

**Investigation into the death of a man who died in a hospital on 25 February
2006, whilst a prisoner at HMP Chelmsford.**

Report by the Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the circumstances of the death of a man who died in hospital on 25 February 2006 whilst he was in the custody of HMP Chelmsford. At the time of his death, he was aged 44 years.

A post mortem was carried out by a Home Office pathologist on 2 March 2006. He found the cause of death to have been alcoholic liver disease.

My colleagues and I would like to extend our sincere condolences to the man's family and friends.

This investigation was conducted by one of my colleagues. A clinical review was also commissioned to examine the medical care and treatment at Chelmsford prison. This has been carried out by a clinical nurse from Essex Primary Care Trust, to whom I am most grateful.

I would also like to take this opportunity to thank the Governor of Chelmsford and the appointed liaison officer for their full and ready co-operation with this investigation.

This version of my report, published on my website, has been amended to remove the names of the deceased and the names of staff and prisoners who were involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

This is the report of an investigation into the death of a man on 25 February 2006 at a hospital to which he had been released on temporary licence from HMP Chelmsford.

The man had been in custody since 27 January 2006. He had been sentenced to three months imprisonment. The morning after his arrival in prison he was seen by a prison doctor. After seeing the man, the doctor felt that he required hospital treatment. He was taken to hospital under the escort of two officers.

On his arrival at the Accident and Emergency Department, he was assessed and subsequently admitted for further care and clinical management.

The man's medical condition continued to deteriorate despite medical intervention. The officers were withdrawn on 21 February, when it was decided to release him on temporary licence due to his ill health and poor prognosis.

My report examines the circumstances surrounding his death, the quality of the written documentation provided, the effectiveness of the prison's arrangements for monitoring the well-being of prisoners temporarily located in a hospital within the community, and communication between the hospital and the prison.

I also refer to the clinical review of his care whilst in prison. This review was carried out at my request. The reviewer comments on the quality of record keeping and concludes that it was of a high standard. The report also highlights good communication between prison healthcare staff and the hospital where the man died.

The hospital contacted the man's next of kin (his partner) to notify her of the death. A letter of condolence was sent to her by the prison very soon afterwards. The deputy governor contacted the next of kin to arrange a visit to the prison to collect the man's personal belongings and to offer any assistance that was required. Unfortunately, the next of kin did not attend, and when a further date was arranged she again did not arrive. I conclude that the deputy governor made every reasonable attempt to meet with the family.

I make one recommendation in this report.

Investigation Process

My practice in apparently natural deaths is to conduct an initial review to determine the extent of the investigation required. My investigator arranged for all the paperwork relating to this man to be sent to her. She was given access to all of his records, including his medical record. Notices to staff and prisoners were sent to HMP Chelmsford in order for them to be displayed around the prison. No member of staff or prisoner expressed a wish to meet with my investigator. I suspect this is because of the very short time that this man was actually in prison – just 16 hours approximately.

A family liaison officer from my office contacted the man's family. She explained the purpose of the investigation, but the family wished to have no involvement.

A nurse from Essex Primary Care Trust carried out a clinical review of the management of this man's health needs whilst in HMP Chelmsford. She and my investigator enquired as to whether this man was assessed properly on his arrival at Chelmsford.

No formal taped interviews were conducted for this investigation.

Her Majesty's Coroner for Essex and Thurrock was informed of the nature and scope of my investigation. A copy of the post mortem report was also requested. This report has been sent to the Coroner to assist with the inquest. The inquest was heard on 12 December 2006 and concluded that the man died of natural causes.

HMP Chelmsford

HMP Chelmsford was built in 1828 as a county gaol. Since 1987, it has been used as a category B local prison and young offender institution.

Two new house blocks and a purpose built sports facility were opened in 1996 to relieve overcrowding and provide extra activities. During 2000, Chelmsford converted one of its residential units to house more young people.

A new healthcare centre was opened in July 2004. It has 12 beds, all single cell occupancy. Healthcare provision is commissioned by Chelmsford Primary Care Trust (PCT) with the Prison Service providing the nurses and the PCT providing the medical officer. The healthcare centre provides care for both medical and psychiatric admissions. Other specialisms available include alcohol and detoxification counsellors and a dedicated mental health team.

Since April 2004, I have investigated two other natural cause deaths at Chelmsford and one death that was apparently self inflicted.

An unannounced inspection of Chelmsford in 2004 by HM Chief Inspector of Prisons records "an establishment continuing to make progress".

The man

He was separated from his partner and had three sons. He was 44 years old at the time of his death.

On 3 October 2005, this man appeared at Southend Magistrates' Court where he was bailed to appear again on 27 January 2006. He returned to court on 27 January and was sentenced to three months imprisonment for possession of an offensive weapon. He was taken from Southend Magistrates' Court to HMP Chelmsford by the escort service, Premier Prison Services.

