PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man at HMP Bristol in November 2011

Report by the Prisons and Probation Ombudsman for England and Wales

June 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Bristol. He was 68 years old. He was found to be unresponsive in his cell and was pronounced dead shortly afterwards by a prison doctor. The post mortem recorded the cause of death as coronary artery atherosclerosis. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer, on behalf of the local Primary Care Trust, carried out a review of the man's medical care in custody. Bristol Prison cooperated fully with the investigation.

The man was remanded to Bristol on 21 April 2011. He reported that he had been diagnosed with hypertension in the community, but had not taken his medication for some months. There was a delay of a few days before his medical records were obtained from his general practitioner. Appropriate medication was then prescribed, but he was not monitored and reviewed in line with best practice. I do not consider that either of these issues had a significantly adverse impact on his medical condition.

Staff acted calmly and competently when they discovered him apparently lifeless in his cell. Despite not using the relevant emergency code, staff brought emergency equipment to the scene quickly. As in a previous investigation at Bristol, we found that next of kin details were not recorded and it was not clear that he had been asked for them.

There are some improvements in procedures to be made, but overall I conclude that the man received appropriate care during his time at Bristol, that this was equivalent to that which he might have expected in the community, and that his death could not reasonably have been prevented.

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 2012**

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SUMMARY

1. On 21 April 2011, the man was remanded to HMP Bristol following his arrest the previous day. During a reception health assessment, he disclosed to a nurse a history of hypertension and arthritis for which he had been receiving treatment. Despite this information, no immediate request for his community medical records was made.

2. Six days later, and following a second assessment with another nurse, the man's community general practitioner (GP) records were obtained. Following a consultation with the nurse, a prison doctor prescribed him medication for high blood pressure. This condition was managed appropriately with medication, although the clinical reviewer notes that he was not systematically reviewed in line with best practice nor was his renal (kidney) function monitored.

3. The man was described by staff as a quiet prisoner who did not raise any concerns with either his personal officer or wing staff. He suffered a collapse on 20 June and was taken to hospital for further tests. There is no information in his medical record about how long he was in hospital or whether he had any treatment. He was not seen by a medical professional on his return. We consider that any prisoner returning from a hospital admission should be assessed by healthcare to check any diagnosis, treatment or medication required.

4. On 28 November, the man ate his evening meal with his cellmate and they watched television as usual. At 10.30pm they both went to bed. The following morning, shortly after being unlocked at 8.30am, the cellmate alerted an officer that he was unresponsive. Having quickly assessed him, the officer shouted to a nearby senior officer that he needed healthcare assistance. The code system in place at Bristol to differentiate the type of emergency and expedite the correct response was not used. In the circumstances of this case, it would not have made any difference to his chances of survival, but in another incident this could have been a crucial weakness.

5. Three healthcare professionals quickly went to the cell and started cardiopulmonary resuscitation (CPR). This was difficult as the man's jaw was stiff and it appeared rigor mortis had set in. An ambulance had been requested but, while waiting for paramedics to arrive, the prison doctor arrived at work and immediately went to the cell. He pronounced him dead one minute later at 8.51am.

6. No next of kin details were recorded for the man and it is not known whether he was asked about his next of kin or refused to give any details. We recommend that this section of a prisoner's record is completed more carefully. The prison did not manage to make contact with the executor of his Will, his nephew, until 22 December. His nephew then arranged his funeral. This took place on 20 January 2012 with the prison's family liaison officer in attendance.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 29 November 2011. An investigator opened the investigation on 5 December and arranged for relevant documents to be sent to the allocated investigator. On 3 January 2012, the investigator telephoned the prison, the Prison Officers' Association (POA) and Independent Monitoring Board (IMB) to introduce herself and invite them to raise any concerns. No issues were raised.

8. The investigator issued notices inviting staff and prisoners to contact her with any relevant information. There was no response.

