Investigation into the circumstances surrounding the death of a male prisoner at HMP Bristol in January 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is the report of an investigation into the death from natural causes of a male prisoner at HMP Bristol on 7 January 2010.

I extend my sincere condolences to the man's family and friends and all those affected by his loss.

This investigation was undertaken by an investigator from my office. I should like to thank the Governor of Bristol, and his staff for their co-operation. A clinical review of the man's care and treatment has been carried out by a doctor from Bristol Primary Care Trust.

The man died suddenly and unexpectedly. He died from a subarachnoid haemorrhage following the rupture of a cerebral aneurysm (this condition is explained later on in my report). The clinical reviewer found that it would not have been possible to anticipate the haemorrhage that caused the man's death.

I make three recommendations. Two concern the likely needs of the cell-mate following a death in custody.

Jane Webb
Acting Prisons and Probation Ombudsman **October 2010**

CONTENTS

Summary	4
The investigation process	5
HMP Bristol	6
Key findings	7
Issues	11
Conclusion	14
Recommendations	15
Meeting with the man’s family after issue of the draft report	16

SUMMARY

The man arrived in HMP Bristol on 9 December 2009. He had been sentenced to just over four months imprisonment for driving offences.

During healthcare reception screening at Bristol, the man denied having any health problems and also said that he was not registered with a general practitioner. The nurse's own assessment of the man was that he appeared fit and healthy.

The man had several contacts with healthcare in early January 2010. He reported to a nurse that he was feeling discomfort from an old leg injury and an appointment was made for him to see a doctor. On a separate occasion he reported pain from a dental abscess and difficulty sleeping. He was prescribed antibiotics, paracetamol and sleeping tablets.

The man's cell-mate said that the man would often ask night staff to leave on the in-cell night light. He would ring the cell bell later on in the night for the light to be switched off. This is what he did on the night of 6 January.

At about 5.45am on 7 January, the night staff, who were carrying out a routine roll check, looked into the man's cell. The man was lying on the floor and his cell-mate was in bed. The staff tried to rouse the prisoners but neither responded. (The man's cell-mate has hearing difficulties and had removed his hearing aid upon going to bed.) It was not entirely clear to staff whether it was an emergency situation so they called a senior member of staff. He arrived a few minutes later and also tried, without success, to obtain a response from the prisoners. Staff then went into the cell and found that the man's breathing was laboured. An emergency call was issued and a healthcare nurse responded.

An emergency ambulance had also been called and the paramedics arrived at just after 6.10am. The man was then taken to hospital where he was placed on a life-support machine. Following examinations, it became apparent that the man would not survive. Life-support was maintained pending the arrival of his family. At post mortem, the man's cause of death was found to be subarachnoid haemorrhage following the rupture of a cerebral artery aneurysm.

THE INVESTIGATION PROCESS

1. The Ombudsman's appointed investigator first visited HMP Bristol on 5 February 2010 when he met the prison's Deputy Governor and the Head of Operations. The investigator did not carry out any formal interviews with staff but he did speak with several people during his visit, including the head of healthcare. He also spoke by telephone with the man's former cell-mate.

2. Bristol Primary Care Trust agreed to carry out a review of the man's clinical care and treatment at Bristol and I am grateful to the clinical reviewer for his report.

3. Upon his initial arrival in Bristol, the man named his ex-wife as his principal family contact. One of the Ombudsman's Family Liaison Officers telephoned both the man's ex-wife and his father to explain the investigation process and to give them the opportunity to raise any issues or concerns they wished to be considered. The man's ex-wife and father both wanted to know why the man rang his cell bell at just after midnight on the night before his death. Both also wanted an explanation of the sequence of events when the man was observed to be lying on the floor of his cell. I hope my report answers the family's questions.

HMP BRISTOL

4. HMP Bristol is a 19th century local prison holding just over 600 prisoners. It receives adult male prisoners and a limited number of young offenders, both convicted and remand, from all local courts. It also serves as a category B facility for the West of England. (A category B prison holds prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult.)

5. The most recent inspection of Bristol by Her Majesty's Chief Inspector of Prisons, was an unannounced short follow-up inspection in March 2008. She found that Bristol had improved since the time of the previous inspection, although she also found that there remained a need for further improvement in a number of areas such as opportunities for purposeful activity.

