



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in August 2014
while in the custody of HMP Bedford**

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 investigation report into the death of a man who died of a heart attack in August 2014, while a prisoner at HMP Bedford. He was 50 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at HMP Bedford. The prison cooperated fully with the investigation.

The man was sentenced to three years and nine months in prison in January 2014 and was sent to HMP Bedford seven days later. Doctors had diagnosed him with cardiac disease several years before he went to prison and during heart surgery in 2013 he had suffered a cardiac arrest. He had other significant health conditions including type 1 diabetes and kidney problems, for which he needed dialysis three times a week. He had had both his legs amputated from below the knee, as a result of peripheral vascular disease.

On 19 August 2014, after returning from a routine dialysis appointment, the man reported feeling unwell. His condition deteriorated and he was admitted to hospital. He did not recover and he died in hospital twelve days later.

The clinical reviewer was satisfied that the man received a good standard of care at the prison and I agree. However, the investigation identified some areas for improvement at Bedford. The man missed a hospital appointment that the prison were aware of, but had not made any arrangements for him to attend as it had not been confirmed by letter. I am also concerned that he was restrained when he was taken to hospital as an emergency before his death, despite his lack of mobility and low security risk.

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

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SUMMARY

1. On 28 January 2014, the man was sentenced to three years and nine months in prison for causing death by dangerous driving. He went to HMP Peterborough and transferred to HMP Bedford, seven days later.
2. The man's health was very poor and he had a number of pre-existing medical conditions at the time of his sentence. He had suffered from type 1 diabetes since 1973, which he controlled using insulin. He also needed dialysis treatment three times a week, after a failed kidney and pancreas transplant in 1995. In 2013, he had suffered a heart attack while undergoing a surgical procedure to insert stents into his heart because of previously diagnosed heart disease. Because of circulation problems, both of his legs had been amputated below the knee, in January 2007.
3. Prison healthcare staff and hospital doctors reviewed the man frequently and he had appropriate care plans to address his numerous health conditions. Because of his very poor health, he was admitted as an inpatient to the prison's healthcare unit, where he lived throughout his time at Bedford.
4. On 19 August 2014, after returning from a dialysis appointment, the man told a nurse he felt unwell. The nurse noted that he was cold and clammy, and suspected complications from diabetes. He sent the man to hospital by emergency ambulance. At hospital, he had emergency surgery to insert a stent into one of his arteries, but suffered a cardiac arrest during the procedure. Hospital staff resuscitated him. Prison staff informed his family that he was in hospital and they were able to visit him.
5. The man's condition deteriorated and, on 22 August, he moved to the hospital intensive care unit. On 30 August, after discussions with the man's family, hospital staff withdrew all treatment. The man died in the early hours of the following morning.
6. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Bedford was equivalent to that he could have expected to receive in the community. The man missed four hospital appointments, one because it clashed with a dialysis appointment and two because of hospital administration errors. However, the prison were aware of another appointment but did not make arrangements for the man to attend because it had not been confirmed in writing. We are also concerned that the man was restrained when he was taken to hospital as an emergency, without an appropriate risk assessment to justify it. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He interviewed three members of staff at Bedford on 6 October 2014. The investigator informed the prison of the preliminary findings of the investigation.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
10. We informed HM Coroner for the Bedfordshire district of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process. They asked the following questions which have been addressed in this report:
 - Were the man's legs appropriately managed?
 - Why had he missed hospital appointments?
 - Was his diabetes appropriately managed?
 - Was his location suitable?
12. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
13. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

HMP BEDFORD

14. HMP Bedford is a local prison which holds up to 506 men. The prison mostly takes sentenced and remand prisoners from Luton Crown Court, Bedford and Luton Magistrates' Courts, as well as sentenced prisoners from London prisons. South Essex Partnership Trust provides healthcare services. The healthcare unit can accommodate up to 13 inpatients.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Bedford was in February 2014. The Inspectorate noted that the delivery of healthcare was good and well integrated into the wider prison. Reception health screening of new arrivals was excellent. Prisoners in the inpatient unit were well supported and had good clinical care. Chronic disease management was well organised and prisoners had excellent access to nurse led clinics dealing with a variety of conditions. Although most prisoners with disabilities felt well supported by staff, the Inspectorate noted that much of the physical accommodation at Bedford was not suitable for men with physical disabilities and there was no dedicated disability liaison officer.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to October 2014, the IMB noted concerns about staffing in the healthcare department and that agency staff were used to cover many of the shortfalls. The IMB was concerned that prisoners missed healthcare appointments too easily when the regime was slightly disrupted, but overall, noted that the healthcare team appeared to deliver a good service.

Previous deaths at Bedford

16. The man's death was the second of natural causes at Bedford since the start of 2012. We have made a recommendation about the risk assessment process for the use of restraints for hospital visits before.