9. On 24 January and 1 February, the investigator interviewed a number of staff and the man's cellmate at Bristol. The Governor of Bristol was given written feedback on the progress of the investigation in February 2012. The local Primary Care Trust commissioned a clinical reviewer to review the clinical care the man received at Bristol. The doctor completed this on 28 February.

10. Her Majesty's Coroner for Avon was notified of the investigation. The Coroner will receive a copy of this report to assist with her enquiries.

11. One of the Ombudsman's family liaison officers contacted the man's nephew on 16 January 2012 to explain the purpose of the investigation and invite him to ask any questions or concerns about the care his uncle received in prison. He did not raise any issues at that stage.

12. The nephew received a copy of the draft report as part of the consultation process. In his response, he expressed his concern that prison staff did not use the correct emergency code during their response to the incident and agreed with the recommendation to improve practice in this area. He further supported the recommendation to ensure accurate and up to date next of kin details are recorded for all prisoners.

HMP BRISTOL

13. HMP Bristol is a 19th century local prison holding just over 600 prisoners. It receives convicted and remanded adult male prisoners and a limited number of young offenders, from local courts. This results in a high turnover of prisoners.

14. Bristol Primary Care Trust (PCT) provides the prison's healthcare services. The healthcare centre has 20 in-patient beds. Avon and Wiltshire Partnership Trust provide mental health services and six full time registered mental health nurses support prisoners.

Her Majesty's Chief Inspector of Prisons

15. The last inspection of Bristol by Her Majesty's Chief Inspector of Prisons was an announced inspection in January 2010. In the concluding paragraph of the introductory section of the report, the Chief Inspector wrote:

> "Managers at Bristol had succeeded in reversing the decline we recorded at the last inspection (in 2005). As a consequence, we were able to raise two of our assessment ratings. However, in spite of these efforts, the effects of continued population pressure meant that Bristol was not yet performing well enough in three crucial areas – safety, respect and activity."

16. Inspectors noted that health services were improving but at the time primary care, for both physical and mental health provision, were under-resourced. They also reported that emergency resuscitation equipment, including defibrillators, were located on each of the wings and in the healthcare centre and that all health services staff had completed training in its use.

Independent Monitoring Board

17. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. In their most recent report, for the period 1 August 2010 to 31 July 2011, Bristol's IMB were positive about the leadership of the prison and reported significant and continued improvement. Relationships between staff and prisoners were mainly good with a reasonable personal officer scheme. In early 2011 the prison had acquired additional GP services.

Previous deaths at HMP Bristol

18. The man is the 23rd prisoner to die at Bristol since the Ombudsman began investigating deaths in prison in 2004. Eleven of these deaths were due to natural causes. Following a death due to natural causes in 2008, we recommended that the Governor ensured next of kin details for every prisoner were accurately recorded and checked. Regrettably, we found this is still not being done.

KEY EVENTS

19. The man was born in 1943. He had not worked since he was 48, when he was medically retired.

20. On 20 April 2011, he was arrested for sex offences and, following an appearance at court, remanded to HMP Bristol the following day. This was not his first time in prison. During his induction, he said he had no thoughts of suicide or self-harm. Staff assessed him as a low risk of harm to other prisoners and suitable to share a cell.

21. The initial health screen, completed by a nurse during the reception process, recorded that he "appears well". He told the nurse that he had not consistently taken his medication for blood pressure and arthritis in the community. The nurse recorded he was a "bit nervous, good eye contact and conversation, bit forgetful, good spirits".

22. On 24 April, the man was seen by another nurse with reported shoulder pain which had persisted since before his imprisonment. She noted that she would contact his community GP and ask the prison doctor if he could prescribe some ibuprofen (an anti-inflammatory and painkiller). The doctor prescribed this medication the following day.

23. The man's blood pressure was 210/140 on 26 April which meant he was hypertensive (had high blood pressure). He asked to see a mental health professional and an appointment was booked for 4 May.

24. The following day, the prison doctor received a fax from the man's community GP. This indicated that the GP had last assessed him in November 2009 and was not aware of any history of shoulder pain. He had last been prescribed hypertension medication in October 2010.

