Circumstances surrounding the death of a man, at Bristol Royal Infirmary in August 2008, while in the custody of HMP Bristol

Report by the Prisons and Probation Ombudsman for England and Wales

March 2009

This is a report into the circumstances surrounding the death of a prisoner at HMP Bristol. The man died of heart failure at Bristol Royal Infirmary on 14 August 2008, having collapsed in the reception area of Bristol three days earlier. He was 65 years old.

At the time of this report no next of kin had been traced. However, I offer my condolences to all those who knew the man and are touched by his loss.

One of my investigators conducted the investigation on my behalf. I am grateful to the Governor of Bristol and his staff for their assistance and cooperation. I am also grateful to the Doctor who completed a review of the medical care the man received in custody on behalf of Bristol Primary Care Trust.

The man had been in custody since 25 June 2008. Although not considered to be in good health when he arrived at Bristol, he had little contact with healthcare during his first few weeks in custody. However, on 2 August he was admitted to healthcare with chest pain. For reasons that remain unclear, the man was unhappy about being located in healthcare and refused both food and medication for the next eight days. On 11 August, the man collapsed in the reception area of the prison. He had been due to go out with local police to be questioned about further serious offences and was likely to be charged. Initially, prison and medical staff attempted to resuscitate him. Paramedics subsequently took over and managed to stabilise the man before taking him to Bristol Royal Infirmary. Despite the best efforts of medical staff, the man failed to fully regain consciousness and died at 9.00am on 14 August.

The clinical reviewer concludes that the food and medication refusal were key factors leading to the man's deterioration and death.

I have endorsed one recommendation made by the clinical reviewer relating to the need to adhere to guidelines on record keeping.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2009**

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SUMMARY

The man was sentenced to 21 days imprisonment on 25 June 2008 and taken to HMP Bristol. On his arrival, a nurse completed an initial health screen during which she noted that the man had some ongoing chronic health conditions, which were being managed by various medications.

Following the health screen, the nurse referred the man to the doctor who assessed him the following day. The doctor also noted the man's previous medical history and arranged for him to be located on the ground floor to assist his mobility. However, the man later signed a disclaimer to say that he was happy to go upstairs.

Apart from collecting his prescribed medication and attending routine appointments for blood tests, the man had little contact with the healthcare team during his early weeks at Bristol.

On 2 August 2008, while collecting his medication, the man told a nurse that he had chest pains and generally felt unwell. In view of his previous medical history, the nurse arranged for the man to be located in the healthcare wing for observation. The following day, another doctor explained to the man that he would need to remain in healthcare until medical staff was satisfied with his condition. The man was unhappy about this decision and said that, if he was not moved back to the wing, he would refuse all medication and food which he did for the remainder of that day.

The following day, a Nurse asked the man why he was refusing his treatment and food. The man repeated that he should be moved back to his wing but also said that his medication was not correct. This was the first time that he had mentioned this. The man also told the Nurse that, even if he was moved back to the wing, he would continue to refuse food and medication. As a result, staff felt that the man should remain in healthcare where his situation could be properly monitored. All necessary documentation was completed, including a food refusal diary.

Over the next week, nursing staff and doctors held numerous meetings to discuss the man's case. They included input from the mental health team, although it was considered that the man had no symptoms of mental illness. Despite the best efforts of staff to encourage the man to accept medication and food, he continued to refuse and signed a disclaimer to that effect.

On the morning of 11 August, a Nurse managed to get the man to agree to resume his warfarin medication, which was essential to the treatment of his heart condition. Later that morning, the man was taken from the healthcare wing to reception. He asked the reception staff why he had been taken there and was told that the police were taking him away for questioning. On being informed of this, the man became unsteady on his feet and collapsed to the ground.

Reception staff immediately requested medical assistance. Staff from the healthcare unit were quick to respond and administered cardio pulmonary resuscitation. An emergency ambulance was called which arrived at the prison within 20 minutes. The paramedics continued the resuscitation attempts before taking the man to Bristol

Royal Infirmary (BRI). On arrival at the hospital, medical staff continued to administer treatment. The man was finally stabilised, although he did not regain consciousness, and was moved to the Intensive Care Unit (ICU).

The prison attempted to trace the man's next of kin, but without success. Due to his deteriorating condition, the hospital contacted the Bristol branch of the MIND charity (who provide an advocacy service) to act as a third party in relation to decisions about the man's treatment.

