

**Circumstances surrounding the death of a man in hospital in
October 2006, whilst a prisoner at HMP Channings Wood**

Prisons and Probation Ombudsman for England and Wales

May 2007

This is the report of an investigation into the circumstances surrounding the death of a man on 20 October 2006 in hospital. The man was in custody at HMP Channings Wood. A post mortem was held at the request of the Coroner and it revealed that his death was due to apparent natural causes. The man was 80 years old at the time of his death.

I extend my sincere condolences to his family and friends.

I would like to thank the Governor at Channings Wood and her staff for their help and assistance. As an integral part of the investigation, I commissioned a clinical review of the care afforded to the man. This was carried out by Devon Primary Care Trust.

The man had been ill for many years with heart and lung disease. He had been a hospital in-patient on many occasions. The cause of death was recorded as: ischaemic heart disease due to coronary artery atherosclerosis (single coronary artery bypass graft to anterior descending coronary artery).

I made four recommendations and noted two points of good practice in the draft report. The prison service did not accept one of the recommendations, which they felt was a generic recommendation in relation to the care of older prisoners, rather than specifically focused on Channings Woods. I have agreed to remove this recommendation. The remaining three recommendations were accepted, along with the two points of good practice.

The man's son, on receiving a copy of the draft report, wished to raise his extreme disappointment in the prison's failure to notify him of his father's deterioration on the morning of 20 October 2006. The man's son says that he has been badly affected by the fact that he was not at his father's bedside when he died. My recommendation concerning this issue was accepted by the prison. The issue of the prison not having up to date details of his home address and contact details have been discussed in the report.

Two recommendations relating to the points raised by the man's family, from the draft report, have been accepted by the prison.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2007

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SUMMARY

The man died on 20 October 2006 in hospital. In 2000, he had been sentenced to 18 years imprisonment for serious offences.

On his reception into custody, the man was noted to have several chronic diseases, including coronary heart disease, emphysema, and chronic obstructive airways disease (COAD). In 1998, he had undergone a triple heart by-pass.

On 17 October 2006, the man was found on the floor of his cell in the Vulnerable Prisoners Unit (VPU) at HMP Channings Wood. Wing staff contacted the healthcare centre and a nurse visited him to assess his condition. The nurse found a slight bruise to his temple and thought he seemed somewhat confused. The nurse made contact with the prison's medical officer who examined the man. After examination, arrangements were made for him to be admitted to hospital for assessment and observation. At 10.15am, the man was taken by a non emergency ambulance to the Accident and Emergency Department at the hospital. He was escorted by two prison officers.

Following an assessment, the man was admitted to a ward. He was given a computerised tomography (CT) scan. The man was diagnosed as having suffered a mild stroke. He remained in hospital for observation. Members of his family visited him in hospital. Three days after his admission, during the morning of 20 October, the man's condition deteriorated and he died.

Restraints were applied to the man on his admission to hospital. The escort chain was removed an hour and half before he died, when it became obvious he was unwell.

The man's family raised several issues, which included confusion over the address of his next of kin. Other issues related to his property and the man's rapid deterioration.

THE INVESTIGATION PROCESS

Following the man's death, one of my colleagues, requested a copy his prison and medical records from a Principal Officer (PO) at Channings Wood. On receipt of the files, my colleague reviewed the available documentation. On 9 November 2006, my colleague visited Channings Wood. She spoke to the PO, a member of healthcare, and to the chaplain.

Notices of the investigation and the Prisons and Probation Ombudsman's terms of reference were sent to the Governor. These informed both staff and prisoners about the investigation.

A clinical review was commissioned from Devon Primary Care Trust to assess the man's care in custody. Devon Primary Care Trust subsequently carried out this review and I am grateful for their report.

One of my Family Liaison Officers wrote to the man's son to tell him about our investigation. On 5 December, my colleagues, visited the man's son, at his home. The man's son raised several issues in relation to his father's medical care, and about communication between the family and Channings Wood. I hope this report provides them with answers to their concerns.