KEY EVENTS

17. On 28 January 2014, the man was sentenced to three years and nine months in prison for causing death by dangerous driving. He was taken to HMP Peterborough. It was his first time in prison.
18. During an initial health screen, a nurse noted that the man had a number of pre-existing medical conditions including diabetes which he controlled using insulin. He had suffered a cardiac arrest in 2013 while undergoing heart surgery to open a blocked artery and he needed regular kidney dialysis, due to a failed kidney and pancreas transplant two years before. The nurse recorded that both of his legs had been amputated below the knee in 2007, because of circulatory problems. His legs needed to be dressed because of moist lesions.
19. Later that evening, a prison GP noted that the man had been receiving dialysis at Watford General Hospital three times a week and had missed his scheduled dialysis appointment that evening. A nurse rearranged the appointment for the next day. The doctor reviewed the man's medication and organised daily reviews of the dressings on his legs. Although the man had prosthetic legs, he could not use them because his stumps were sore and he used a wheelchair to get around.
20. The man lived in the healthcare inpatient at Peterborough. On 4 February, he transferred to HMP Bedford to make it easier to attend ongoing hospital appointments.
21. A reception health screen at Bedford noted the man's pre-existing medical conditions and that he smoked cigarettes but did not want help to give up. The man was admitted as an inpatient to the prison's healthcare unit and remained there throughout his time at Bedford. As the unit is a no smoking area the man agreed to use nicotine replacement patches to help him not to smoke.
22. The same day, the interim Head of Healthcare arranged with the dialysis unit at Watford General Hospital that the man would attend every Tuesday, Thursday and Saturday. She booked suitable transport, (which could take his wheelchair) with a local taxi firm. The Head of Healthcare informed the prison's security department about the man's physical condition and mobility problems.
23. Later on 4 February, a prison GP noted that the man had arrived with a considerable amount of medication, not all of which was listed on his prison medical records. He requested the man's community GP records to clarify this. He noted the man's cardiovascular disease and that he was under the care of a consultant vascular surgeon at St Mary's Hospital, Paddington. He informed the hospital that the man was now at Bedford. He arranged care plans for the man's diabetes, wound care for his legs and daily nurse reviews.

24. The next day, another prison GP reviewed the man and recorded that as the man would be having dialysis treatment on the day of the diabetes clinic at Bedford, he might need to receive diabetic care at Bedford hospital. It was subsequently agreed that it was sufficient for nurses to test the man's blood sugar levels each day and liaise with the visiting diabetes nurse specialist for advice as necessary. Records show that nurses saw the man regularly to monitor his blood and give him insulin. Against advice, he tended to keep his blood sugar levels slightly higher than normal because he wanted to avoid becoming hypoglycaemic (low blood sugar). The man asked the GP if he could move to a standard residential wing where he could smoke. The GP advised against the move and prescribed nicotine patches to help him avoid smoking.
25. On 6 February, the man went to Watford General Hospital for dialysis. Because he was a Category D prisoner, the lowest prison security category, the prison released him on temporary licence to attend his dialysis appointments three times a week. As he had mobility problems, an officer accompanied him. The man was released on temporary licence for subsequent hospital appointments.
26. On 12 February, a prison GP reviewed the man as nurses were concerned about the condition of his legs. He had two lesions above the knee on his left leg, which appeared to be moist, and an ulcer on his left inner thigh. The GP noted that healthcare staff should continue to liaise with the vascular care unit at Saint Mary's Hospital to keep them updated about the man's condition, which they did.
27. That day, the man missed an appointment at St Mary's Hospital vascular clinic. Although the GP had informed them on 4 February that the man was at Bedford, the hospital had sent the appointment letter to the wrong address. The hospital initially rearranged this for 3 April but that clashed with a dialysis appointment, so the man was unable to attend. It is not clear if the hospital arranged an alternative date at the time.
28. The man continued to attend Watford General Hospital for dialysis treatment. On 7 April, the GP wrote to the renal unit at Watford General Hospital as the man had reported experiencing severe pain since his amputation wounds had been debrided on 29 March. (This is a process involving the removal of dead, damaged or infected tissue to encourage the growth of healthy tissue.) She noted that the skin surrounding the wounds was extremely red and inflamed and prescribed antibiotics. The GP was concerned that he was developing osteomyelitis (a bone infection) and that his pain was a circulatory condition related to his previous heart problems.
29. On 10 April, a consultant nephrologist at the renal unit wrote to the man's cardiologist at St Mary's and asked the consultant to review the man at the earliest opportunity. St Mary's arranged an appointment for 9 May.

