PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at outside hospital in November 2012, while in the custody of HMP The Mount

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the report of an investigation into the death of a man, a prisoner at HMP The Mount, who died at outside hospital in November 2012. The cause of his death was hypovolaemic shock (rapid blood loss) due to ruptured enlarged veins and cirrhosis of the liver. He was 55 years old. I offer my condolences to the man's family and friends.

One of my investigators carried out the investigation and a clinical reviewer conducted a review of the man's clinical care in prison. HMP The Mount cooperated fully with the investigation.

The man had been in prison for over 4 years. He had been treated for hepatitis C before he went to prison and was later diagnosed with cirrhosis of the liver. The investigation found some improvements were needed in care planning and medical record keeping and I am concerned that restraints were used for hospital escorts which were not justified by a fully considered risk assessment. However, I am satisfied that overall, the man received thorough and prompt care at The Mount After his death the prison made commendable efforts to trace and inform his family.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2013**

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SUMMARY

1. The man was remanded into custody on 18 February 2008 and subsequently received an indeterminate sentence for public protection with a minimum period to serve of three years 201 days**.** It was not his first time in prison.

2. The man had received treatment for hepatitis C before he went to prison and his treatment continued when he transferred between prisons during his sentence. On 30 April 2010, he was referred to hospital by a prison GP and underwent a liver biopsy. The results showed that he had developed cirrhosis of the liver, most likely caused by hepatitis C. In August 2012, six weeks after he transferred to The Mount, a specialist nurse in blood borne viruses referred him to a consultant gastroenterologist who diagnosed chronic liver disease.

3. On 22 October 2012, the man reported that he had black faeces and the prison GP suspected bleeding in his gastrointestinal system. He was admitted to a local hospital and tests revealed he had non-bleeding varices (dilated veins prone to bleeding) in his stomach. He was prescribed medication to relax the blood vessels and to reduce the risk of further bleeding.

4. On the evening of 17 November, the man reported that he was in pain and unable to move. At that time, his observations were normal but during the early hours of 18 November, his condition worsened and he was taken to hospital by emergency ambulance. Examinations showed evidence of blood in his stomach and he was given two blood transfusions. He remained in hospital as an inpatient.

5. The man vomited blood and collapsed on a morning in November. Hospital staff resuscitated him but his condition continued to deteriorate and, three hours later, they carried out further cardiopulmonary resuscitation. Although successful, the nurses told the escort officers that it was unlikely that he would survive. His condition deteriorated again and he died a short time later. The prison had difficulty tracing his family and it took the family liaison officer eight days to contact his son and notify him of his father's death. Help with funeral expenses was offered.

6. The clinical reviewer concludes that both primary and secondary care providers monitored and treated the man appropriately. He moved a number of times during his sentence but the clinical reviewer considers that this did not affect his continuity of care. We are satisfied that he received good medical care in prison. However, we endorse her recommendation about the need for improvements in care planning and medical record keeping. We also make a recommendation about the use of restraints for hospital visits.

THE INVESTIGATION PROCESS

7. Notices were issued announcing the investigation to staff and prisoners at the Mount, asking anyone with relevant information to contact the investigator. No one came forward.

8. The investigator visited The Mount on 27 November 2012. He met the family liaison officer, the manager of the wing where the man lived and spoke to staff and prisoners. He received copies of his prison records, including his medical record. On 9 January, he returned to the prison and interviewed five members of staff. He gave preliminary feedback on the findings of the investigation to the Head of Residence.

9. West Hertfordshire Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care at the prison. She was given all relevant documentation to assist her review.

10. The investigation report has been sent to the Coroner to assist his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers contacted the man's family by telephone and in writing but did not receive a response.

HMP THE MOUNT

12. HMP The Mount in Hertfordshire is a medium security prison holding approximately 800 adult male prisoners.

13. Healthcare services are commissioned by Hertfordshire Community Care Trust. The healthcare centre is open from 8.00am to 6.30pm Monday to Friday and from 8.00am to 5.00pm at weekends. The Mount has a full-time GP, with the service augmented by locums as necessary. An out of hours service is provided through the Hertfordshire Urgent Care Services. There are no inpatient beds at The Mount

HM Inspectorate of Prisons (HMIP)

14. HM Inspectorate of Prisons (HMIP) carried out a short follow-up inspection of The Mount in October 2011. Inspectors found that the prison had made good progress addressing the healthcare related recommendations made after the previous full inspection in 2009. Prisoners were generally positive about access to, and communication with, health services staff. Partnership arrangements between commissioners, health services staff and the prison were effective. Health care facilities were satisfactory and a wide range of services and clinics were provided in the prison but Inspectors considered there were insufficient escorts for external appointments. Prisoners had satisfactory access to the doctor.

Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. In its most recent report, for the period March 2011 to February 2012, the IMB at The Mount reported favourably on the healthcare provided. They were satisfied that the clinical needs of all prisoners were met and noted that significant improvements and advancements had been made since their last report.

Previous deaths at HMP The Mount

16. We have investigated four deaths at The Mount since 2007. Three were from natural causes. Recommendations were made in those reports about updating risk assessments and the use of restraints for prisoners in hospital. Regrettably, similar concerns are reflected in this report.

KEY EVENTS

17. On 18 February 2008 the man was convicted at a magistrates' court of robbery and possession of an imitation firearm. He was remanded to HMP Leeds and subsequently received an indeterminate sentence for public protection with a minimum time to serve of 3 years 201 days. He was 51 years old and it was not his first time in prison.

18. The man, who had been an intravenous drug user in the past, had been diagnosed with hepatitis C, before going into prison. He had undergone pegylated interferon treatment. This is a course of treatment lasting six months at a time, consisting of weekly injections of a chemically modified version of interferon. The aim of the treatment was to stimulate the immune system. Regular full blood counts were necessary for the duration of the treatment as were consultations with a chronic disease management clinic. This treatment was repeated while the man was in custody. However, detailed records of his treatments were not kept until a computer-based medical record system, SystmOne was introduced in 2009.

19. The man transferred to HMP Dovegate on 22 August 2008. At that time, he was under the care of a consultant physician at outside hospital for his hepatitis C treatment. In January 2009, the consultant physician advised the man that his recent course of treatment had been unsuccessful and a second course would be necessary.

20. On 29 January 2010, the man transferred to HMP Holme House. During the reception process, a nurse recorded that he was generally fit and well. He declined a vaccination for hepatitis B and told the nurse that he had been treated for hepatitis C in 2006. Healthcare staff continued to monitor his blood for hepatitis C and he had routine consultations in line with his treatment plan.

21. On 10 February 2010, the man requested a transfer to HMP Wealstun. The reason for his request was not clear from his records. A healthcare administrator at Holme House explained to him that in order to facilitate his transfer, he had to sign a disclaimer cancelling all further planned hospital appointments. He agreed to this.

22. The man transferred to HMP Wealstun on 28 April. The reception nurse recorded that he had undergone a six-month course of treatment for hepatitis C and required further treatment. She referred him to the GP and he was seen two days later, on 30 April. The GP noted that the man's recent course of pegylated interferon treatment had been unsuccessful and she referred him to the specialist liver unit at an outside hospital the same day. A doctor assessed him at the hospital on 21 July and recommended a liver biopsy with a view to a further 12-month course of pegylated interferon treatment. However, the doctor doubted that the treatment would lead to a successful outcome.

23. The man had limited contact with the healthcare department until 17 September 2010. He had undergone a liver biopsy which showed that he had developed cirrhosis of the liver (a combination of poor function and scarring) caused by hepatitis C. A second course of pegylated interferon treatment

started on 23 May 2011.

24. During the treatment, the man saw healthcare staff frequently and administered the required injections himself with their support. On 23 August, a nurse specialising in viral hepatitis at outside hospital informed the man that the treatment would end as blood tests were positive for polymerase chain reaction (PCR - used to copy small segments of DNA in an attempt to lessen the effects of the hepatitis C). At that stage of his treatment, medical staff hoped that he would have tested negative for PCR. The nurse informed him that new treatments were due to be released in the next 12 months which she hoped would be more effective for him.

25. The man transferred to HMP Highpoint on 26 April 2012. A nurse noted in the reception healthscreen documents that he had been prescribed tramadol and naproxen, both painkillers, but was generally "fit and well". Although he had a long history of hepatitis C, the nurse recorded that he had tested negative for hepatitis C antibodies. A GP at Highpoint saw the man on 15 May, but made no reference to hepatitis C in his entry in the medical records.

26. On 18 May, the man transferred to HMP Lindholme. A nurse conducted a health screen in reception but again there was no mention of hepatitis C. There is no evidence from the man's medical records that he was seen by a GP after his reception.

27. On 12 June, blood samples were taken from the man to test for blood borne viruses. He tested positive for hepatitis C and was referred to a consultant virologist at outside hospital. The outcome of that consultation, if it took place, was not recorded in the man's medical record.