HMP CHANNINGS WOOD

Channings Wood is a category C training prison, built on the site of a former Ministry of Defence base. The prison officially opened in July 1974. A building programme took place in the 1980s and early 1990s adding further accommodation. It currently holds 667 prisoners.

The prison takes men with a wide range of sentence lengths. It contains a specialist Therapeutic Community for tackling drug abuse and a Vulnerable Prisoner Unit which specialises in Sex Offender Treatment Programmes.

Many prisons do not have healthcare centres that provide on-site 24-hour care and inpatient beds. Channings Wood falls into this category. Its healthcare centre operates from 8:00am to 8:00pm on weekdays and from 8:00am to 5:00pm during the weekend. General practitioner surgeries are held Monday to Friday. Prisoners who want to see a doctor go to the healthcare centre between 8:15am and 8:45am, or between 11:30am and noon, and appointments are booked for as soon as possible thereafter. An out of hours doctor service is provided by the PCT in line with community based services. The same procedure is followed for seeing a dentist or optician.

The Vulnerable Prisoner Unit houses 150 men in a house block and a prefabricated building. It forms a separate unit in the prison and is in its own compound. During the week, prisoners spend time out of their cells. They are unlocked at 8:00am and, if they attend work or education, remain out of their cells until lunchtime. Those who do not attend activities are locked up from 8:45am until 10:30am. After lunch, prisoners are unlocked for purposeful activities at 1:40pm; those who do not take part are unlocked at 3:30pm. All prisoners are again locked up at 4:40pm and unlocked an hour later for tea. Prisoners on association are out of their cells from 6:15pm to 7:30pm, at which time all prisoners are locked in for the night. A similar schedule operates at the weekend, although prisoners do not attend work and the evening lock up is at 5:00pm.

KEY EVENTS

On his initial reception into HMP Exeter, a full medical history and a list of current medication was recorded in the man's medical notes. The man had complex health needs including asthma, chest and breathing difficulties. He had a triple heart bypass operation in 1998.

The man was transferred to Dartmoor in September 2000. During his time at Dartmoor, the man spent time in both a residential wing and the healthcare centre. He also spent some periods in hospital under escort as an in-patient.

In October 2003, the man transferred to Channings Wood. He requested the transfer as he felt the climate and dampness associated with the area surrounding Dartmoor was affecting his health. He was placed in the Vulnerable Prisoner Unit (VPU) following the transfer.

Over the next two years, the man spent a number of periods in hospital as an in-patient. All appointments were escorted, and restraints were used following a risk assessment by a prison manager. In light of his offences, it was deemed that, although he was in ill health and an older person, he still posed a public protection risk.

In November 2005, the man was the subject of a 'disabled inmate assessment'. The assessment recorded his mobility, general health and other factors that would need to be taken into consideration to ensure his welfare and suitability of location. The man was able to be independent in his cell, on the wing and was self caring. The review was repeated every three months so any physical or mental changes to his welfare could be noted. The man had further assessments in March, June and September 2006. In September 2006, the man was also assessed in the elderly care clinic. A full report noted his health and social care needs in relation to his age, medical condition, prescribed medication and the promotion of health and active life in older age.

On 1 September 2006, the man was discharged from hospital following a short admission. He had been admitted so that he could be observed while starting a new steroid medication. A management plan was recorded in his prison medical notes. The management plan included weekly blood tests, monitoring of blood pressure, administering of his steroids by healthcare staff, and monitoring his reaction to the new medication.

On 20 September, the man was seen by a nurse as he was complaining of feeling unwell. His observations were taken and he was advised to take an anti-acid medication. On 5 October, the man reported sick with stomach pains; his observations were again recorded. He was later seen by the doctor on 9 October. The doctor suggested an alteration to his medication to relieve some of his stomach discomfort. The man's prescription chart was amended accordingly.

