Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Fisher, a prisoner at HMP Hewell, on 20 May 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*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr David Fisher died of acute bronchitis and alcoholic liver disease while a prisoner at HMP Hewell on 20 May 2015. He was 61 years old. I offer my condolences to Mr Fisher's family and friends.

Mr Fisher had a long history of alcoholism and associated health problems, including heart disease. He had been recalled to prison and had been at Hewell for less than two weeks before he died. The investigation found that Mr Fisher was appropriately admitted to the prison's inpatient unit for treatment and monitoring of his withdrawal from alcohol. Healthcare staff implemented an effective cardiovascular care plan and when Mr Fisher became unwell, promptly assessed him and sent him to hospital. Sadly, he died the next day. I am satisfied that the standard of care Mr Fisher received at Hewell was equivalent to that he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2015**

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Summary

Events

1. On 25 March 2014, Mr David Fisher was sentenced to 22 months in prison and released on licence on 12 September. On 8 May 2015, he arrived at HMP Hewell after being recalled to prison for breaching his licence conditions.

2. Mr Fisher had a long history of alcohol abuse and suffered from ischaemic heart disease and high blood pressure. When he arrived, he was admitted to the prison's inpatient unit to stabilise his blood pressure and monitor his alcohol withdrawal. Mr Fisher completed a short alcohol detoxification programme and nurses implemented a cardiovascular care plan to monitor and treat his heart condition and blood pressure.

3. On 18 May, Mr Fisher complained of constipation and a nurse gave him lactulose oral solution. The next day he had diarrhoea, which a nurse considered was because he had taken too much laxative.

4. Later that day, Mr Fisher said he was still constipated and a nurse gave him a further dose of lactulose. Shortly before 10.00pm, Mr Fisher's cellmate was concerned about him. A nurse assessed him and found he had poor urine output, and his blood pressure and temperature were low. The nurse considered he was dehydrated and sent him to hospital.

5. Mr Fisher was admitted to hospital. Doctors found he was severely dehydrated and his health continued to decline. He died in hospital of acute bronchitis and alcoholic liver disease on 20 May.

Findings

6. The clinical reviewer found that Mr Fisher had a long history of alcoholism and significant health problems. When he arrived at Hewell, healthcare staff appropriately admitted him to the prison's inpatient unit to stabilise his alcohol withdrawal and monitor him. When Mr Fisher became unwell, healthcare staff assessed him promptly and ensured he went to hospital quickly. We are satisfied that Mr Fisher received an appropriate standard of care at the prison, equivalent to that he could have expected to receive in the community. We make no recommendations.

The Investigation Process

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

8. NHS England commissioned a clinical reviewer to review Mr Fisher's clinical care at the prison.

9. The investigator obtained copies of relevant extracts from Mr Fisher's prison and medical records. She and the clinical reviewer interviewed two members of healthcare staff at Hewell on 22 July 2015.

10. We informed HM Coroner for Worcestershire of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Fisher's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked if he had received appropriate medication to help his withdrawal from alcohol. She was very positive about the sensitivity of the prison's contact with her after her son's death.

12. Mr Fisher's mother received a copy of the initial report. She identified one factual inaccuracy, which has been amended.

13. The initial report was shared with the Prison Service. They identified two factual inaccuracies, which have been amended.

Background Information

HM Prison Hewell

14. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr Fisher was at the Blakenhurst site, which comprises six houseblocks, holding around 1100 men. Worcestershire Health and Care NHS Trust provide health services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Hewell was in July 2014. Inspectors found that all new arrivals were assessed for physical and mental health needs and any substance misuse issues. There was a good range of primary care and screening services but delivery of some health services had been affected by staff shortages. Inpatient care was satisfactory but the environment was not sufficiently therapeutic. Prisoners were positive about the care they received from the integrated substance misuse service and said they had received good support for drug and alcohol problems.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2014, the IMB recognised that healthcare managers had worked hard to improve the efficiency of health services but the IMB was concerned about the number of unfilled vacancies for nurses. The IMB noted that there had been continued upgrades to the healthcare impatient unit.

Previous deaths at HMP Hewell

17. Mr Fisher was the fifth prisoner at Hewell to die of natural causes since 2014. There were no significant similarities with the circumstances of the previous deaths.

Key Events

18. On 25 March 2014, Mr David Fisher was sentenced to 22 months in prison for attempted robbery and was sent initially to HMP Hewell. On 12 September 2014, he was released on licence from HMP Featherstone. On 8 May 2015, Mr Fisher was recalled to prison and returned to Hewell after breaching the conditions of his licence.

19. Mr Fisher had a long history of alcohol abuse and poor health. He suffered from high blood pressure and ischaemic heart disease. He had had two heart attacks and had had four stents fitted. When he arrived at Hewell on 8 May, a nurse assessed him and admitted him to the prison's inpatient unit to monitor and stabilise his blood pressure and his withdrawal symptoms from alcohol. He told nurses he did not take the medication he had been prescribed because he wanted nature to take its course. Nurses implemented a cardiovascular care plan to monitor and treat Mr Fisher's heart condition and blood pressure. They referred him to the integrated substance misuse service.

20. On 9 May, Mr Fisher refused to see a member of the substance misuse team. A nurse noted that he was refusing treatment and medication. Later that day, a prison GP saw Mr Fisher and noted his alcohol dependency and ischaemic heart disease. Mr Fisher said he had experienced intermittent chest pain over the past year and had suffered from shortness of breath with mucus at the back of his throat for the previous past three weeks. The GP examined Mr Fisher's chest and noted it was clear with good airway entry and his heart sounds were normal. The doctor noted that Mr Fisher had said he was now willing to take his medication. He reviewed Mr Fisher's medications and prescribed diazepam to alleviate symptoms of alcohol withdrawal.

