Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Bristol on 28 January 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

This is the investigation report into the death from a heart attack of a man, a prisoner at HMP Bristol, in January 2015. He was 42 years old. I offer my condolences to his family and friends.

A clinical review of the man's clinical care at Bristol was undertaken. The prison cooperated fully with the investigation.

In November 2013, the man was remanded to HMP Bristol and remained there except for a short period when he was bailed in 2014. In December 2014, he was sentenced to six years and two months in prison. He received treatment for drug and alcohol misuse and had multiple chronic health problems.

On 9 January 2015, the man became acutely unwell and was taken to hospital as an emergency. The hospital admitted him and began a range of tests on his heart but he discharged himself before these were completed. The next day, a prison nurse persuaded him to go back to hospital. In hospital, his condition deteriorated significantly and he died towards the end of January.

The clinical reviewer considered that more thorough assessments might have led to a hospital admission earlier than 9 January, although this was unlikely to have altered the outcome for the man. Prison GPs did not always systematically review records and follow up identified actions. I am also concerned that, despite his critical condition, he remained restrained in hospital until very shortly before his death and that no one from the prison contacted his family to inform them of his admission to hospital.

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 **August 2015**

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SUMMARY

1. The man had been at HMP Bristol since November 2013, apart from a brief period in 2014, when he was bailed while on remand. He suffered from many chronic health conditions, including asthma, epilepsy and heart problems. He had a history of alcohol and drug abuse. Nurses saw him frequently to review his health conditions and referred him to a doctor as necessary.

2. In early January 2015, nurses saw the man a number of times, as he was breathless and had a rapid heartbeat, but did not take his clinical observations. On 5 January, a doctor reviewed him and requested chest and abdominal X-rays, but did not record any assessment of his respiratory or cardiovascular system. The next day, he was not well enough to attend hospital for X-rays.

3. On 8 January, a nurse was concerned the man appeared very unwell and discussed his condition with a prison GP. The doctor decided he did not need to see him urgently, but did not record the reasons.

4. The next day, 9 January, another nurse noted that the man looked very unwell. His heart rate was high and his oxygen saturation levels were low. She referred him urgently to a GP. He said he had chest and abdominal pain and the GP sent him to hospital as an emergency. At the hospital, doctors admitted him for tests. Officers used an escort chain to restrain him while he was in hospital.

5. On 17 January, the man discharged himself from hospital but went back the next day, after a prison nurse persuaded him to continue with his treatment. His condition deteriorated in hospital and he died towards the end of January.

6. The clinical reviewer had a number of concerns about the man's GP care at the prison including that doctors did not refer to medical notes or fully assess him when they saw him. Requested investigations were not always followed up. For these reasons, the clinical reviewer did not consider that his care was equivalent to that he could have expected to receive in the community. The clinical reviewer considered that a GP assessment on 7 or 8 January 2015 might have led to his earlier admission to hospital, but in view of the length of time he spent in hospital, did not consider that this would have affected the outcome.

7. We are not satisfied that the use of restraints when the man went to hospital was fully justified and there was an unnecessary delay when officers asked for permission to remove the restraints. We are also concerned that no one informed his next of kin when he was admitted to hospital. We make three recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

10. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. She and the clinical reviewer interviewed prison staff in March 2015, and she interviewed a prison manager by telephone in March 2015.

11. We informed HM Coroner for Avon of the investigation, who gave an initial cause of death. We have sent the coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's mother (his nominated next of kin) and stepfather, to explain the investigation. His partner also wrote with concerns about his care. The family asked the investigation to consider whether he should have been admitted to hospital earlier and asked why they had not been informed earlier about his hospital admission. They also asked if his partner had been informed of his death in a timely and appropriate way.

HMP BRISTOL

13. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health and Medco Secure Health Services provide primary healthcare and substance misuse services. Avon and Wiltshire partnership provide mental health services. All wings have a treatment room staffed by a nurse and healthcare assistants during the day. There is a nurse and a healthcare assistant on duty to cover the prison throughout the night.