30. On 15 April, the man attended the diabetes clinic at Watford General Hospital for an annual diabetes review. No concerns were noted and his next annual appointment was scheduled for 1 April 2015.
31. On 8 May, the consultant examined the man at St Mary's Hospital and wrote to a prison GP outlining his findings. He said there were areas below the man's left knee that had not healed correctly. He referred the man for an MRI scan to check for any signs of osteomyelitis.
32. On 12 May, the GP discussed with the man the possibility of transferring his dialysis care to Bedford Hospital as it was an 80 mile round trip to Watford. (In the event, this was not possible as Bedford Hospital was unable to provide dialysis treatment.) The man asked the GP if he could move to C wing which had a cell adapted for disabled prisoners, as this would mean he would be able to smoke. She advised against the move and prescribed further nicotine replacement patches.
33. On 23 June, the GP reviewed the man after his MRI scan indicated that there were no signs of osteomyelitis, but he had a build up of fluid behind his left knee. She was concerned that his ongoing pain and discomfort meant he had been unable to wear his prosthetic legs and referred him to a tissue viability nurse at Bedford Hospital and to an occupational therapist. She considered the man would benefit from either a foam wedge or a hospital bed so he could elevate his knee and be more comfortable.
34. On 26 June, the GP telephoned the tissue viability nurse for advice on the care of the man's wounds. On 2 July, the nurse visited the man and noted that his left leg was cool to the touch and his skin below the knee joint was a dusky pink. She recorded that he had four wounds below his left knee and that there was a redness of the skin, tenderness and eschar (dead tissue) to his stump. She had no concerns about his leg, but said that if there were any further problems or signs of infection he should be referred to a GP immediately.
35. On 11 July, the man told nurses he was concerned about the tenderness and redness of his left knee and the GP reviewed him. The doctor noted that, although his leg looked redder, there were no signs of discharge or increased temperature in the area of his knee. He prescribed antibiotics.
36. On 21 July, the man received an electric hospital bed with a pressure relieving mattress.
37. On 31 July, the man missed an outpatient's appointment at the vascular clinic at Watford General Hospital to consider his suitability for vascular surgery to help the circulation problems in his leg. The hospital rearranged the appointment for 7 August and informed the prison by telephone, but the man also missed this appointment. The prison said that they had not received a letter about either appointment and they needed one to arrange his release on temporary licence and transport to the hospital.

38. On 8 August a consultant nephrologist, at the renal unit of Watford General Hospital wrote to the GP as he was concerned that the man had missed the two appointments which had been arranged for a vascular surgeon to see the man as quickly as possible. He said the man's leg was becoming increasingly problematic, and was at risk of becoming infected and gangrenous. The hospital made a further appointment for 6 November.
39. On 15 August, the GP reviewed the man and noted that he was experiencing "excruciating pain" and that his left leg was "dusky with a black flap and cold to the touch". The man told the GP that the morphine tablets were not effective but oramorph (liquid morphine) relieved his pain. The GP faxed a letter to the vascular clinic outlining her concerns and asking whether there he should be admitted to hospital.
40. On 18 August, a GP reviewed the man again and noted that his left leg appeared to have improved and he was in less pain. He agreed that a vascular specialist needed to review the man but he did not consider he needed to be admitted to hospital urgently.
41. On 19 August, the man had routine dialysis treatment at hospital. When he got back to the prison he told a nurse that he did not feel well. A nurse checked the man's vital signs (heartbeat, blood pressure, breathing rate and temperature) at 5.00pm, 5.20pm and 5.40pm. A prison GP also reviewed the man but his assessment and the nurses observations were not recorded in the man's clinical notes. The man said he was going to bed to rest.
42. At 8.30pm, a nurse went to the man's cell to take a routine blood sugar reading. This was within normal range, but the nurse thought that the man appeared dazed and decided to check him again later. The nurse went back to see the man at 11.30pm and noted that the man appeared more dazed than previously. The nurse asked a custodial manager who was in the healthcare unit at the time, to open the man's cell. He checked his blood pressure, which was normal, but he noted that his pulse was slightly raised and he felt cold and clammy. At 11.34pm, a nurse asked the custodial manager to radio the control room and request an emergency ambulance.
43. Paramedics arrived at 11.39pm and a second paramedic crew arrived at 11.55pm. They checked the man's vital signs and gave him intravenous fluids. At 12.39am on 20 August, they took him by emergency ambulance to Watford General Hospital. Two prison officers accompanied him and used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.)
44. Hospital staff examined the man and diagnosed him as having a calcified artery for which he needed emergency surgery. Shortly after the surgery, he suffered two cardiac arrests and was resuscitated.
45. At 11.00am, the prison arranged for two officers to act as family liaison officers. Before the family liaison officer contacted the man's sister, his registered next of kin, hospital staff had already informed her that his

condition had deteriorated and advised her to go to the hospital. At 3.55pm, the family liaison officer introduced himself to the man's sister and his niece at the hospital and ensured that they had his contact details.