28. The man returned to Wealstun on 23 June, but refused to participate in a reception health screen. On 4 July, he chose not to attend a GP appointment and said that he intended to "transfer out again soon anyway".

29. The man moved to HMP The Mount on 13 July. On reception, a nurse noted that he had been treated for hepatitis C. On 28 August, a specialist at The Mount in the fields of blood borne viruses and sexual health examined the man and discussed his previous failed treatments. The nurse referred him to a consultant gastroenterologist at outside hospital who assessed the man on 11 September.

30. The consultant gastroenterologist wrote to the specialist nurse, noting that the man's initial pegylated interferon treatment had failed due to suspected alcohol misuse and confirming that his second course of treatment had been terminated early as there had been insufficient improvement to warrant continuing. He also informed the nurse that the man had fibrosis (excess fibrous connective tissue in an organ) and cirrhosis. He referred him for an ultrasound scan of his liver, to be followed up by further scans at six monthly intervals. The scan took place eight days later and revealed that he had chronic liver disease. In addition, he referred the man for a gastroscopy

(examination of the inside of the gullet, stomach and duodenum) to check for oesophageal varices, dilated veins that have a strong tendency to bleed.

31. The specialist nurse in the fields of blood borne viruses and sexual health at The Mount saw the man on 2 October, after he had complained of suffering from “pins and needles” for the previous 24 hours and he referred him to the GP. The GP conducted an electrocardiogram (ECG - used to measure the electrical output, and rhythm of the heart) and diagnosed a muscle strain. The man’s symptoms persisted and on 18 October, a locum GP referred him for a chest X-ray. He refused to attend the appointment. There are no records in his medical notes about what, if any, action was taken in relation to the missed appointment.

32. On 22 October, the man told a nurse that although he had not eaten solid foods for the previous two days, he had noticed that his faeces appeared black. The nurse suspected that he had a melaena (black faeces arising from a bleed in the gastrointestinal system). She referred him to the GP, who examined him the same day. The GP noted the man’s history of hepatitis C and cirrhosis and suspected that he had had an upper gastrointestinal bleed (UGI - bleed caused by enlarged veins in the oesophagus or stomach). The man was admitted to outside hospital as an emergency, where he had a gastroscopy. The results showed non-bleeding varices. Propranolol was prescribed (to relax blood vessels and slow the heart rate to improve blood flow and decrease blood pressure) in an attempt to reduce the risk of a further bleed.

33. The man returned to The Mount the next day. The Sister noted he was much improved. He told her that he felt that the medication he had been prescribed could have contributed to the gastrointestinal bleed.

34. On 24 October, the specialist nurse at The Mount in the fields of blood borne viruses and sexual health contacted the consultant gastroenterologist at outside hospital for advice about the man’s medication. The doctor said that the current prescriptions were fine and could be taken in conjunction with propranolol. He said healthcare staff should be aware of the possibility of future haematemisis (vomiting of blood) or melaena. On 30 October, a prison GP spoke to the consultant gastroenterologist about the man’s discoloured faeces. The consultant gastroenterologist advised that at the time of the gastroscopy no bleed was noted. He did not consider there was any big risk of a gastrointestinal bleed and that any risk was minimised by the use of propranolol.

35. At 5.10pm on 17 November, a nurse was called to the man’s cell as he was in pain and unable to move. He took his observations which were normal. He advised the man that if his symptoms got worse he should inform wing staff who would contact healthcare immediately. His symptoms continued and he still reported passing dark stools. At 1.50am on 18 November, he was taken to outside hospital as an emergency admission. The hospital conducted an endoscopy to establish the cause of the pain.

36. After the endoscopy, the nurse from the prison contacted a Sister at the hospital to obtain an update on the man's condition. She told him that although there was evidence of blood in the stomach, it did not appear to be from a recent bleed. They would carry out a further endoscopy, as well as blood transfusion in the next two days and he would remain in hospital. He later had two blood transfusions.

37. As is standard practice, the prison carried out a risk assessment before the man went to hospital to consider the security measures required, including the use of restraints. The form should include a medical assessment but there were no comments from healthcare staff in the medical section. Staff assessed him as a high risk of escape (on a scale of low, medium, high) with medium escape potential and a low risk of outside assistance. The main justification for this was actions and behaviour during a previous prison sentence three decades before. No risk to the general public was noted. The residential manager authorised the risk assessment. She instructed that two staff should accompany the man and that he should be restrained during the journey with single standard handcuffs (a handcuff placed on the prisoner, the other half worn by one of the escort officers). While he was in hospital, escort staff should use an escort chain (a long chain with a handcuff at each end attached to the prisoner and an officer).