21. On 10 May, a nurse from the substance misuse team discussed Mr Fisher's alcohol detoxification plan with him. Mr Fisher told her that alcohol had been a problem for him for forty years. He said that he had suffered from depression in the past. Later that day, a nurse talked to him about mental health support and his care plan.

22. On 11 May, a prison GP reviewed Mr Fisher after an abnormal liver function test. Because of Mr Fisher's alcohol abuse, the results were abnormal as expected, but she noted that healthcare staff should repeat the test in four weeks. Later that day, another prison GP discharged Mr Fisher as an inpatient and he moved to a standard prison wing. The GP advised him how to access healthcare services and explained that he would need to collect his medication each day.

23. On 12 May, a substance misuse specialist reviewed the progress of his alcohol detoxification. Mr Fisher said he understood how his alcohol problem had affected his health. On 13 May, Mr Fisher completed the alcohol detoxification programme and healthcare staff noted he did not show any withdrawal symptoms. Healthcare staff continued to see Mr Fisher daily as part of his cardiovascular care plan.

24. On 18 May, Mr Fisher asked a nurse for something for constipation and she gave him some lactulose oral solution. She advised him to inform healthcare staff if his constipation continued. At 2.27pm on 19 May, a nurse saw Mr Fisher, who

said he felt weak and had diarrhoea. She considered he might have taken too much laxative and advised him to drink plenty of fluids. At 5.52pm, Mr Fisher said he was still constipated, and asked for some lactulose. A nurse gave him a further dose.

25. At 9.51pm that evening, a nurse reviewed Mr Fisher after his cellmate was concerned about him. She noted he had poor urine output, his blood pressure and temperature were low and she considered he was dehydrated. She arranged for Mr Fisher to go to hospital immediately. Two officers accompanied him but did not use restraints.

26. Mr Fisher was severely dehydrated and doctors admitted him to hospital. A prison manager telephoned Mr Fisher's mother to inform her and arranged for her to visit him.

27. Hospital doctors treated Mr Fisher with intravenous antibiotics and his condition began to improve. At 8.20am on 20 May, officers placed Mr Fisher on an escort chain (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). Later that day, the hospital informed prison healthcare staff that Mr Fisher's health was very poor and he had only a fifty per cent chance of survival. At 1.15pm, the duty governor gave officers permission to remove Mr Fisher's restraints. Mr Fisher's condition continued to decline and he died in hospital at 6.00pm on 20 May. His mother was with him at the time.

Contact with Mr Fisher's family.

28. On 21 May, the prison appointed Senior Officer (SO), as the prison's family liaison officer. The SO spoke to Mr Fisher's mother and offered advice and support. He remained in contact with her until after the funeral, which was held on 12 June. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

29. After Mr Fisher's death, the prison care team offered prison and healthcare staff support. The prison posted notices informing staff and prisoners of Mr Fisher's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Fisher's death.

Cause of death

30. The coroner gave the cause of death as acute bronchitis and alcoholic liver disease.

Findings

Clinical care

31. The clinical reviewer noted that Mr Fisher had a forty-year history of alcoholism. He had significant health problems, including ischaemic heart disease and had had two previous heart attacks. He had a long history of not taking his prescribed medication, although he appeared to start taking this again when he was recalled to Hewell.

32. When Mr Fisher arrived at Hewell, a nurse properly assessed him and he was admitted immediately to the inpatient unit to monitor and stabilise his alcohol withdrawal and his blood pressure. He was appropriately prescribed diazepam to relieve symptoms of alcohol withdrawal. He successfully completed detoxification and agreed to take his prescribed medication. The clinical reviewer commented that healthcare staff developed an effective cardiovascular care plan to manage Mr Fisher's heart condition and high blood pressure. When Mr Fisher became unwell, a nurse assessed him promptly and arranged for him to be taken to hospital quickly.

33. Mr Fisher was at Hewell only eleven days before he was admitted to hospital. In the days before he had taken lactulose for constipation, although he had also suffered some diarrhoea. The clinical reviewer considered that the dose of lactulose was appropriate.

34. The coroner gave the cause of death as acute bronchitis and liver disease. Mr Fisher had complained of intermittent chest pain, breathlessness and mucus on 9 May, but at the time, a GP examined him and noted his chest and airway were clear. On 11 May, there was an expected abnormal liver function test, and a prison GP arranged a follow-up test in four weeks. The clinical reviewer was satisfied that Mr Fisher received appropriate care and his declining condition was caused by his body slowly shutting down due to liver disease.

35. We agree with the clinical reviewer that the standard of care Mr Fisher received at Hewell was equivalent to that he could have expected to receive in the community.

Restraints

36. When Mr Fisher went to hospital on 18 May, officers did not use restraints. Hospital doctors treated Mr Fisher with intravenous antibiotics and noted that his condition had improved. At 8.20am on 20 May, the duty governor gave permission for officers to apply an escort chain. The escort risk assessment said Mr Fisher was now mobile, had a history of violence and was a high risk to the public if he escaped. Unfortunately, Mr Fisher's condition started to deteriorate quickly. At 1.30pm, at the request of one of the escorting officers a manager gave permission to permanently remove the restraints. We agree that it was appropriate to apply restraints when Mr Fisher's condition improved. When his condition deteriorated, officers immediately removed the restraints and we therefore do not make a recommendation about this issue.

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