25. Following receipt of this fax, a nurse spoke to him on the wing. He told her that he did not like the nurse at his GP's surgery and had not returned to get a repeat prescription for six months. He confirmed that he would like to be prescribed medication while in prison, as he was feeling unwell. A doctor reviewed his medical record and consulted a nurse. The doctor did not meet him directly. The doctor prescribed lisinopril, felodipine and bendroflumethiazide which are all used to treat hypertension. At interview, the doctor said that he told the nurse that if his blood pressure did not fall to within the normal range, he should be informed and the prescription of lisinopril would need to be increased.

26. On 28 April, the man appeared at Magistrates' Court and his case was adjourned until 26 May. Around a week later, he had several tests including blood, liver function, urea and electrolytes and cholesterol. The results of these tests were all within the normal range.

27. As planned, on 4 May, he was assessed by a nurse from the Community Mental Health Team (CMHT). The nurse noted that he looked tired. He said he had referred himself regarding thoughts connected to his offending behaviour and

how he could control these. The nurse told him that the CMHT could not assist him as he was not having psychiatric difficulties. He agreed with this assessment and said it had been "worth a try". The following day, he was discussed at the Single Point of Entry Meeting (SPEM) by the CMHT. It was agreed that mental health treatment was not appropriate.

28. A nurse measured his blood pressure on 21 May which was 144/103. Although improved, this was still higher than the normal range. The nurse informed the doctor, who doubled his prescription of lisinopril the following day.

29. On 26 May and 2 June, the man appeared at Magistrates' Court and his case was committed to Crown Court.

30. The personal officer scheme allocates a named officer to each prisoner who they can approach for advice or to resolve complaints. The man's personal officer made an entry on 16 June on his contact record. He recorded that he had settled well on the wing, was working in recycling and was generally a quiet prisoner. The officer made further similar entries from August to November. The officer told the investigator that the man never approached him with any issues. Another officer who worked on D Wing where the man lived and saw him daily, described him as a very heavy smoker and quiet prisoner who sometimes socialised with the older prisoners. He never raised any issues with her.

31. During the morning of 20 June, the man collapsed while at work and was unconscious for around 30 seconds. A nurse attended immediately and assessed him. She recorded that he was pale but talkative. He told the nurse that he had lost consciousness once before, around six months previously (before he was in prison). A prison doctor reviewed him and asked for an ambulance to be called. Paramedics attended and completed an electrocardiogram (ECG – measures the electrical activity of the heart). The result was satisfactory but he was taken to hospital for further checks and observations.

32. The Primary Healthcare Manager told the investigator that the man returned to Bristol later that day, although this was not recorded on his medical record. No discharge summary accompanied him as no diagnosis or treatment had been identified by the hospital and the tests had not identified any concerns.

33. At Crown Court on 24 June, the man pleaded guilty to one of the charges against him. (However, although convicted, he remained unsentenced until he died due to further assessments and information requested by the court.) A prison doctor prescribed him omeprazole (used to treat stomach problems as a result of prolonged use of ibuprofen) on 27 June.

34. On 10 July, a nurse assessed him as he told her he had felt dizzy two days previously. She checked his pulse and blood pressure, which was recorded as 140/93. In interview, the doctor said that, although this was still higher than it should be, it was not "desperately high" and had improved since his arrival at the prison. The nurse advised him that if he had any further feelings of dizziness, he should inform healthcare staff.

35. A letter from the man's solicitor dated 15 August and received the following day, requested that the prison doctor refer him for a computerised tomography (CT) scan. (A CT scan is used to obtain a detailed image of part of the body, in this case his brain). This was to fulfil the court's request that he be assessed for dementia. The doctor telephoned the solicitor to suggest that he ask a consultant psychiatrist to refer him for the scan. He requested that this appointment be sent straight to the healthcare department so that they could arrange for a member of staff to escort him to the hospital.