38. The escort officers asked the man if he would like the prison to inform his next of kin of his condition but he said that he did not want his family to know.

39. At 4.55am on a morning in November, one of the escort officers recorded that the man had been vomiting blood and nurses had attended. At 6.05am, she noted in the man's escort record, "vomiting copious amounts of blood, doctor been in attendance for 20 minutes". In both entries, she recorded that the man was still restrained by an escort chain. .

40. At 6.15am, the man attempted to get out of bed, but while doing so collapsed and became unresponsive. One of the escort officers called for help. While waiting for the nurses to attend, she removed the man's restraints to enable resuscitation. At 6.20am, the man regained consciousness and the escort officer reapplied the restraints.

41. The man had an X-ray of his stomach at 7.10am. The escort chain was removed for the procedure and reapplied immediately afterwards. After the X-ray, one of the escort officers asked the man for the contact details of his next of kin. She passed the information on to nurses at the hospital and staff at The Mount. A member of the chaplaincy team at The Mount acting as family liaison officer attempted to contact the man's son both by telephone and by visiting the address he had given, but was unsuccessful.

42. At 8.55am, the officer who had taken over escort duties from his colleague recorded that the man was distressed and in considerable pain. Nurses gave him pain relief. It was apparent to the officer that the man's condition was deteriorating so he contacted the duty governor at The Mount to request

permission to remove the restraints. The then Head of Security and Operations, agreed.

43. After the officer's telephone update, the Head of Security and Operations updated the risk assessment completed on 18 November, to reflect the man's deteriorating condition. The medical section of the risk assessment noted that he was "having intense treatment which would be easier to administer without constant use of cuffs". In the security section, he was assessed as medium risk to the public, low risk of hostage taking, medium risk of escape with low risk of outside assistance. The Head of Security and Operations noted on the risk assessment that restraints were no longer necessary and the presence of two prison officers would be sufficient to manage any risk posed by the man.

44. At 9.03am, the man again required resuscitation, which continued until 9.25am when a pulse was noted. A senior sister told the escort officers that although he had a pulse he was not expected to survive. The man died at 10.00am.

45. In the last hours of the man's life, The Mount tried to contact his son to tell him of his father's deteriorating condition. The family liaison officer was unable to contact the man's son as the number the man had given was incorrect and he did not live at the address provided. The family liaison officer spent eight days contacting various individuals and organisations in an attempt to trace the man's son. After exhaustive efforts, he was able to inform him of his father's death in person on 29 November.

46. The Mount held a memorial service for the man on 11 December. His funeral was held on 13 December. The service was conducted by a member of the chaplaincy team and representatives from The Mount attended. In line with national guidance the prison contributed to the cost of the funeral.

ISSUES

Clinical care

47. The clinical reviewer makes a number of observations and recommendations on clinical matters. We have reflected some of her concerns but have not repeated them all.

48. The man had a longstanding history of hepatitis C and cirrhosis for which he received extensive treatment before his imprisonment and this continued in prison. He had developed dilated veins as a result of those conditions. Both primary and secondary care providers were aware that possible symptoms such as dark stools and vomiting blood were possible so medication to both stop and prevent bleeding was prescribed.

49. The man transferred between several prisons throughout his time in custody. Although his condition was not always fully recorded during healthscreens, there is no evidence that this impacted on his treatment. On the whole, the sharing of medical information between the prisons was carried out efficiently and referrals to secondary care providers were made promptly. When the man was admitted to hospital, prison healthcare staff telephoned the hospital daily to check his progress and when he returned to prison, they contacted his consultant to discuss his discharge recommendations.

50. The clinical reviewer established that prisoners with blood borne viruses are well catered for at The Mount. The healthcare department has strong relationships and well-established methods of communication with secondary care providers. The prison's specialist in this field has developed a variety of in-reach services (where specialists in various fields attend the prison on particular days rather than prisoners waiting for outpatient appointments). They are supported by a range of protocols between The Mount and secondary care providers. These protocols include compacts for prisoners to sign and information for prison staff to enable them to support prisoners undergoing treatment while retaining medical confidentiality. We are satisfied that the man's treatment and the handling of his medical care at The Mount was prompt and appropriate.