6. 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 its report for the year from 1 August 2008 to 31 July 2009, the Independent Monitoring Board (IMB) at Bristol wrote in a chapter about its overall assessment of the prison that:

> "… HMP Bristol has generally improved over the reporting period. The prison has Level 3 status (one below the highest level) and is striving to move to the next stage. The Board is confident that, in a spirit of challenge and partnership, when the concerns in this report are addressed fully the prison should improve further."

7. Since my office took over responsibility for investigating all deaths in prison custody in 2004, there have been 20 deaths attributed to natural causes at Bristol up to and including the man's death.

KEY FINDINGS

8. The man arrived in Bristol on 9 December 2009 having been sentenced at court to four months and four days imprisonment. As part of the standard prison reception process the man was seen by a nurse for a health screening assessment. The man reported being a heavy drinker, although he declined an offer of assistance with this. He said he was not registered with a general practitioner and denied having any health problems. He also denied having ever misused drugs. Nothing was recorded about the man declaring any drug allergies. The nurse's own assessment of the man was that he appeared "fit and healthy".

9. Another aspect of prison health provision is a follow-up secondary health assessment within one week of the initial assessment. The man declined to have a secondary assessment. He was advised to contact a nurse if he had any health problems.

10. The man did not have a prison job and nor did he go to education. However, the man's cell-mate, told my investigator that he would come out of his cell at association times and was on friendly terms with other prisoners.

11. On 2 January 2010, the man saw a nurse to report discomfort in his leg. He told the nurse that he had had a skin graft about two years previously following an injury to his shin. The nurse examined the man's leg and noted that the area was "inflamed and hot to touch". The nurse made an appointment for the man to see a doctor.

12. Two days later, the man had a consultation with one of the prison doctors about a separate matter. The man reported having a dental abscess, although he said he had pierced the abscess himself the previous night. The man was "not keen" to see a dentist, but would like antibiotics. He also reported trouble sleeping since coming into prison. The doctor prescribed sleeping tablets (zopiclone) and a course of antibiotics (metronidazole) for the dental abscess. The doctor also noted the man telling him that he was getting into trouble for ringing his cell bell at night. The report of the consultation makes no mention of the man's symptoms from two days previously when he was experiencing discomfort in his leg.

13. On the following day, the man had a consultation with another of the prison doctors. The doctor prescribed 32 paracetamol tablets, although she made no note about the man's medical complaint that day, nor about her reason for prescribing medication. She did note that the man should take one or two paracetamol tablets, four times per day when required. The doctor subsequently told the independent clinical reviewer, that she had written the prescription for dental pain.

14. The man's cell-mate, has hearing difficulties and wears a hearing aid. The cell-mate told the investigator that he and the man got on well together. He said that for about the last ten days before his death the man had complained of headaches but nurses "fobbed him off with aspirin".

15. My investigator spoke with Bristol's healthcare manager about procedures allowing nurses to dispense un-prescribed medication (known in the prison as 'special sick'). The healthcare manager said that nurses can prescribe up to three days worth of 'special sick' medication for conditions such as headache or toothache. After that, the prisoner must be seen by a doctor. Prisoners can report 'special sick' either during drug dispensing rounds or can inform an officer who will ask a nurse to call into the wing. All medication dispensed through the 'special sick' process should be recorded in the prisoner's clinical records. The man's records contain no reference to him being issued with any 'special sick' medication.

16. The man's cell-mate also told my investigator that the man had been getting into trouble for ringing his cell bell at night. He explained that staff usually switched off the in-cell night light at around 11.30pm each night. The man would often ask for the light to be left on at that stage and would ring the cell bell an hour or two later to ask for the light to be switched off. The cellmate said that it was at about 1.15am on 7 January, that the man rang the cell bell for the night light to be switched off. The cellmate fell asleep shortly after that. (The records show that the cell bell was in fact activated at 0.53am – not 1.15am as the cellmate thought – and was answered one minute later.) The cell-mate said that later in the night he heard the man making "weird breathing noises". This was at about 3.00am. Although the cell-mate said that he now felt guilty for not doing anything, he had not realised at the time that there was anything to worry about.

17. From around 5.30am, an officer and an officer support grade began to carry out the final roll check of the night shift before arrival of the day staff. The officer reached the man's cell at around 5.45am and on looking into the cell saw him lying face down on the floor. The officer knocked on the door and shouted out, but got no response from either prisoner (the man's cell-mate, who was in the top bunk, was sleeping and was not wearing his hearing aid). The officer called to his colleague and he came across from the other side of the landing. They tried once more to get a response from the two prisoners, but again without success. In their statements, both members of staff mention that the man was making "strange noises".

