period of one week by healthcare staff at Shepton Mallet to establish whether North Bristol PCT would cover the cost of care if he transferred to Bristol. However, it is unlikely that this delay adversely affected the man's care as he remained in hospital whilst the decision took place and this was arguably the best place for him at this time. Once it was agreed that he could be transferred to Bristol prison, this was achieved speedily and there was continuity of care.

The decision to prepare an application for early compassionate release was taken in early June as soon as it was clear that the man's condition was terminal and after medical opinion was given on his likely life expectancy. Appropriate steps were taken, including the completion of the medical section of the application by the man's consultant at Frenchay Hospital which was returned to Shepton Mallet. This is all in accordance with Prison Service Order 6000 (Early Release on Compassionate Grounds). A new bedwatch risk assessment took place a few days later and his restraints were removed. However, two escorting officers remained at his bedside.

Given the man's weak and terminal state, it is arguable that the risk assessment and subsequent removal of restraints could have taken place earlier.

Despite these minor criticisms, overall I would like to commend the staff involved in caring for the man at both Shepton Mallet and Bristol. They tactfully and sensitively dealt with a man who was clearly difficult to care for. In attending to the man, staff were faced with difficult and sometimes unpleasant situations. Comprehensive, respectful, and sensitive records were kept at both establishments, particularly from a healthcare perspective.

The Governors at both Shepton Mallet and Bristol should commend discipline and healthcare staff for their support and patience in caring for the man who died.

RECOMMENDATION

The Governors at both Shepton Mallet and Bristol should commend discipline and healthcare staff for their support and patience in caring for the man who died.

Response to the report

The Governors at both Shepton Mallet and Bristol accepted the recommendation. A notice to staff was issued commending discipline and healthcare staff for their support and patience in caring for the man who died. The notice was published on 7 December 2006.