14. At least one GP is on duty during the week from 7.00am to 8.30pm, and on Saturday afternoon and Sunday morning. An out of hours service is used at other times. There are no inpatient beds.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Bristol was in October 2014. Inspectors found healthcare provision had improved and reception screening was streamlined and swift. Access to the nurse and GP were good and clinical treatment was sound. A wide range of clinics was run, including for chronic diseases. Prisoners with drug or alcohol problems received prompt treatment and a good level of care on a dedicated unit.

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 July 2014, the IMB commented that prisoners were able to see a nurse every day on the wings, including to collect medication. They had access to treatment for minor illness or injury and could see a GP on the same day for urgent needs.

Previous deaths at Bristol

17. The man was the second prisoner to die from natural causes at Bristol since the start of 2014 and there has been another death since. There were no significant similarities with the circumstances of the other deaths.

KEY EVENTS

18. On 22 November 2013, the man was remanded to HMP Bristol charged with robbery and false imprisonment. He had a history of drug and alcohol misuse. He took medication for epilepsy, and was recorded to have a deep vein thrombosis and an aneurysm in his right leg and cellulitis in his left leg. He was taking oral anticoagulant medication. His blood pressure was high. He received treatment for drug and alcohol withdrawal.

19. In January 2014, nurses recorded a number of times that the man had raised blood pressure and a prison GP prescribed medication. The GP asked for monitoring blood tests but he did not attend for a test on 30 January. The two following tests were unsuccessful, because the blood had deteriorated before testing. There is no record of any further action at the time.

20. In February, March and June 2014, the man reported using illicitly obtained drugs in the prison. Each time he was referred for further drug treatment.

21. On 11 September, the man was released on bail but was remanded back to Bristol on 21 November. He had been using crack cocaine, heroin and benzodiazepines. He had also been drinking heavily and began a detoxification programme.

22. On 23 December 2014, the man was sentenced to six years and two months in prison. He remained at Bristol. Later that day, a nurse carried out a further health screen and he said he had no medical concerns. The nurse noted he had a history of asthma, epilepsy and cardiac problems and a history of alcohol and drug misuse. The nurse arranged routine blood tests.

23. On 24 December, a prison GP saw the man, who complained of pain in his loins. The doctor noted the blood test results were abnormal and diagnosed a possible kidney infection, for which she prescribed penicillin.

24. On 29 December, the man told a nurse he was not urinating very often or eating. He said he had continued pain in his loins. She referred him to a GP. Later that day, a GP saw him and prescribed tramadol for pain relief, for one week.

25. On 4 January 2015, a nurse saw the man when he reported feeling unwell and short of breath. She noted he was tachycardic (fast heart rate) and possibly hypertensive (high blood pressure). She gave him a note to excuse him from work and advised him to contact healthcare staff if he needed this extended. The next day a GP saw him and prescribed more tramadol. He requested chest and abdominal X-rays, which were arranged for 6 January.

26. The man did not attend the hospital appointment for the X-rays on 6 January. His medical record said he was not fit to go, but no other details were recorded.

27. On 7 January, a nurse examined the man when he complained of exhaustion and breathlessness. She signed him off work for a week but there is no record that she took any other action.

28. On 8 January, the man told a nurse that he was short of breath. The nurse noted he looked very unwell. She suggested he should have an urgent GP review. The GP discussed this with the nurse and decided an urgent appointment was not necessary. There is no explanation for this decision in the records.

29. At 10.20am on 9 January, the man went to the medical hatch on his wing and told a nurse that he had been sitting in a chair all night with chest, back and leg pains. The nurse noted he was tachycardic and his oxygen saturation levels were low at 86%. She referred him to a GP urgently and the GP examined him at 11.08am. He told the GP that he had chest and abdominal pain, nausea and vomiting. The doctor arranged for him to go to hospital by emergency ambulance.