18. The staff called for the attendance of the night orderly officer. They were not certain that it was necessarily a medical emergency at that stage. When the night orderly officer arrived he went into the cell and tried to get a response from the man by shouting and shaking him. The night orderly officer then noticed some blood on the floor and issued a 'Code Red' emergency alarm. This was issued at 5.50am. (A 'Code Red' alarm indicates that a prisoner is bleeding and that healthcare attendance is needed.) Although the man did not respond to the night orderly officer's efforts, he was breathing unaided.

19. At night time in Bristol, nurses do not carry keys so if they are required to attend to a prisoner they must be escorted to the wing. When the nurse on duty heard the Code Red call she collected the emergency equipment pending arrival of the assistant night orderly officer. When the nurse arrived at the cell she

examined the man and found that his breathing was laboured and he had a rapid pulse. The man's blood oxygen saturation[1] was low so the nurse gave him oxygen. She also asked the night orderly officer to call an ambulance. The nurse used a torch to check the man's pupils and from their appearance thought it likely that there was bleeding in his brain.

20. The call to the ambulance service was made at 6.00am and the ambulance arrived 12 minutes later. After they had examined the man, the paramedics decided that he needed to be taken to hospital.

21. The man was of a large build. He was about six feet tall and weighted around 19 stones. As he needed to be taken down four flights of stairs the only safe option was thought to be to use a 'motorised evacuation chair'. (This is an electrically powered chair with wheels that can negotiate stair ways.) The assistant night orderly officer told my investigator that he collected the chair and the man was strapped in. Unfortunately, when staff attempted to use the chair it could not be used properly due to the steepness of the stairs and the cramped layout. Staff decided, instead, to physically carry the man with him remaining in the chair. He was carried by three officers and one paramedic.

22. The ambulance was timed as leaving the prison at 7.05am. The man was accompanied by two prison officers but no cuffs or other restraints were deemed necessary.

23. Staff at the prison checked the man's records for details of his next-of-kin and a possible name and address were identified. This turned out to be the man's ex-wife and the mother of his children. Due to the urgency of the situation, prison staff telephoned the number listed, but without success. Travel conditions were poor that day following heavy snow fall, so the prison asked the local police to help. Police officers visited the man's ex-wife at her home to inform her of the news. By this time hospital staff had already explained to the prison that the man's death was inevitable but he was being kept alive artificially pending the arrival of his family.

24. The man's ex-wife went to the hospital with other family members and they were met there by a trained family liaison officer, and one of Bristol's chaplains. Bristol then withdrew all its staff from the hospital to allow the man's family to be alone with him in his final few hours. The man died in hospital at 4.30pm.

25. The prison held a hot debrief the following morning to consider the events of the previous day. A member of the prison care team attended the meeting and staff were informed of the support available from that team.

26. At post mortem, the man's death was found to have been caused through a subarachnoid haemorrhage which was secondary to a cerebral artery aneurysm (bleeding into the brain following the rupture of a blood vessel).

[1] Oxygen saturation is the amount of oxygen circulating in the bloodstream. Normal saturation levels are between 95 to 100 percent. the man's saturation was 55 percent when first checked and fluctuated between 89 and 93 percent with oxygen.

27. Bristol's Head of Operations, made further contact with the man's family to offer support with funeral arrangements and expenses. The family came into the prison and visited the man's cell. The same chaplain said a prayer at the cell. The family met the man's cell-mate, and he gave them a condolences card that had been signed by a number of the prisoners. The man's property was also handed to the family. There was further contact between the prison and the family during the course of the following weeks and the chaplain conducted the man's funeral.

28. The investigator asked the head of operations about the actions of the officer and the officer support grade when they first discovered the man. In particular, whether they should have gone into the cell straight away without waiting for the night orderly officer to attend. The head of operations said that the staff acted correctly in first calling for senior support. This was because there were two prisoners in the cell and the situation with the man was initially unclear. This was especially so because some prisoners choose to sleep on the floor rather than on their beds. (All prisons have contingency plans dealing with entry of cells at night time. Ordinarily, staff should only enter a cell in the case of an emergency and before entering must consider the potential risks and dangers of doing so.) The investigator also asked the head of operations whether the night staff could recall why the man pressed his cell bell earlier in the night. The head of operations said that the night staff could not recall the reason.