His family have been contacted by my family liaison officer. She told them how I would be approaching the investigation and what it might include. She also offered them the opportunity to meet and discuss any concerns they might wish to raise. The family declined the offer of a meeting, and do not wish to have any further involvement with this investigation.

Events leading to the man's death

Following his sentencing, this man arrived at HMP Chelmsford at 5.30pm on 27 January 2006.

On his arrival, he was medically assessed in reception. (Reception is an area within the prison where prisoners are seen by a nurse and asked a variety of screening questions pertaining to their health and medical history.) This assessment was carried out by a nurse. The man disclosed that he had an enlarged liver due to an excessive alcohol intake. He also said that he suffered with hypertension and was on regular medication, although he was not sure what the medication was. The nurse recorded her own observation from his physical appearance. She noted that he was shaking, yellow in appearance, had shortness of breath and a dry mouth. The man denied any use of illegal drugs, and said that he had no mental health problems. The nurse concluded the first reception health screen by referring him to the doctor.

Within his medical record, the nurse wrote: "Admit to HCC (Healthcare Centre) SOB++ (shortness of breath) Enlarged liver, excessive alcohol, waiting for ultrasound appointment."

Along with the clinical reviewer, I judge that the initial health screening was detailed and that this man was appropriately admitted to the healthcare centre.

He was located in cell 001 in the healthcare centre. The centre can hold 12 patients. All cells are single occupancy - ten are known as safer cells (to reduce the risk of deliberate self-harm by patients) and the other two have special beds in them to accommodate patients with any physical disability.

There are usually two/three officers working in the healthcare centre along with three/four nurses. The nurses are both RGN (registered general nurses) and RMN (registered mental nurses).

The next day, 28 January, the prison doctor saw this man at 11.35am. This consultation took place in the healthcare centre.

The doctor wrote the following entry in the medical record:

"Not feeling well, loss of appetite. PMH (previous medical history)

1 - Hypertension not on medication.

2 - Liver Cirrhosis alcohol induced. Has had blood tests and was supposed to go for abdominal ultrasound.

O/E (on examination)

Adb(abdominal) Distension++, Dilated abdominal veins++ Abdominal ascites++ Liver palpable smooth tender. Oral mucosa/tongue dry.

Impression - 1 - Dehydration,

2 - Abdominal Ascities ?liver Cirrhosis,

3 - ?Portal Hypertension.

Plan - Admit to hospital.”

Following this consultation, the man was taken to the Accident and Emergency Department of a nearby hospital by prison escort.

When circumstances permit, a risk assessment has to be carried out when a prisoner leaves an establishment. This assessment is to assess the level of security required. At 12 noon on 28 January, the risk assessment for him was carried out and recorded on a form. It was signed by a member of healthcare, security, Governor and I/C (in charge) escort.

Sections that were completed in this form and are relevant;

1.1 Reason for appointment (ie broken arm, eye injury etc)

Ans Liver failure.

1.4 Is the condition life threatening?

Ans Potentially

1.6 Will the use of restraints impede the consultation and /or treatment? If Yes explain how.

Ans Please be advised by hospital staff, at times a closeting chain may be preferred.

1.7 Does the prisoner have a history of feigning illness or self-harm to obtain an outside visit to hospital?

Ans Has just arrived some 16 hrs ago so no history.

1.8 Given his condition is the prisoner able to escape unaided?

Ans With difficulty.

The form concluded with the instruction that this man was to remain on his escort chain at all times and that he would be supervised by two officers.

The form also covers visiting restrictions should the prisoner become an inpatient at hospital. All visitors to the patient had to be booked with the security department. Visitors would receive a rub down search using a hand held metal detector and a thorough manual search of in possession belongings before a visit commenced. The visits would coincide with hospital visiting hours.

He arrived at the hospital at approximately 12.40pm. The PER (prisoner escort record) for this journey shows that he was double cuffed on leaving the prison at 12.15pm, this would be reduced to a single cuff for a doctor's examination.

On arrival, he was seen and assessed in the Accident and Emergency Department. He underwent a series of tests before being admitted.

At 1.10pm, a request was made to Oscar 1 (the senior operational officer in charge of the prison) to put the patient on a closet chain whilst he was being assessed in the hospital. This request was granted. At 2pm, the prison was notified by an officer that the man was going to be admitted to the hospital.

On his admission, a bedwatch log had to be arranged. The purpose of the log is to provide escort staff with a picture of events surrounding the admission. It records changes in medication, treatment, location, behaviour and level of restraint. The log is also to show that staff have made regular security checks on restraints and equipment at least hourly and on staff handover, as instructed in Chelmsford's local security policy.