36. It is noted in the medical record on 7 September, that a psychiatrist had assessed the man and determined he needed a brain scan. The same day the doctor discussed this with the healthcare manager, who agreed that there were no medical issues to warrant a CT scan being arranged by primary care. The doctor recorded that any scan recommended by the solicitor would need to be funded by them or the man. It is not recorded whether this was communicated to the solicitor and in interview the doctor could not recall any detail surrounding this request for a brain scan.

37. While reviewing the man's medical record, the doctor also noted his loss of consciousness on 21 June. The doctor concluded that this might have been related to his high blood pressure but that this was now being more successfully managed with medication.

38. On 18 September, a nurse noted on the medical record that she would speak to the doctor since the man had been prescribed ibuprofen for a significant period. The doctor discussed his ibuprofen prescription with him on 23 September. This included the effect of the medication on his kidneys and it was established that he was not suffering from dyspepsia (discomfort associated with eating). They agreed that he would take paracetomol in the first instance and subsequently ibuprofen if the shoulder pain continued.

39. The man made a further request for paracetomol and ibuprofen on 4 November. A nurse recorded that she believed he had chronic ongoing pain and stated that he should be reviewed and prescribed as appropriate. This took place and further prescriptions of ibuprofen and paracetomol followed during November.

40. On 14 November, the man's prescription of felodipine was changed to amlodipine. This was due to financial constraints but the doctor told the investigator that the drugs are from the same family and used to treat the same condition. The doctor also confirmed that he never met him but was satisfied that the consultation between himself and other healthcare staff was sufficient to treat his hypertension.

41. A prisoner shared a cell with the man towards the end of November. He told the investigator that they got on well together. He never complained to him of any issues with the prison or of being in any pain. He had dinner with him in their cell at around 5.15pm on 28 November. They talked and watched television for the rest of the evening. An officer locked their cell door around 7.00pm, as was usual. The officer recalled that he was sitting in his cell, watching television and

smoking a cigarette. The cellmate said that he and the man both went to bed around 10.30pm. He went to sleep a few minutes later and noticed nothing unusual during the night.

42. At 6.35am, the officer checked the cellmate, as he was subject to suicide and self-harm monitoring procedures. At the time, she noticed the man was lying in his bed but made no further observations.

43. The officer then unlocked the man's cell at about 8.30am. She continued to unlock the rest of the wing. The cellmate told the investigator that he left the cell at this point to collect his medication, assuming that the man was still asleep. He returned minutes later and started talking to him. When he received no response he gently shook him and then immediately rang the cell bell (Each cell has a bell to be used by prisoners in the event of emergency or if they require staff attention).

44. Meanwhile, Officer A had been supervising the issue of medication nearby when he realised the man's cell bell was ringing. The officer went straight to the cell and opened the door. The cellmate told the officer that he thought the man was dead. The officer asked him to leave the cell and he then went in. The officer later recorded that he had been motionless, pale, his lips were very pink and he was lying on the lower bunk with a sheet pulled to the top of his chest.

45. The officer tried to wake him but received no response. From the cell door he shouted to a Senior Officer (SO), who was nearby, to request healthcare assistance. The SO said that he knew it was a serious situation by the expression on the officer's face. He alerted a Healthcare Assistant (HCA), and two nurses who were issuing medication in the nearby treatment room on the wing.

46. The HCA was the first to arrive at the cell. This was within a matter of seconds of assistance being requested, according to the officer. The HCA told the investigator that she was unaware that it was an emergency until she arrived at the cell and was asked to check the man's pulse. At that point she asked for more nurses to attend, checked his pulse and noticed that he was cold to the touch. Nurse A then arrived at the cell with the oxygen bag, followed by Nurse B shortly afterwards. The HCA attached the oxygen saturation machine to the man, which indicated there was no pulse. The HCA told the investigator that she noticed his hand and neck were stiff. She immediately went to get the emergency bag containing a defibrillator (a device that corrects an abnormal heart rhythm by delivering electrical shocks to restore a normal heartbeat).