30. Two prison officers escorted the man to hospital and used handcuffs for the journey and an escort chain in hospital to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

31. The man was admitted to hospital. Doctors began a range of tests to determine the reasons for his irregular heartbeat. On 10 January, he told the prison escorts that he would like his mother informed that he was in hospital, but there is no record that anyone did this. On 17 January, he discharged himself from hospital, before the full range of tests had been completed.

32. The next day, 18 January, the man complained of chest pain. A nurse noted he had swollen legs, shortness of breath and an irregular pulse. The nurse warned him that he could have a heart attack and persuaded him to go back to hospital. The hospital admitted him again. He had an ECG and an ultrasound scan as doctors tried to determine the reasons for his breathlessness.

33. No one from the prison had informed the man's parents that he was in hospital, but his mother rang the hospital and spoke to him on 18 January. On 20 January, a scan showed he had a blood clot in his leg and doctors gave him blood-thinning medication. A chest scan showed he had an infection in his heart and he began a course of antibiotics.

34. The man remained in hospital and his condition deteriorated. On 23 January, a hospital consultant told him and his parents, who were visiting him at the time, that his condition was serious.

35. On 24 January, the man was confused, struggling to speak and the infection had spread to the bones in his back. Hospital staff told the prison that his prognosis was very poor. His brother and parents visited him.

36. At 8.00pm on 27 January, prison managers reviewed the man's security arrangements but decided he should remain restrained by an escort chain. Officers removed the escort chain briefly to allow a nurse to change his clothes. The hospital moved him from a general ward to the intensive care unit and a prison manager gave permission for officers to remove the escort chain for

approximately 30 minutes, while nurses attached arterial lines to him. At 1.30am, his family arrived and said they would stay with him at the hospital.

37. At 7.55am, the man had a cardiac arrest. A nurse asked the officers to remove the escort chain as hospital staff tried to resuscitate him. The resuscitation attempt was unsuccessful and he never recovered. At 8.07am, a nurse brought his family to his bedside. A hospital doctor certified his death at 8.20am. The Coroner subsequently gave the cause of death as acute congestive cardiac failure, infective endocarditis, intravenous drug use and alcohol excess

Liaison with the man's family

38. After the man died, the prison appointed an officer to be the family liaison officer. At around 9.20am, she and a prison manager met the man's family at the hospital. His mother, who he had named as his next of kin, asked the family liaison officer to let his partner, who was a prisoner at HMP Holloway, know of his death. At 10.35am, she contacted Holloway and arranged for member of the chaplaincy team to speak to the partner. A chaplain informed her that morning and visited her again later that day to offer additional support.

39. The family liaison officer remained in contact with the man's mother. His partner was able to attend the funeral on 16 February 2015. The prison contributed to the funeral costs in line with national guidance.

Support for staff and prisoners

40. A Governor's notice informed staff and prisoners of the man's death and offered support to those who might have been affected.

41. A prison manager went to the hospital to debrief the escort staff and offered support.

ISSUES

Clinical care

42. The clinical reviewer noted that nurses had recorded the man's deteriorating physical health for three days before his admission to hospital, but no one made a complete assessment of his condition until 9 January. This should have included recording his temperature and other clinical observations such as blood pressure, pulse rate and oxygen saturation levels. When a GP saw him on 5 January, he did not record any systematic assessment of his respiratory or cardiovascular system, despite noting that he was breathless. On 8 January, when a GP decided that he did not need an urgent appointment, she had no clinical observations on which to base the decision and did not record her reasons.

43. It is possible that an earlier assessment, based on full clinical observations, might have led to the man being admitted to hospital earlier at the beginning of January. However, in view of the length of his hospital stay, and taking into account the fact that he discharged himself on 17 January, the clinical reviewer did not consider that an earlier hospital admission would have altered the outcome for him.