On 17 October at 7.30am, a nurse attended the VPU at the request of wing staff. The man had been discovered on the floor of his cell at morning unlock. On arrival at the man's cell, the nurse observed the man sitting on his bed. He appeared to

have urinated in his cereal bowl. The nurse said he initially seemed slightly confused and she saw a bruise on the left side of his temple. The nurse took the man's observations and gave him a full physical examination.

The man told the nurse that he had fallen when he went to the toilet at 5.00 am. The nurse checked this with the wing staff. On his last night check at 6.30am, he had not been seen on the floor. The nurse thought that the man might have had a Transient Ischaemic Attack (TIA) (a very minor stroke). The nurse advised the man to rest in bed.

Later, the man was examined by the prison's medical officer. The doctor decided that the man should be taken to a hospital's Accident and Emergency (A&E) Department for an assessment. At 10.15 am, the man was escorted to hospital by two officers. He was able to walk from his cell, with support, into the main wing area. He was provided with a wheelchair, and taken to hospital in a non-emergency ambulance. On admission to the A&E department, the man was seen by the medical staff and located onto a ward. At 5.00 pm, the man underwent a CT scan. He was then seen by a doctor who confirmed that he had suffered a mild stroke and would need to remain in hospital.

The man was kept under observation, and further tests were carried out over the next two days. The man also received physiotherapy. He was conscious and still under restraint during this period. On 19 October, the officers who were escorting him were informed by medical staff that the man would probably remain in hospital for two weeks. He had become incontinent and was having oxygen periodically to help with his breathing.

On 20 October at 2.40 am, a doctor was called to examine the man as he had been complaining of chest pain. The man was given a nebuliser and a chest x-ray was taken. He was prescribed diamorphine to help with the pain and he then slept for a short while. At 9.35 am, the doctor requested that a consultant see the man, as his condition was causing concern. At 10.00 am, the man's condition was deteriorating rapidly and he was examined by a consultant. One of the bed watch officers, a Principal Officer (PO) contacted the Duty Governor for permission to remove the escort chain. This was agreed by the Governor, with the stipulation that the chain was to be re-applied if there was an improvement in the man's condition.

The man was placed on a constant nebuliser and seemed to be slightly better. At 11.30am, the PO thought the man had died. The officer asked for a doctor to attend. The man's death was confirmed by the doctor at 11.57am.

Whilst the man was in hospital, his son and his family visited regularly.

During the afternoon of 20 October, the Deputy Governor, and the chaplain, visited the address given by the man for his son, to inform him of the sad news of his father's death. On arrival at that address, they were told that the man's son and his family were no longer living there. However, the householders were related to the man's son's partner and were able to contact her by telephone, she then rang him to tell him of his father's death.

The chaplain kept in regular contact with the man's son offering support and assistance. The man's son visited the prison to see his father's cell and to meet with staff and prisoners on the wing.

A letter of condolence was sent to the man's son by the Duty Governor on 26 October. The prison offered assistance with funeral expenses and this was taken up by the family. The family were particularly grateful for this assistance and the immediate support. The family also appreciated the kindness and assistance of the chaplain.

The man's son asked the chaplain to conduct his father's funeral service at a church near to Channings Wood. The funeral took place on 6 November and was attended by a Governor and an officer from the VPU. At the same time as the man's funeral, a memorial service was held in the prison chapel for his friends within the prison. This service was conducted by another member of the chaplaincy team. A collection made on the VPU unit was donated to a charity.

ISSUES

Clinical Review

A review of the man's medical care was commissioned from Devon Primary Care Trust (PCT). The Commissioning and Development Manager for the PCT, undertook the review. The reviewer examined the man's prison medical records, and received a report provided by the prison's medical officer. A panel of clinicians also contributed to the review process.

The review identified that the man was an aged and frail man with a chronic medical history of ischaemic heart disease and disorder. He had been admitted to hospital on several occasions during his sentence, and attended out patient appointments with specialist consultants.

On 17 October 2006, following the man's admittance to hospital, he was diagnosed with a cerebral infarct (stroke). It is noted that ischaemic episodes often result in further complications, or a very swift decline, in the 72 hour period after the initial event. The man received support from an occupational and speech therapist. On 19 October, his mobility was noted to be improving. His death on 20 October was preceded by a rapid deterioration in his health.