The representative from MIND, attended the hospital the following day and spoke with another Nurse in the ICU. She also spoke with the consultant treating the man. The consultant's opinion was that, even if they managed to revive the man, he would be unlikely to have capacity to make decisions regarding his treatment due to brain damage incurred by the heart attack. The representative from MIND attended the hospital again the following day after the hospital notified her that the man had regained consciousness. However, he was unable to communicate as his condition remained critical and he continued to drift in and out of consciousness.

On 14 August, Bristol MIND were contacted again by the hospital and informed that the man's condition had deteriorated overnight and that continued treatment would result in a further cardiac arrest. It was thought there was little hope of the man making a recovery and that he was only being kept alive through massive cardio vascular support. As a result, a medical decision was taken to stop treatment. At 8.58am on 14 August 2008, the officer staffing the bedwatch was notified that the man had died.

As no next of kin had been traced, the man's funeral was arranged by the prison and conducted by the prison chaplain. It was attended by members of the prison's senior management team.

The clinical reviewer concludes that the man's refusal of food and medication had impacted on his condition, but that his care had been appropriately managed. I have endorsed his recommendation regarding improvements required in record keeping.

THE INVESTIGATION PROCESS

1. The Governor of Bristol provided the man's prison and medical records for examination. Notices were issued to staff and prisoners to inform them of the investigation process and to give them the opportunity to speak with the investigator. No responses were received.

2. My investigator, carried out interviews with a member of the healthcare staff, and with a third Doctor of the prison's Independent Monitoring Board (IMB), when he attended Bristol on 16 October. He also considered statements that had been provided by several prison staff to the Governor.

3. My investigator wrote to HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of my report will be made available to the Coroner to assist with his enquiries.

4. One of my Family Liaison Officers (FLOs) was appointed to be a point of contact between my office and the man's next of kin. However, neither the prison nor I have been able to trace any next of kin.

HMP BRISTOL

5. HMP Bristol is a local prison, located in a largely residential area in the middle of the city. It can accommodate up to 606 adult male prisoners.

6. HM Chief Inspector of Prisons carried out a follow up inspection in March 2008 following a previous inspection in 2005. She reported that the Inspectorate "were extremely encouraged by the significant developments in all aspects of health services". In a recommendation regarding the transfer of healthcare services at Bristol, Dame Chief Inspector of Prisons said:

> "There were robust links between the establishment and the PCT. Health services were strongly supported by the Governor and there was robust and effective operational and clinical leadership. Health services were fully assimilated into the regime and there were innovative working practices in the healthcare department. All health services staff were employed by one of three organisations: the PCT, the Avon and Wiltshire Partnership Trust or the prison. However, from May 2008, staff would only be employed by either the PCT or the Avon and Wiltshire Partnership Trust. Staffing and managerial issues were beginning to reach a steady state and there were only two nursing vacancies at the time of the inspection. There had been a lengthy period of staff sickness but this had been addressed through the occupational health service. Administrative support was efficient, and current staffing levels and skill mix were good, and included registered nurses, healthcare officers and healthcare assistants. PCT bank nurses were used where necessary and the number of agency nurses had been significantly reduced."

7. The Bristol Independent Monitoring Board's annual report 2006/07noted the "high quality of staff and prisoner relations". They welcomed the commissioning of healthcare by Bristol PCT and the review of the necessary skills mix that accompanied it. My investigator asked a member of the IMB at Bristol, if the board had any current concerns. The Prison's IMB said that there were no issues that directly related to the death of the man. However, he had concerns regarding the smoking policy in certain areas of the prison. As in the community the prison is bound by smoking legislation which means that smoking is only permitted in designated areas. The prison's IMB said that in some areas of the prison these rules were causing prisoners who smoked unnecessary stress, particularly in the healthcare wing.

8. Since my office was entrusted responsibility for investigating all deaths in prison custody in 2004, seven deaths at Bristol have been attributed to natural causes. Recommendations made following these deaths have not been repeated in this report.

KEY FINDINGS

9. The Man was sentenced on 25 June 2008 to 21 days imprisonment for failing to surrender to bail. He was also remanded on other charges. On his arrival into custody at HMP Bristol that same day, a nurse assessed him and a first reception health screen was completed. During the assessment, the man said that he had seen a doctor within the last few months due to heart failure and arthritis. He provided a list of the prescribed medications that he had been taking:

    - warfarin (anticoagulant)
    - frusemide (loop diuretic used in the treatment of heart failure)
    - ramipril (used to treat hypertension and heart failure)
    - simvastatin (used to control elevated cholesterol levels)
    - omeprazole (used to treat peptic ulcers or reflux)
    - bisoprolol (a beta blocker used to treat cardio vascular disease)
    - imdur (used in the treatment of angina)
    - spironolactone (diuretic used to treat heart failure).

