Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Brown a prisoner at HMP Ashfield on 10 February 2018

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 I oversee can improve their work in the future.

Mr David Brown died on 10 February 2018 from complications following surgery while a prisoner at HMP Ashfield. He was 69 years old. I offer my condolences to Mr Brown's family and friends.

I am satisfied that the care Mr Brown received in prison was equivalent to that which he could have expected to have received in the community. However, I am concerned that his family were not properly informed before he underwent serious surgery.

I am also concerned that he was escorted under restraint when he first went to hospital.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2018**

Contents

Summary

Events

1. On 1 September 2011, Mr David Brown was sentenced to 22 years imprisonment for sexual offences. He served time at several prisons before he was transferred to HMP Ashfield on 15 June 2017.

2. Mr Brown had several health concerns during his time in prison. He was being actively monitored for heart disease, high blood pressure and lung conditions. He had also been successfully treated for cancer, which was also being monitored.

3. In 2013, Mr Brown had been diagnosed with an abdominal aortic aneurysm. (An abdominal aortic aneurysm (AAA) is an enlargement of the aorta, which although not an immediate cause concern, required monitoring.) In July 2017, a significant enlargement was observed, and Mr Brown was placed on three monthly reviews. In October, there was a slight change and Mr Brown stayed on three monthly checks.

4. On 4 January 2018, a prison GP was concerned about Mr Brown's AAA, and arranged for a scan the same day. The next day another GP reviewed this scan and referred Mr Brown to the vascular surgeon, who reviewed Mr Brown a few days later.

5. On 30 January, Mr Brown was admitted to Southmead Hospital for emergency surgery. Following the operation, he experienced complications and never recovered. At 1.56pm on 10 February, Mr Brown was pronounced dead.

Findings

Clinical care

6. We agree with the clinical reviewer that the care Mr Brown received was equivalent to that which he could have expected to receive in the community. We consider that the prison appropriately referred him to the hospital when necessary. When his AAA became a cause for concern, specialist advice was sought immediately.

Contact with Mr Brown's family

7. We are concerned that the prison did not formally inform Mr Brown's family when he went to hospital, despite him requiring very serious surgery.

Escorts and security

8. We are also concerned that the prison decided to restrain Mr Brown when he first went to hospital, despite him being very poorly.

Recommendations

- The Director at Ashfield should ensure that the prison complies with Prison Service policy about contacting the families of seriously ill prisoners.

- The Director and Head of Healthcare at Ashfield should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Brown's prison and medical records.

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

12. We informed HM Coroner for Avon of the investigation. She confirmed Mr Brown's cause of death. We have sent the coroner a copy of this report.

13. The investigator wrote to Mr Brown's daughter to explain the investigation and to ask whether she had any matters she wanted the investigator to consider. She did not respond to our letter.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Ashfield

15. HMP Ashfield is a specialist medium security adult male prison for prisoners convicted of sexual offences. It accommodates approximately 400 men and is managed by Serco.

16. Healthcare is provided by an amalgamation of Hanham Health, Bristol Community Health and Avon and Wiltshire Partnership Mental Health Trust. The healthcare unit provides on-site chronic disease management including diabetes, respiratory and cardiovascular disease screening.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Ashfield was conducted in August 2015. Inspectors found that health services were effective and responsive, long-term conditions were identified and care was good. The inspection report noted the appointment system for internal and external referrals was very good and comparable to the best community GP practices.

Independent Monitoring Board

18. 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 June 2017, the IMB reported that Ashfield was a very well-run prison. They noted that prisoners generally reported a high level of satisfaction with the quality of healthcare, could access GP appointments promptly and offered a wide range of specialist clinics.

Previous deaths at HMP Ashfield

19. Mr Brown was the fifth prisoner at Ashfield to die since January 2015. There were no similarities with the circumstances of the previous deaths.

Key Events

20. On 1 September 2011, Mr David Brown was sentenced to 22 years imprisonment for sexual offences. He was initially sent to HMP Exeter and spent time at several prisons before transferring to HMP Ashfield on 15 June 2017.

Mr Brown's prison medical history

21. Mr Brown had a history of high cholesterol, hypertension (high blood pressure) and minor coronary heart disease. He was prescribed ramipril for hypertension and simvastatin for high cholesterol. During his time in prison, Mr Brown developed several other health conditions.

22. In 2013, Mr Brown was diagnosed with an abdominal aortic aneurysm (AAA). At the time, the extent of the AAA was 37mm, and required regular reviews. He was also confirmed as suffering from a form of heart failure and a misfunctioning heart valve.