29. When the investigator spoke with the man's cell-mate, he said that he was dissatisfied with his treatment following the man's death. He said he was not offered counselling, all that he received was some sleeping tablets, and not even a sufficient number of those. In addition, when after five days he was eventually allowed back in the cell, it had not been cleaned.

30. The investigator asked the healthcare manager about support offered to cell-mates following a death in custody. The healthcare manager said cell-mates are offered mental health support and that might include a transfer to healthcare. After that, ongoing support is provided according to their needs.

ISSUES

Clinical care

31. The man died from a subarachnoid haemorrhage which was secondary to a ruptured cerebral artery aneurysm. A cerebral aneurysm is the bulging out of a weak or thin point of a blood vessel in the brain. The aneurysm will not necessarily rupture and an un-ruptured aneurysm may go unnoticed throughout a person's lifetime. Similarly, most cerebral aneurysms remain unnoticed until or unless they rupture. Where the aneurysm does burst it will cause bleeding into the surrounding tissue. This bleeding is called a haemorrhage. A subarachnoid haemorrhage is where the bleeding is into the space between the skull and the brain. The prognosis for people whose aneurysm has ruptured largely depends on factors such as the age and general health of the individual, the location of the aneurysm, the extent of bleeding and the time between the rupture and medical attention. It is thought that around 40 per cent of patients whose aneurysm has ruptured do not survive the first 24 hours.

32. The clinical reviewer considered whether the man's collapse could have been predicted. He explained that the early symptoms of a subarachnoid haemorrhage may include an extremely severe headache, vomiting, neck stiffness and weakness. The clinical reviewer points out that there is no evidence of the man having these early symptoms. Instead, the post mortem findings indicate a sudden, devastating and un-survivable haemorrhage leading to a rapid collapse and death.

33. The man's cell-mate, said that the man had been suffering with headaches for around ten days before his death. The man's cell-mate said that the man complained to nurses and they responded by giving him aspirin. The healthcare manager told my investigator that nurses are able to dispense medication without prescription for complaints such as headaches. However, this can only be done for up to three days and any such medication should be noted in the prisoner's records. The man's records contain no such entries.

34. The man did have contact with clinicians in the days leading up to his death. On 2 January (five days before his death), he saw a nurse to report discomfort from an old leg injury. There is no record that he also reported a headache. On 4 January (three days before his death), the man saw a doctor to report a dental abscess and he asked for antibiotics. He also reported trouble sleeping since arriving in custody. The doctor wrote prescriptions for antibiotics and sleeping tablets. Again, there is no record that the man reported a headache. On the following afternoon (less than two days before his death), the man was prescribed paracetamol. But this, it seems, was for toothache. There is no obvious explanation why the man's cell-mate would falsely report that the man had suffered with headaches in his final ten days, but the documented evidence is clearly at variance with what the man's cell-mate has said.

35. The clinical reviewer's overall conclusion was that the man's death could not have been predicted. He made one recommendation which I have adopted and adapted into a recommendation of my own:

The healthcare manager should remind staff of their responsibility to document all contacts, particularly where prescribing occurs, in accordance with the standards of the General Medical Council and the Nursing and Midwifery Council.

The man's use of the cell bell

36. The man's ex-wife, as well as his father, both asked for clarification about the man's reasons for pressing his cell bell on the night of his death and whether staff responded appropriately. The records show that it was at 0.53am that he rang the cell bell and the bell was answered one minute later. The staff on duty that night could not recall why the man had pressed his cell bell. The man's cell-mate told my investigator that it had been the man's practice to ask staff to leave the night light on and to ring the cell bell later when he wanted the light switched off. He said that this is what happened on that particular night.

37. The man himself mentioned to one of Bristol's doctors that he was getting into trouble with staff for ringing his cell bell at night. Cell bells should only be used in the case of an emergency so I would expect a prison to take action if a prisoner was misusing his cell bell. If a prison fails to take appropriate action, abuse of the system will lead to confusion among prisoners about when they should or should not use the bell. This might also lead to mixed messages from staff with some officers attempting to control the abuse and others condoning or at least allowing it to continue. Much more importantly, staff may cease to respond promptly to bells if they believe that it is likely to have been used for a trivial reason. The Governor might wish to consider usage of the cell bell system by prisoners and how abuse of the system is dealt with by staff.