10. The nurse referred the man to the doctor due to his physical health and age. A doctor assessed the man the following day and recorded that he used a walking stick and required an assessment of his mobility to ascertain whether he was suitable to be located on a normal wing. The man told the doctor that, in addition to the medication he had brought with him, he had been prescribed nicotine patches by his doctor but was still smoking. The doctor discussed other forms of nicotine replacement therapy with him but the man was not prepared to try them. Following the assessment, the doctor confirmed that he was fit to be located on the ordinary wing on either the ground floor or first floor landing. The man later signed a disclaimer to say that he was able to manage the stairs to the second floor landing.

11. Due to the nature of the man's offence, he was placed in D wing, which is for vulnerable prisoners. (These are generally prisoners whose offences make them more susceptible to verbal or physical abuse from other prisoners.) It was recorded in the man's wing history file that he settled in well. He kept himself clean and tidy but, although he got on well with his cellmate, he did not associate with many other prisoners.

12. As mentioned above, the man had been taking warfarin. This required him to provide regular blood samples for International Normalised Ratio (INR) tests. He was seen at least once a fortnight for these to be carried out by nursing staff. The test results were normal and gave no cause for concern. The man raised no other concerns regarding his health or healthcare until 2 August 2008.

13. At 4.30pm on 2 August, the man went to the treatment room on D wing. He told a Nurse that he had chest pain and generally felt unwell. The Nurse checked the man's blood pressure, which was 88/64, and his pulse, which was 51bpm. Neither of these readings would normally give cause for concern but, given the man's previous medical history, the nurse arranged for him to move

to the healthcare wing for observation. When the second doctor saw the man the following day, he explained that he would remain in the healthcare wing for observation. The man was unhappy and said that if he remained in the healthcare wing he would refuse food and medication.

14. Although advised by this doctor that it was in his best interests to remain in healthcare until he had settled, the man continued to refuse medication and food. Nursing staff checked his pulse rate and blood pressure regularly throughout the remainder of that day. On the morning of 4 August, the man again refused his medication and food. Another nurse spoke to him to try and find out his reasons and recorded in his medical notes:

> "I've spoken to the man [sic] to establish his reasons for not eating since he came to HCC on the 2/8/08 for observation re – chest pain. He states:
>
> - he should be moved back to D wing 3/8/08 but still kept in HCC
> - all his medications are not correct.
>
> He also states even if he is moved back to D wing he will continue the food and fluid refusal. Also said 'no one can force him to eat'."

15. In view of his continued refusal to take food, fluid and medication, the nurse started recording each refusal in the man's care plan. A doctor recorded in the man's medical notes on 6 August that, "If a space on D wing becomes available he can go if he eats and takes his medication."

16. However, the man had earlier stated that he would continue to refuse food and medication regardless of his location. Accordingly, the doctor felt that it would be better for the man to remain in healthcare where medical staff could continue to monitor him.

17. The doctor also followed up the man's comments to a nurse on 4 August about his medication. He contacted a fifth Doctor, who had treated the man before he had been taken into custody. The doctor confirmed that the medication listed on the man's reception into prison was correct. Another doctor recorded in the man's medical notes that he seemed to accept the decision.

18. However, during a multidisciplinary review meeting held by healthcare staff on 7 August to discuss the man's care plan, the man said again that medication was missing. He insisted on this in spite of being shown a fax from the fifth doctor confirming that the correct medication had been listed on his reception into prison. During the review, the man also said that he was upset that he was unable to have a cigarette as he usually smoked about 20 a day. In line with hospital and other medical practices in the community, the healthcare centre at Bristol has a strict no smoking policy but patients have access to nicotine replacement therapy if they wish. The man acknowledged that he could be stubborn.

19. During the review, it was agreed that a doctor would clarify again with the man's community doctor, the medication he had been on prior to custody and

any pre-arranged follow up appointments with the cardiologist at Bristol Royal Infirmary (BRI). The other doctor wrote to the cardiology department at BRI on 8 August. On the same day, the man was assessed by a consultant psychiatrist who concluded that the man had no mental illness that would impair his capacity to refuse the cardiac medication.