Other significant entries may include visits to the prisoner, whether family, friends or legal visits. It will also include any telephone calls made by the prisoner and any correspondence received.

A bedwatch log commenced at 5pm on 28 January.

Escort staff also had responsibility to ensure that the prison was contacted at regular intervals (no more than four hours) to update them on the current situation. The instruction given is that the quality and standard of the log should be checked at the end of shift by the in charge escort. The log continues with several entries made per day until the man was released on temporary licence on 21 February.

My investigator examined the bedwatch logs for this man beginning 28 January and ending 21 February. She checked that the contents were factual, consistent and accurate.

Continuous entries in the man's prison medical record after his admission to hospital show regular liaison with the hospital in the community regarding his condition, treatment and prognosis.

It is noted from the documentation that on 21 February the man received the last rites from the hospital chaplain, as he was very poorly. This was also the day that he was released on temporary licence. The application for this release was completed on behalf of the man by the prison's probation department. The licence was applicable until the end of his treatment (it was a daily licence, meaning that the situation would be reviewed on a daily basis). It also stated that daily visits from an Orderly Officer should take place. The release on temporary licence was granted and signed by the deputy governor. A follow up contact and monitoring log shows that the daily visits did take place following the temporary release.

On 23 February, his condition was reported as deteriorating slowly and his family were by his bedside. The following day, he was placed on a morphine pump. At 7pm on 25 February, he passed away. The prison sent a letter of condolence to his family.

The deputy governor made two attempts to meet with the family, but each time they failed to attend. For this reason, discussions regarding financial help for the funeral and a representative attending from the prison never arose.

Issues

Should this man have been admitted to the healthcare centre on his first night or should he have gone straight to hospital? Did this have an impact on his chances of survival?

My view, and that of the clinical reviewer, is that the initial healthcare screening was detailed and that the man was appropriately placed in healthcare. Although the nurse was concerned he was jaundiced, his GP was aware of his symptoms and he was awaiting further investigations. There was no evidence of this man requiring immediate or emergency medical attention.

Could he have been released on temporary licence sooner, and would this have benefited him?

The clinical review recognises the need to balance the risks associated with issuing a licence and the welfare of the prisoner. The reviewer adds that the involvement of the healthcare staff in specific instances could enable licences to be issued judiciously.

Was the level of security adequate or too high and did this impede the man's medical treatment?

There is no evidence to suggest that the level of security impeded the man's medical treatment. Although he was cuffed until 20 February, the day before he was released on temporary licence, and was very ill with liver failure, he remained mobile and alert. Having reviewed the circumstances, I believe that the decisions made in respect of security were appropriate.

Were sufficient observations made and recorded?

In addition to the bedwatch log, management checks were carried out and recorded. I judge that HMP Chelmsford met all due requirements.

Conclusions

This man was seen and assessed appropriately at the prison. He was located in the healthcare centre and seen by a medical officer within 16 hours of his arrival. The healthcare staff maintained a high level of communication with the local hospital following his admission. The healthcare records were of a high standard, all entries were dated, timed and legible. The writers' signatures also appeared in print.

Bedwatch Entries

The entries within the bedwatch logs were examined to ensure that they were factual and sensitive records. They show the patient's treatment, progress and any change in behaviour and demonstrate that the prison was updated on his condition throughout his stay at the hospital. The entries were fully consistent with what was required.

Release on Temporary Licence

He was released on temporary licence on compassionate grounds on 21 February. He died six days later. The clinical review notes that whilst the balance of risk has to be recognised, so does the welfare of the prisoner. This must be right. I agree with the clinical reviewer that it would be beneficial to have regular multi-disciplinary meetings between all involved in health related matters (ie healthcare staff, bed watch officers etc). This would ensure a complete picture is provided, enabling the right decision to be made at the most appropriate time. In fact, I understand the issue of this man being released on temporary licence was raised by the prison's probation department and agreed the same day.

Recommendations and Good Practice

In view of the findings in the clinical review, I make one recommendation to the Governor of Chelmsford:

There should be regular multi-disciplinary meetings once a prisoner has been an in patient at a hospital in the community for more than a week, so that decisions made about him are appropriate, timely and well informed.

The Prison Service accepted this recommendation and has reported that the Head of Healthcare will organise weekly review meetings to include a representative from the Security department and an Operational Manager. The notes will be published in the prison's daily briefing sheet.

Good Practice

- Record Keeping - This was of a high standard with entries timed, dated and legible. Having said that, it is becoming common practice for medical records to be computerised: this may be something the Governor can consider in conjunction with the PCT.
- Communication - Prison healthcare staff made regular contact with the hospital regarding this man and his prognosis. This was recorded in his medical record and showed an on going concern for him and his welfare. Where appropriate, the information was relayed to governors.