44. The prison GPs had ready access to the computerised prison medical record system. However, a GP said that doctors did not routinely review medical records before or during appointments, due to time constraints. Sometimes this meant that GPs made no assessments of the condition, which had prompted the GP appointment. On at least two occasions, abnormal blood tests were not followed up, and repeat samples were not taken.

45. The clinical reviewer said that community GPs are expected to review medical records to build up a complete and comprehensive picture of the patient's long term and acute conditions. He considered that all prison GPs should do the same, and note the reasons for the assessment and any enquiries made about the patient's problem

46. For these reasons, the clinical reviewer concluded that the man's clinical care at the prison was not equivalent to that he might have expected to receive in the community. He made some recommendations about delivery of healthcare services, which we do not repeat in this report, but which the Head of Healthcare will need to address. We make the following recommendation:

    The Head of Healthcare should ensure that all clinicians seeing patients adequately review their medical record, assess and appropriately examine the patient, take clinical observations as appropriate and record their assessments, in line with national guidelines.

Use of restraints

47. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007, made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

48. When the man went to hospital on 9 January, the risk assessment shows the prison considered him a low risk in all areas including hostage taking and escape. Healthcare noted he had chest pains, but did not comment on how or whether his medical condition impacted on his risk of escape, as required by the 2007 High Court judgement. A prison manager authorised the use of restraints and an escort chain was used in hospital. Managers reviewed the use of restraints regularly, but did not change the level of restraint.

49. On the morning of his death, the man was in the intensive care unit of the hospital, critically ill and connected to monitoring equipment. One of the escort officers said that when he arrived on duty the man was motionless in bed. A nurse was trying to navigate around prison staff as the man was still restrained. He said he asked one of the night escort officers if the restraints should be removed. She told him that she had checked with the prison during the night and had been told they should remain on.

50. One of the night escort staff told us that hospital staff had said that there was a risk that the man might try to leave the bed if he came round. She understood he had been violent and aggressive towards nurses, which was why he had remained restrained. However, there is nothing in the escort record to support this account of his behaviour. It said he was frustrated and anxious, but despite being seriously ill, remained polite to staff.

51. In view of his deteriorating health, the new escort officers considered that the man did not need to be restrained. However, their instructions were that restraints could only be removed with prior approval, except in a life-threatening emergency. At 7.05am, they discussed his condition with a custodial manager. He asked them to call back at 8.00am, as he needed to get the agreement of the duty governor. At 7.55am the man went into cardiac arrest. A nurse started chest compressions and asked for the restraints to be removed. An officer managed to remove the handcuff from him but it became trapped in the bedrail causing a slight delay to its complete removal.

52. We are concerned that the man remained restrained almost to the point of his death, which was distressing for all involved, including the escort officers. His original risk assessment for his hospital admission on 9 January did not adequately consider how his condition impacted on his risk of escape and subsequent reviews did not take this into account. At the very least, a review of

his risk the evening before he died should have resulted in the restraints being removed. By this time, he was critically ill, immobile, attached to monitoring machines and in intensive care. We do not consider that managers at Bristol applied the principles of the 2007 High Court judgment when considering the use of restraints.

53. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. 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.

Liaison with the man's family

54. After the man's death, we are satisfied that the prison appropriately arranged that his partner should be informed and supported. We also consider that the prison family liaison officer appropriately supported his parents. However, we are concerned that the prison did not inform his family when he was admitted to hospital.

55. The man had asked for his mother to be contacted on 10 January, the day after he had been taken to hospital. However, no one from the prison contacted her to let her know he was seriously ill in hospital. She told us that she had learnt this from his partner's father on 18 January.

56. Prison Rule 22 says that the prison should inform the next of kin of a prisoner if they are seriously ill. The man went to hospital on 9 January with serious symptoms. He was subsequently diagnosed with a heart infection and was having further tests. We consider the prison should have informed his next of kin when he was taken to hospital. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all clinicians seeing patients adequately review their medical record, assess and appropriately examine the patient, take clinical observations as appropriate and record their assessments, in line with national guidelines.

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.

3. The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.