1. Medical staff continued to record the man's refusal and encouraged him to take food and fluids. A nurse told the investigator that, although adamant that he would not take medication, the man was happy for nursing staff to take his pulse regularly and to provide blood and urine samples as required. On 10 August, it was recorded in the man's medical notes, care plan and food diary that he was drinking hot and cold liquids. My investigator asked a nurse about this and the Nurse said, "I have my own view that I think he might have been drinking something. I questioned him once before and he said he was not, but I could see his lips were not dry and he had access to a sink."

2. On the morning of 11 August, the nurse saw the man and, after a discussion with him, recorded that he had agreed to resume taking warfarin but would continue to refuse all other medication. An entry in his medical record confirmed that he would resume taking warfarin that evening. The nurse carried out an INR test and checked the man's observations, which were all normal. My investigator asked the Nurse how the man appeared to him on this morning compared to when he had moved to healthcare on 2 August. The nurse replied, "I did not see any significant change in him."

3. At around 9.50am the same morning, the man was taken to reception in order to be taken to a police station for questioning (police officers will often visit prisons in order to interview prisoners or make requests to take prisoners out to local police stations for further questioning if additional charges are likely). Two officers searched the man (all prisoners are given a full search before leaving or entering the prison). The man asked where he was going and who was escorting him. The first officer wrote in his statement to the Governor that, when told that the police had arrived to collect him, the man became unsteady on his feet and collapsed to the floor. As with all transfers or escorts, a Prisoner Escort Record (PER) should have been completed which would indicate to the persons taking charge of the prisoner any medical or security requirements. In the man's case this would have informed the police about his ongoing food and medication refusal. However, my investigator was unable to find a copy of the PER in the documentation provided so it is unclear as to whether this information was going to be passed on.

4. The first officer informed a senior officer who was in charge of the reception area that the man had collapsed, and along with the second officer, put him into the recovery position. The senior officer telephoned the control room (the radio network was busy) and reported a code blue in reception. (Prisons generally use coding systems to notify staff of a medical emergency. The most commonly used are codes red and blue. Red indicates that a person is bleeding and blue indicates breathing difficulties. These codes enable healthcare staff to ensure that the necessary medical equipment is made available.) The control room then requested medical assistance.

5. A doctor and two nurses were in the healthcare centre. When the code blue was called over the radio network, they went to reception taking emergency medical equipment with them. When they arrived the doctor asked for an emergency ambulance to be called. Other medical staff who had heard the code blue also went to the reception area and, along with the doctor, administered cardio pulmonary resuscitation (CPR) to the man. The medical staff also used a defibrillator (a machine that administers an electric shock in order to return a heart to a normal rhythm). The man was defibrillated six times.

6. The ambulance, along with three paramedics, arrived at 10.10am. The paramedics continued the resuscitation attempts. After a discussion between two of the doctors and the paramedics about the man's condition, he was transferred by emergency ambulance to BRI at 10.45am, escorted by two staff.

7. The man's arrived at the hospital at 10.55am. Medical staff continued CPR until 11.48am when his condition stabilised, although he remained unconscious. The man was then transferred to the Intensive Care Unit (ICU). The escort was reduced to a single officer later the same afternoon as the man remained sedated.

8. As the prison had been unable to identify any next of kin, the doctor at BRI contacted Bristol MIND (a leading mental health charity) which provides an independent mental capacity advocacy service. The representative from MIND, attended BRI on 12 August, the day after the man was admitted to hospital. She spoke with the nurse in the ICU and read the man's medical notes. MIND had contacted the prison to obtain the background to the man's condition, including the food and medication refusal. The representative from MIND also spoke with the consultant treating the man. He told her that, in his opinion, if it was possible to revive the man he would be unlikely to have sufficient capacity to make decisions regarding his treatment due to brain damage incurred as a result of the heart attack.

9. The following day, the representative from MIND visited the man again after she was notified by the hospital that he had regained consciousness. However, he was unable to communicate although he did respond to his name. The man's condition remained critical and he continued to drift in and out of consciousness.

10. On 14 August, the consultant informed Bristol MIND again that the man's condition had deteriorated overnight and that if treatment was continued it would result in a further cardiac arrest. In his opinion, there was no hope of the man making a recovery and he was only being kept alive through a large amount of cardio vascular support. The man was not in pain or discomfort and it was proposed that treatment should be stopped to allow him to die with dignity. As a result, a medical decision was taken to stop treatment. At 8.58am on 14 August, the officer on bedwatch duty was notified that the man had died.

11. Following the man's death, in the absence of any next of kin, the prison arranged his funeral. The service was taken by the prison chaplain and attended by members of the senior management team.