The clinical review concluded that the man had received thorough and timely medical attention throughout his time in custody. Prompt referrals for further opinions or interventions were made in relation to his chronic respiratory and cardiac problems. Other healthcare needs in relation to age related conditions were dealt with appropriately.

The man was well supported within the constraints of Channings Wood.

The reviewer made two recommendations:

- Consideration should be given to the most appropriate and suitable prison accommodation for elderly and frail prisoners, who may experience limitations in ordinary accommodation.
- Consideration should be given and documented as early as possible to compassionate release (where appropriate) as part of a considered multi-disciplinary plan, to manage a prisoner with a terminal illness and chronic progressive conditions.

Whilst I understand the thrust of the second of these recommendations, in my view early release on compassionate grounds was not appropriate for the man due to the very serious nature of his index offences.

The reviewer also noted three points of good practice:

- The medical record was well ordered and clearly written throughout.

- Disability assessments were completed at regular intervals, reviewing the man's capability.
- His care and treatment were exemplary and commendable under the constraints of being within a prison setting.

Family concerns

On 5 December, two of my colleagues met with the man's son at his home address. He raised some concerns in relation to his father's illness and communication with the prison. He was also anxious about the loss of a gold chain, which he said he knew his father had in his possession whilst in Channings Wood.

The man's son's concerns may be summarised as follows:

- Why did his father deteriorate so quickly whilst in outside hospital?
- Why was he not told about the deterioration in time for him to get to the hospital?
- Why was there inconsistency amongst prison staff in their dealings with the family and the advice they were given?
- Why did the prison have out of date next of kin contact details?
- Is it possible for the Coroner's Court to protect the family's privacy?
- What has happened to the gold chain?

I will endeavour to answer each of these questions in turn.

The man's rapid deterioration was a result of ischaemic disease from which he had been suffering from over a long period. His condition declined very quickly on 20 October. He had become increasingly unwell during the night and was given pain control medication. At 10.00 am on 20 October, the man was examined by a consultant as his condition had worsened again. The man died just one and a half hours later.

The time between the man becoming seriously ill and his death was relatively short. There was no information on the bed watch log sheets that indicated hospital staff had thought it appropriate for the man's family to attend the hospital. Although the escort chain had been removed on authorisation of the duty Governor, the next of kin were not contacted. The man's deteriorating medical condition was very sudden, and it might not have been possible for his family to have been made aware of this situation and attend the hospital before his death. Nevertheless, the man's son was understandably saddened not to have been given the opportunity to be at his father's bedside. There seems to be some confusion about whose responsibility it was to have the man's next of kin, the hospital or the prison.

The prison should ensure that there are clear procedures and arrangements, agreed with ward staff, for contacting the next of kin in the event of an emergency.

The man's son commented on the inconsistency of prison officers escorting his father whilst he was in hospital. On occasions, he found the escort officers to be unresponsive and unhelpful. At other times, he thought the escort officers were empathetic and friendly. He believed these officers were staff who knew his father well.

The man's son spoke particularly about his father's watch. The battery needed to be replaced, so he took the watch away and replaced the battery. But when he returned to the hospital to hand it to his father, one of the escorting officers refused to allow it. This understandably upset both himself and his father. At a subsequent visit, with a different escorting officer, the man's son was allowed to give the watch back to his father.

Channings Wood has issued local instructions for bedwatch duties. Point 13 of these instructions state, 'Any items for the prisoner must be searched before they are handed over by visitors.' It is apparent that the refusal of the officer to allow the man's son to pass his father his watch was not in keeping with this instruction. The watch could have been scrutinised by staff before the man was given it.

Officers should be reminded to follow local instructions for bed watches and to be sensitive to relatives when they visit prisoners in hospital.

The man's next of kin details were last up dated by him in 2003. An application submitted by the man recorded an address for his son. The address was in fact the home of the parents of his son's partner. More recent information regarding next of kin details was not found.