46. The man remained in hospital and prison healthcare staff kept in regular contact with the hospital for updates on his condition. The family liaison officer kept in touch with the man's family.
47. The man's condition deteriorated and on 22 August hospital staff moved him to the intensive care unit. At 11.30pm on 30 August, hospital staff withdrew medical treatment, after speaking to the man's family. The family liaison officer and an operational manager were at the hospital at the time and supported his family. The man died at 1.03am the next morning. His family was with him at the time.
48. The family liaison officer remained in contact with his family after the man's death. On 14 September, she arranged for them to see where he had lived at Bedford. On 16 September, two officers attended the man's funeral. In line with national guidance the prison contributed towards the costs.
49. The Governor issued a notice informing staff and prisoners of the man's death. He expressed condolences and informed prisoners of the support available. All prisoners subject to suicide and self-harm prevention procedures were monitored in case they had been adversely affected by the news of the man's death.
50. A manager debriefed the staff who were present at the time of the man's death and the prison's care team offered support to any staff who felt affected by his death.
51. A post-mortem examination found that the cause of death was 1) acute myocardial infarction (heart attack), coronary atherosclerosis and thrombosis (obstruction of the coronary arteries); 2) gangrene of lower limb, diabetes mellitus and chronic renal failure.

ISSUES

Clinical care

52. The man suffered from a number of complex medical conditions, made worse by many years of heavy smoking and poor self-management of his diabetes. Healthcare staff gave the man his medication appropriately and monitored his blood glucose levels regularly. Against medical advice, the man said he preferred to keep a higher level of glucose in his blood to avoid hypoglycaemia.
53. The clinical reviewer was satisfied that healthcare staff at Bedford reviewed the man's vascular problems frequently. Local community tissue viability nurses and wound care nurses saw and treated him when necessary. Two doctors, who had treated him for some years, provided consultant care. His wounds were dressed as advised, and doctors often discussed pain relief with him and provided this as necessary.
54. The clinical reviewer noted that the man's care in Bedford was good and generally well recorded. GPs reviewed him frequently and he received appropriate diabetic and vascular care. There were clear, well documented care plans for all of his conditions. The clinical review identified some areas for improvement, which the Head of Healthcare will need to address, but, overall, she found the standard of care given to the man was at least equivalent to that he would have expected to receive in the community. Although management of appointments could have been better, there is no evidence that this affected the outcome for the man and we are satisfied that he received appropriate care.

Missed hospital appointments

55. The man missed four vascular appointments while at Bedford, one was because it clashed with a dialysis appointment and two were through hospital administration errors. However, the prison was aware of an appointment in August, but did not make arrangements for the man to attend because it had not been confirmed by letter. We consider that staff should have let the hospital know if they needed a letter and this was not an appropriate reason to miss an important hospital appointment of which the prison was aware. We make the following recommendation:

The Governor should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

Use of restraints

56. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 judgement 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 the risks posed by the same prisoner when suffering from a serious medical condition.

57. Throughout his time at Bedford, the man attended Watford General Hospital three times a week for dialysis treatment and other hospital appointments. Every time, the prison released him on temporary licence with an officer accompanying him to help and support him, because of his mobility problems.
58. On 19 August, when the man was unwell and the prison called an emergency ambulance, a custodial manager completed a risk assessment for the escort. He sought advice from the Head of Security who advised using an escort chain and two officers to escort him. The risk assessment noted that the man was a category D prisoner (the lowest prison security category for prisoners who can reasonably be trusted not to try and escape). No risks were identified. There was no input on the risk assessment form from healthcare staff in relation to the man's medical condition or how this impacted on his risk of escape, as the 2007 High Court judgement requires.
59. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. It is hard to understand why the prison staff decided to restrain the man on this occasion. We recognise that this was for a short time for the journey to hospital and the man was not restrained after that, but the decision was not justified.
60. The need to justify the use of restraints for very ill prisoners being taken to hospital is a matter we have raised with the prison before. Although the prison has accepted our previous recommendations about this matter, it does not appear that the legal position is understood if the Head of Security advises the use of restraints for a category D prisoner who has had both of his legs amputated. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Governor should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.
2. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.	Accepted	Custodial managers have been reminded that cancelling appointments should not be done save in exceptional circumstances. Healthcare staff have been reminded that they must let the prison authorities know when a prisoner is required at hospital.	Completed The Governor Head of Safer Prisons and Equalities
2	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	This is now routine practice at HMP Bedford and is a feature of the complex needs review meeting. Staff are aware of the legal position on this and the risk assessment for escorts reflects the need to consider whether restraints are necessary.	Completed Head of Safer Prisons and Equalities