ISSUES

Transfer to healthcare

12. Following the man's complaint of chest pains, he was transferred to the healthcare wing for further observations. The clinical reviewer considers this to have been well managed with one exception. It was documented that an electrocardiogram (ECG) should have been carried out, but the clinical reviewer could find no record of this having been completed or reviewed. (An ECG is a test to measure the electrical activity of the heart.) The clinical reviewer says in his report that "performing an ECG would have been good practice but would have been unlikely to have changed the course of events". In view of this, I make no further recommendation.

Refusal of food and medication

13. The man gave two different reasons for refusing his food and medication:

    - not being able to return to D wing
    - not being prescribed the correct amounts of medication.

    In relation to his location, the healthcare staff had arranged for the man to return to D wing when a space became available. However, he said that, even if he were moved back to the wing, he would continue to refuse food and medication. Therefore, the doctor thought it would be better for him to remain in healthcare for observation. The doctor also confirmed with the man's doctor that the medication that had been listed on his reception into custody was correct and the man reportedly accepted this. In spite of this, he complained during a case review the following day that items were still missing. Given this inconsistency on the man's part, it is difficult to say why he continued to refuse food and medicines. It is apparent from his medical notes and care plan that the man was aware of the importance of his medication and he signed a disclaimer to that effect. The recording and monitoring of the refusal was very clear, and staff were aware of the policies and protocols that needed to be followed. The food refusal policy at Bristol ensures that individuals are monitored closely and regular multi disciplinary meetings are held to discuss issues and ways of bringing the refusal to a positive conclusion. The refusal of medication was also recorded on the prescription charts. With continued support and encouragement from staff, the man finally agreed to restart warfarin medication and had been taking limited amounts of fluids. It is unfortunate that his decision came too late. I agree with the clinical reviewer that the healthcare team handled the man's refusal of food and medication appropriately.

Escort Documentation

14. As previously mentioned, when the man was collected on the morning of 11 August 2008 in order to be taken out by the police a PER form should have been completed. This would have advised the police that the man had been refusing potentially life saving medication for the past week, as well as refusing

food. If the man had collapsed in police custody as he did in the reception area, his death would have been a matter for the Independent Police Complaints Commission (IPCC). The PER documentation would have been critical evidence. However, my investigator was unable to find a copy of the PER form during the investigation so it remains unclear what information had been provided. Although I have chosen not to make a formal recommendation, the Governor will wish to satisfy himself that PER forms are being completed in all cases when a prisoner is being escorted outside of the prison and that critical medical information is provided.

Following the issue of my draft report the Governor commented on the above issue and said:

All prisoners who are escorted from HMP Bristol so have a PER form completed. The PER document is a central element of the discharge process. A PER document is generated at the stage of the diary entry about the transfer and would then be used to brief the receiving party. It is extremely unfortunate that a copy of the PER was not available to your investigator, however this may be due to the fact that as the escort did not take place the unused PER was destroyed as would be the practice for any cancelled escort. If [the man] had been discharged via reception as per the diary entry then a copy of the PER would have been retained at reception. However, the tragic events that occurred meant that, although medical staff did receive a full briefing from Bristol Healthcare staff, the written PER evidence is not available.

Medical Documentation

15. When reviewing the man's medical documents, the clinical reviewer found them to be incomplete and the available records were limited. He also found that not all entries were signed and that it was difficult to identify individual clinicians. I make the following recommendation:

The Head of Healthcare should remind all clinical staff of their obligations to comply with the rules regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.

In response to my draft report, the Prison Service commented on the above recommendation and said:

A documentation audit is being undertaken over the next month with all staff and with the PCT audit tool. This will then be followed by a report outlining the needs. The target date for completion of this is 1 April 2009.

Conclusion

16. The man was clearly not in good health, having had a history of heart disease and having been admitted to BRI coronary unit only a short time before entering custody. Despite his medical problems, he continued to be a heavy smoker and refused potentially life saving medication for reasons that it is difficult to understand. By so refusing, the man put himself at risk. Despite the advice of the medical team at the prison, he continued to do so.

17. It may be relevant that the man was likely to be charged with serious offences had he gone to the police station on 11 August. It is probable that he was experiencing considerable anxiety.

18. The clinical reviewer concludes that the food, fluid and medication refusal were the key factors leading to the man's deterioration and death. Although some minor shortcomings have been identified, I concur with the view of the clinical reviewer that they did not adversely impact on the man's condition.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should remind all clinical staff of their obligations to comply with the rules regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.