47. Nurse A's first impression, based on her nursing experience and the man's appearance, was that he had died. However, she asked staff to move him to the floor. The officer and Nurse B moved him, as requested. The HCA and Nurse A both believed that he remained on the mattress, which was moved to the floor. The officer's recollection was that he was taken off the mattress and placed directly on the floor. (Either arrangement would have provided a sufficiently firm surface for resuscitation.)

48. A nurse began chest compressions at 8.35am in an attempt to resuscitate the man while Nurse A tried to insert an airway. This proved impossible as his jaw was stiff. She attached the ambu bag (used to aid resuscitation) to him and the defibrillator, which advised not to shock. They continued resuscitation attempts. The officer left the cell and asked the SO to contact the doctor. The SO did this via his radio and also asked for an ambulance to be called, along with more healthcare staff. The SO then handed over management of the emergency to the SO of the wing.

49. Within the next few minutes, three more nurses and two more SOs arrived, along with other members of staff. At around 8.50am, a doctor went to the cell. He had just arrived at the prison and immediately went to the man's cell, having been informed there was an emergency. The doctor's assessment on seeing him was that he had been dead for some time. He was unresponsive to resuscitation, rigor mortis had set in and there appeared to be post mortem lividity on his left thigh (a discolouration of the skin and a sign that he had been dead for some time). The doctor pronounced him dead a minute later.

50. The chaplain, an IMB member, care team and police all arrived shortly afterwards. Despite several requests to the prison, the investigator has been unable to ascertain whether the requested paramedics were cancelled or subsequently arrived at the prison.

51. A few minutes later, at 9.00am that morning, a hot debrief took place (a meeting to learn any immediate and urgent lessons, as well as to check on staff welfare following serious events and emergencies, such as deaths in custody). Staff discussed the man's death, the emergency response and were offered the support of the care team or a governor. A critical incident debrief took place for staff a few weeks later. (This meeting is intended for staff to reflect on the emergency, consider what lessons might be learned and check on the continuing welfare of the staff involved.) All staff interviewed said they had felt adequately supported following the death.

52. The post mortem report recorded the cause of death as coronary artery atherosclerosis (the arteries leading to the heart gradually become blocked). The doctor told the investigator that risk factors associated with this disease are smoking, poor diet and high blood pressure.

53. No next of kin details were recorded for the man. A line had been placed through the space for these details on his personal summary sheet which was recorded as being completed by an officer on 21 April 2011. The investigator contacted the prison to speak to the officer but was told that the only officer working in reception with that particular surname was another officer. The officer told the investigator that he could not remember if he had met the man but that if he put a line through the space for these details it would mean that the prisoner had told him they had no next of kin. The officer said that if they had refused to give him any details he would write "refused" on the sheet.

54. A governor was appointed the prison's family liaison officer. The man's legal representative and the police were involved in trying to establish his next of kin.

Following their enquiries, his half brother was identified and the governor telephoned him on 7 December to inform him of his brother's death. The man's half-brother was already aware of his death. He requested that the prison organise the funeral and this was due to take place on 23 December.

55. However, on 22 December, the man's nephew was identified as the executor of his Will. He wished to be considered as the next of kin and organise the funeral. The prison offered to contribute towards funeral expenses but this was declined. The funeral took place on 20 January 2012 and the governor attended.

ISSUES

Delay in getting community GP records

56. Prison Service Order 3050 (PSO, a policy document applicable to all prisons in England and Wales), regarding continuity of healthcare for prisoners, instructs that:

> "When a prisoner enters reception … efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with."

57. The man arrived at Bristol on 21 April. On the same day, he was assessed by a nurse and disclosed he had been receiving medication for arthritis and high blood pressure in the community. No attempt was made to obtain his community GP records. The nurse no longer works at Bristol. However, when he was assessed by another nurse on 24 April she noted she would obtain the records and on 27 April a doctor received them. The doctor prescribed him medication for high blood pressure the same day.