The response when the man was found

38. The officer and the officer support grade were conducting the early morning roll check on A wing when they saw the man lying on the floor in his cell. The time was 5.45am. The staff tried to obtain a response from the man or his cell-mate, but neither responded (the man's cell-mate has hearing difficulties and had removed his hearing aid to sleep). The staff called for the attendance of the night orderly officer, who arrived a few minutes later. When he attended he unlocked the cell and it was only then that staff realised that it was a potential emergency and that support from healthcare was needed.

39. Only one of the two members of staff who first attended the man's cell was a fully trained officer. There were two prisoners in the cell and the situation with the man was unclear. It was entirely appropriate therefore for the staff to call for senior assistance rather than to go into the cell at that stage.

Asking the police to contact the man's family

40. When it became clear that the man was unlikely to survive, the prison realised that his family needed to be contacted swiftly. The man had not identified any next-of-kin when he came into the prison, but a likely person was identified from checking his letters and telephone records (this person turned out to be his ex-wife). Due to the urgency of the situation, combined with poor travelling conditions caused by heavy snow falls, Bristol first tried to make contact by telephone. When this proved unsuccessful, the local police were asked to help. Police officers visited the man's ex-wife's home to inform her about what had happened. This allowed her to attend the hospital with other family members and to be with the man for the final few hours of his life. I consider that Bristol deserves to be commended for its swift, thoughtful, pragmatic and compassionate approach.

Support for the man's cell-mate

41. The man's cell-mate complained to my investigator about the lack of support following the man's death. He said that he was issued a small supply of sleeping tablets, but no counselling. I understand from the evidence of the healthcare manager that mental health support is offered to cell-mates following a death in prison. The man's cell-mate also complained that when he was moved back to the cell, which was some days after the man's death, the cell had not been cleaned. There was still blood on the cell floor and the toilet had not been cleaned. I am certain that the failure to clean the cell was an inadvertent oversight, but that will be of no consolation to the man's cell-mate.

I recommend that the Governor assure himself that arrangements are in place to ensure appropriate support is offered to cell-mates following a death in custody.

I recommend that the Governor assure himself that appropriate arrangements are in place to ensure that cells are cleaned adequately following a death in custody.

CONCLUSION

42. The man appeared fit and well apart from minor ailments. Unfortunately, he had an undiagnosed cerebral artery aneurysm that ruptured at some time in the early hours of 7 January 2010. The rupture resulted in an extensive subarachnoid haemorrhage which the clinical reviewer has said was un-survivable.

RECOMMENDATIONS

The following recommendations were made in the draft version of this report. The service's response is included in italics following each recommendation.

1. I recommend that the Governor assure himself that arrangements are in place to ensure appropriate support is offered to cell-mates following a death in custody.

   Service response: Recommendation accepted and action completed. This now forms part of the Death on Custody contingency plans.

2. I recommend that the Governor assure himself that appropriate arrangements are in place to ensure that cells are cleaned adequately following a death in custody.

   Service response: Recommendation accepted and action completed. This now forms part of the Death on Custody contingency plans.

3. The healthcare manager should remind staff of their responsibility to document all contacts, particularly where prescribing occurs, in accordance with the standards of the General Medical Council and the Nursing and Midwifery Council.

   Service response: Recommendation accepted and action completed. A reminder has been issued to all staff.

MEETING WITH THE MAN'S FAMILY AFTER ISSUE OF THE DRAFT REPORT

In accordance with set procedures, copies of the report were sent in draft form to the man's family as well as to the Prison Service and HM Coroner.

The man's father requested a meeting to discuss the draft report and he was visited by the investigator and another of my family liaison officers. The man's brother was also at the meeting. The man's father said that as a child, his son had been allergic to aspirin. It concerned him therefore that his son might have been given aspirin by the nurses; as was suggested by his son's cell-mate. He wondered whether aspirin could cause an aneurysm to rupture.

Following the meeting, the investigator asked the clinical reviewer for his comments. The clinical reviewer said that aspirin will lead to a slowing in the clotting process so wounds or injuries tend to "ooze" for longer. Aspirin can therefore lead to a more prolonged bleed. However, aspirin would not precipitate (or cause) a bleed the clinical reviewer also pointed out that there was nothing in the man's clinical records about him having an allergy or intolerance to aspirin. Nor is there any evidence that the man was ever given aspirin. The man was prescribed paracetamol, but the clinical reviewer advised that this drug has no effect on the clotting or bleeding process.