On the day of the man's death, the Duty Governor and the chaplain went to this address. On arrival, they were informed that the man's son and his partner were no longer living there. It was fortunate that the occupants of the house were able to make contact with the man's son's partner.

The man's son told my colleagues that he had given his mobile phone number to his father. He was upset that up to date information was not recorded in his father's prison file.

The following recommendation, in regard of updating next of kin details, has been raised in a number of my reports and I urge the Prison Service to review its policy for maintaining next of kin details to ensure they are current.

An annual check of next of kin details should be incorporated into the sentence planning process

One of my colleagues, spoke to the man's son and his partner regarding the family's privacy. A newspaper report had been published about the man's death, which included a reference to his son living locally. Both the son and his partner were concerned that at the inquest further references might be made. My colleague offered to write a template letter that they could use to send to the Coroner outlining their concerns. The man's son and his partner agreed that this was a positive way to address this issue.

The last point raised by the man's son referred to a gold chain he understood he father owned. He thought that this chain had been ordered by his father through a catalogue

before he was admitted to hospital. The chain was not in his father's possession at the hospital, or part of the property handed to him following his father's death.

The chaplain, had tried to trace the whereabouts of the gold chain but was unable to find any reference to it. A Governor was also asked to find information about the chain. He checked through computer records from July 2006 up to the man's death. There were no catalogue orders during this period. The man spent his money on either newspapers or canteen. The canteen does not sell items such as jewellery. A chain was not recorded in the man's property records. I am unable to shed any additional light on the gold chain that the man may have owned.

The use of restraints

The man was restrained on an escort chain up to one and a half hours before he died. (An escort chain is a long length of chain with a handcuff at either end. One handcuff is attached to the prisoner and the other to an officer.)

In April 2006, the man had been an in-patient in hospital. During this stay in hospital, the man had again been restrained by an escort chain. He was visited at the hospital by a friend who, a few days later, wrote a letter of complaint to the Minister of State, regarding the use of restraints on an elderly and frail man. This letter of complaint was forwarded to Prison Service Headquarters, who in turn passed the letter to the Governor of Channings Woods, who responded.

The Governor explained in her letter that the man was restrained due to several factors:

- The man was subject to Multi Agency Public Protection Arrangements (MAPPA) 2 and was a Schedule 1 offender.
- The man was in total denial of offences and had refused to engage in any offending behaviour work.
- He had been convicted of extremely serious offences in 2000.
- The use of the closet chain was specified on the Security Risk Assessment based on the level of risk the man presented at that time.

I believe the use of the chain at this time was appropriate.

As noted, the man was also restrained using an escort chain during most of his final stay in hospital. Although obviously unwell and in very poor health, the man was still able to sit in a chair until a few hours before his death. The Security Assessment completed on 17 October 2006 indicated that restraints should be applied unless authority for their removal was given by the duty Governor at the prison.

At 10.00 am on 20 October, when the man's condition had deteriorated, a PO contacted a Governor without delay to request permission to remove the restraint. Permission was given and the restraints removed.

I note that the location of the offences for which the man had been convicted was in the immediate vicinity of a hospital. There was a high possibility that some of his victims were still living in the area. The reasons outlined in the Governor's letter earlier in 2006 had also not changed.

I therefore understand the reasons why the man was restrained for much of his final three days of life. I would add, however, that the removal of the closet chain before he died was appropriate and timely.

RECOMMENDATIONS

- 1. The prison must ensure that there are clear procedures and arrangements, agreed with ward staff, for contacting the next of kin in the event of an emergency.**

Accepted

- 2. Officers should be reminded to follow local instructions for bed watches and to be sensitive to relatives when they visit prisoners in hospital.**

Accepted

- 3. An annual check of next of kin details should be incorporated into the sentence planning process.**

Accepted

Good Practice

- 1. The medical record was well ordered and clearly written throughout.**

Accepted

- 2. Disability assessments were completed at regular intervals, reviewing the man's capability.**

Accepted