58. The doctor told the investigator that the man had not been taking medication for six months before he was remanded to prison. The doctor believed the delay of six days in obtaining his community medical records and prescribing him medication would not have had an impact on his health. He said that ideally the records would be obtained and medication prescribed quicker than this. Overall, he is satisfied that there is no general delay in obtaining community GP records at Bristol.

59. The clinical reviewer also concludes that the six days it took to obtain his GP records and prescribe the man's medication did not place him at significant risk. Nevertheless, in other cases a delay could make a difference. We therefore make the following recommendation:

The Head of Healthcare should ensure that reception staff request community GP records for all new arrivals in prison, within 24 hours, with particular priority for those who report a chronic disease or other significant condition in their medical history.

Clinical care

60. The man had a history of hypertension. He had stopped taking his medication for six months before his remand to Bristol. Within a week, he was prescribed medication for high blood pressure and the dose was reviewed as necessary by the doctor.

61. The clinical reviewer concludes that in relation to the management of the man's hypertension:

> "Restarting previous medication was appropriate and titrating lisinopril against response was appropriate. A blood test was appropriately taken for renal

function, and cholesterol and liver function about a week after restart the results of which were unremarkable. In best practice a baseline renal function and a repeat at each increase in an ACE inhibitor should be performed. There was no evidence of these."

62. Lisinopril is an ACE (Angiotensin Converting Enzyme) inhibitor. ACE inhibitors are used primarily to treat blood pressure. The clinical reviewer told the investigator that best practice is that before an ACE inhibitor is started a baseline renal function test should be taken. This should be repeated after any change in dose of the medication and subsequently reviewed annually.

63. The clinical reviewer also adds:

> "The dose of lisinopril was increased to 5 mg appropriately as control was inadequate. Although this was likely to be sufficient for good management of the bp [blood pressure] there was no clear plan for review, or evidence of a further review."

64. He said that once the man's medication was increased, he would have expected a review date to have been set, normally around a month later, to assess its effectiveness. He notes the absence of a systematic review of blood pressure and full monitoring of renal function as minor factors in his review. However, we make the following recommendation,

The Head of Healthcare should ensure that the management of hypertension is systematically reviewed and renal function is appropriately monitored when ACE inhibitors are prescribed.

65. On 20 June, the man collapsed. Having been assessed by a prison doctor, he was taken to hospital via ambulance for further tests. He had a further bout of dizziness around 8 July and was advised to tell healthcare staff if this happened again. The clinical reviewer concludes that this advice and the admission to hospital were appropriate. However, there is no record of how long he spent in hospital, whether any diagnosis was made and whether any follow-up treatment or medication was needed.

66. The Primary Healthcare Manager told the investigator that since the man's death she had been made aware that he had only remained at the hospital for a number of hours and that his observations while there were all normal. However, this is not documented in his medical record. She said she would not expect a discharge summary from the hospital for such a short stay where test results had been unremarkable.

67. However, the Healthcare Manager added that she believed that it would be good practice for every prisoner returning to Bristol following a hospital admission, to be assessed by healthcare staff. This would involve checking whether the prisoner had any discharge documents, if treatment had been recommended, medication was needed or a diagnosis had been made. She was aware this was standard practice at other prisons. She had only been working at Bristol for six weeks at the time of speaking to the investigator on 4 April 2012.

68. The clinical reviewer comments on the lack of discharge documentation that, "this should have been followed up and outcomes documented in the clinical record". Accordingly, we make the following recommendation:

The Head of Healthcare should ensure that every prisoner returning to Bristol after a hospital admission is assessed by a healthcare professional and that this is documented on the prisoner's medical record.

69. Despite these recommendations, it is worth highlighting the clinical reviewer's conclusions that,

> "There is no evidence that there was an action that could have been taken that would have led to any different outcome. Compliance with medication was almost certainly better by the patient within prison compared with in the community."

Management of the emergency situation

70. It is good practice for a prison to operate an emergency code system. This informs staff not only that there is an emergency but also of its nature. This enables them to better prepare, including taking the correct emergency equipment. Two nurses, a doctor and the officer who discovered the man all confirmed that a code system was in operation at Bristol. This included the use of "code blue" if someone was discovered not breathing, as was the case with him.