Record keeping and care plans

51. On occasion, the man's medical records did not always have sufficient detail. Some contained little information with no outcome of referrals or evidence of the follow up actions taken. The clinical reviewer considers the entries probably did not fully reflect the consultations with the man.

52. The clinical reviewer notes that the healthcare team at The Mount kept in good contact with the hospital about the man's progress each day and this was well documented in his medical record. When he was discharged from hospital on 23 October there was appropriate discussion with the hospital about the discharge recommendations. The healthcare team at the prison monitored him closely but there was no specific care plan to determine how

often, or for how long, they should review him. Neither did they note the observations to be taken or what questions should be asked in order to identify a gastrointestinal bleed. The clinical reviewer considers that the records should have specified blood pressure checks, pulse rate and rhythm, respiratory rate and discussions about bowel movements and vomiting. We make the following recommendations:

The Head of Healthcare should ensure that staff record all contact with patients in line with General Medical Council and Nursing and Midwifery Council guidelines.

The Head of Healthcare should ensure there is a care plan for prisoners with acute conditions which includes care after an admission to hospital, the frequency and duration of observations and the signs and symptoms to be checked.

Escort Security

53. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgment also indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process.

54. The man attended hospital both as an outpatient and for extended stays. The risk assessment carried out before his emergency admission to hospital on 18 November 2012, as well as the subsequent review when he became an inpatient, were not clearly based on the risk he posed at that particular time. Part of the risk assessment was based on events from a previous sentence 30 years earlier when he apparently attempted to escape. There was no medical opinion in the risk assessment about how his state of health impacted on his risk, although the Head of Security and Operations took this into account when the risk assessment was revised an hour before the man's death.

55. The High Court judgment deemed that handcuffing a prisoner during life saving treatment was degrading and British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others. In their record of events, the escort officers noted that while undergoing two separate blood

transfusions on 18 November, the man remained under restraint. We do not consider that there was sufficient evidence to indicate that he presented such a risk as to justify the use of an escort chain during this invasive procedure.

56. At 6.15am on a morning in November, the man vomited blood and subsequently collapsed. One of the escort officers correctly removed the restraints while hospital staff administered cardiopulmonary resuscitation. Immediately after he regained consciousness the escort chain was reapplied until 8.55am, when the Head of Security and Operations authorised their removal.

57. We recognise that the Head of Security and Operations appropriately authorised the removal of the restraints not long before the man's death. This was a decent decision. However, we are concerned that until that stage there is no evidence that risk assessments took into account medical opinion about how his state of health affected his risk as the High Court judgment and subsequent Prison Service guidance requires. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances and are based on the actual risk the prisoner presents at that time. Unless there are exceptional circumstances restraints should not be used during life saving treatment.

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Family liaison

58. When the man's health seriously deteriorated, the family liaison officer unsuccessfully attempted to contact the man's son, using the contact details recorded in prison records and given again by the man shortly before his death. After considerable effort, the family liaison officer eventually made contact on 29 November, eight days after the death and broke the news to him in person. We consider that the efforts made by the family liaison officer to trace the man's son were commendable.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff record all contact with patients in line with General Medical Council and Nursing and Midwifery Council guidelines.

   Accepted. "The Head of Healthcare will now audit and monitor record keeping, particularly by temporary staff. An audit trail for this purpose will be maintained."

2. The Head of Healthcare should ensure there is a care plan for prisoners with acute conditions which includes care after an admission to hospital, the frequency and duration of observations and the signs and symptoms to be checked.

   Accepted. "Care plans are in place, however they will be reviewed and monitored by the Senior Nurse Practitioners. There is currently a named Nurse who checks all discharge summaries from hospital acute and long term admissions."

3. The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances and are based on the actual risk the prisoner presents at that time. Unless there are exceptional circumstances restraints should not be used during life saving treatment.

   Accepted. "The current escort risk assessment which is signed off by the Duty Governor/Head of Security has been updated to make it clear that restraints can be removed for emergencies and/or LIFE saving medical treatment. As an establishment we continue to run an approved single Officer escort list which is updated monthly to ensure restraints are not used on our lower risk prisoners or those that have been allowed ROTL or escorted absences. All prisoners are re-assessed within 24 hours of the escort being confirmed as a bed watch and then visited every 72 hours from that point by a Custodial Manager or above. Any reduction in risk or concerns about the ability to provide medical treatment in a decent and safe manner will be assessed as part of those visits. The new risk assessment has been seen and approved by the Governor of The Mount."