71. In this instance, an officer was not carrying a radio and healthcare staff were nearby. They were simply informed that they needed to attend the man's cell by a senior officer on the wing. In fact, the HCA who first reached the cell had not realised it was an emergency and had not taken the emergency equipment, such as a defibrillator, with her.

72. The emergency bag was retrieved very quickly and chest compressions were started on the man within a few minutes of the alarm initially being raised. Healthcare staff reacted quickly, calmly and competently in managing the emergency situation. We do not believe the use of a code system would have changed the outcome for him.

Identifying the man's next of kin

73. Prison Service Instruction (PSI) 52/2010, Early days in custody, states that, on reception into the prison, staff must ensure that the next of kin details or nominated contact are accurately recorded.

74. When a prisoner dies, PSO 2710, Follow up to deaths in custody, further states that prison managers must:

> "Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened."

75. No next of kin details were recorded on the man's personal record, a line was simply placed through this space. It is not clear from the document why this was the case and whether he was asked about his next of kin. The investigator has not been able to identify the officer who completed it.

76. It is important that prisoners are asked for their next of kin details and their answers are recorded, even where this involves a refusal to give details, or a prisoner says he has none. Following the man's death, it took over a week to identify that he had a half-brother. A further two weeks then passed until the executor of his will, his nephew, came forward.

77. Following a death due to natural causes at Bristol in 2008, where the prisoner's next of kin details were out of date, we recommended that the Governor ensured the accuracy of every prisoner's next of kin details and that these were checked annually. This recommendation was accepted by the prison. It is therefore disappointing to repeat a similar recommendation:

    The Governor should ensure that staff check the accuracy of every prisoner's next of kin details and record the reasons for the absence of this information. Staff should make an annual check of these details.

CONCLUSION

78. The man was remanded to prison at the age of 67 years old in April 2011. He had a significant history of hypertension but had been non-compliant with medication in the community prior to his arrest. He was prescribed blood pressure medication in prison until he died seven months later.

79. This investigation has resulted in several recommendations to the Head of Healthcare and Governor of Bristol for improvements in the management and treatment of such prisoners. In spite of this, overall, we conclude that the man's care was equitable to that which he would have received in the community and his death could not have been prevented.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that reception staff request community GP records for all new arrivals in prison, with particular priority for those who report a chronic disease or other significant condition in their medical history.

   This recommendation was accepted. All new receptions will receive a secondary health screen within 48hrs of being received at the establishment. During this screening process each patient will sign a consent form which will allow the healthcare department to contact and obtain up to date medical records. This will include recent medications and treatments.

2. The Head of Healthcare should ensure that the management of hypertension is systematically reviewed and renal function is appropriately monitored when ACE inhibitors are prescribed.

   This recommendation was accepted. All patients identified with Long Term/Chronic Disease concerns will be seen by a suitably qualified healthcare professional to review and maintain current health status as per NICE Guidelines and National Service Frameworks. General Practitioners will conduct reviews as indicated within GP practice in the community

3. The Head of Healthcare should ensure that every prisoner returning to Bristol after a hospital admission is assessed by a healthcare professional in reception and that this is documented on the prisoner's medical record.

   This recommendation was accepted. All prisoners returning from hospital including appointments and admissions will be seen by a suitably qualified healthcare professional at reception to ensure further appointments are identified. Treatments are recorded and any further advice from community healthcare providers are recorded on System One.

4. The Governor should ensure that staff check the accuracy of every prisoner's next of kin details and record the reasons for the absence of this information. Staff should make an annual check of these details.

   This recommendation was accepted. LNTS to be published, reminding staff of this, especially if a prisoner refuses to give information. Information is currently collected by GEOamy, reception and induction; Personal officers will be prompted to collect this information on a regular basis. Prisoners at risk to themselves are asked for NOK details when an ACCT is opened.