23. In 2014, Mr Brown was diagnosed with B cell lymphoma (blood cancer in the lymph nodes). This was successfully treated with chemotherapy and the cancer remained in remission.

24. In 2016, Mr Brown was diagnosed with Barrett's oesophagus (inflammation of the gullet caused by stomach acid which can rarely develop into cancer of the gullet). He was prescribed 20mg of omeprazole daily to treat this. In December, he was diagnosed with chronic obstructive pulmonary disease (COPD - a range of lung conditions which cause breathing difficulties). He was placed on a COPD care plan and prescribed salbutamol and tiotropium bromide inhalers to treat this.

Mr Brown's time in HMP Ashfield

25. On 15 June 2017, Mr Brown was transferred to HMP Ashfield. A nurse reviewed Mr Brown at a health screen on reception. He recorded Mr Brown's history of COPD and lymphoma. The next day, a nurse performed a secondary health screen. She noted his history of cardiovascular disease and referred him for electrocardiograph (ECG) recording. On 28 June, Mr Brown had an ECG which was recorded as normal.

26. On 12 July, a nurse saw Mr Brown after he complained of dizzy spells. She noted that these had been occurring 3-4 times a day but that there was no pattern. She scheduled a GP review but advised him to seek medical assistance if they got worse. On 19 July, a prison GP reviewed Mr Brown. He noted that Mr Brown had flickering vision prior to the dizziness but experienced no headache or palpitations. The GP arranged for blood tests to check for diabetes, and referred Mr Brown to the hospital cardiologist.

27. On 19 July, Mr Brown attended Southmead Hospital for an AAA review. The clinic's advice letter stated that Mr Brown's AAA measured 46mm wide, and that a further review was required in three months. On 3 October, the clinic reviewed Mr Brown again, and recorded that his AAA now measured 47mm. They advised a further review in three months.

28. On 21 July, a prison GP reviewed Mr Brown's blood tests and recorded that he had diabetes. On 2 August, a prison GP saw Mr Brown and noted that he had type-2 diabetes mellitus (a metabolic disorder causing high blood sugar due to low insulin levels or insulin resistance). She prescribed metformin to treat this, and scheduled a diabetic review. On 8 August, a nurse reviewed Mr Brown, and gave him dietary advice. On 6 September, a prison GP saw Mr Brown and noted that he was tolerating the metformin well, so increased his dose.

29. On 10 August, a prison GP recorded that Mr Brown's QRISK2 score (a predictive algorithm which assesses a patient's risk of cardiovascular disease) indicated that Mr Brown had a 70% chance of a cardiovascular incident within the next 10 years. The National Institute for Care Excellence (NICE) recommends that statins should be prescribed for patients with more than a 10% risk. Mr Brown was already taking prescribed statins.

30. On 19 October, a nurse saw Mr Brown after he complained of discomfort in his upper abdomen. He examined Mr Brown, and recorded that his abdomen was slightly swollen. The nurse noted that Mr Brown had a GP appointment the next day and advised him to raise this issue then. The following day, a prison GP reviewed Mr Brown for his ongoing COPD problem. There was no record of any discussion about his abdominal pain.

31. On 6 November, a prison GP reviewed Mr Brown following an advice letter from a vascular nurse at the hospital. She noted that he was advised to take aspirin for his AAA problem, and she prescribed this.

32. On 20 November, a prison GP reviewed Mr Brown due to his worsening abdominal pain. He noted that Mr Brown had mild upper abdominal tenderness and that his abdomen was soft. The GP doubled Mr Brown's dose of omeprazole for two weeks to reduce his stomach acid. Four days later, a nurse saw Mr Brown after he complained of chronic stomach cramps. He told her that this had been happening for a week, but only when he lay down. The nurse noted that the increased omeprazole dose had made no difference and that he thought that Mr Brown's pain was due to the increased dose of metformin. On 28 November, a prison GP reviewed Mr Brown. He noted that he had no vomiting or weight loss and appeared well. He suspected irritable bowel syndrome and prescribed buscopan. He advised a further review if Mr Brown's condition did not improve.

33. On 30 December, a nurse noted that Mr Brown was still suffering with abdominal pain and cramps despite the buscopan. She requested a GP review for him. On 4 January 2018, a prison GP reviewed Mr Brown. She examined him and noted that she could feel his aneurysm and that it was tender in that area. The GP was unable to contact the on-call vascular consultant, but booked Mr Brown in for a scan at the prison later that day. The following day, a prison GP reviewed the results of this scan, and noted that Mr Brown's AAA now measured 53mm. He referred him to the vascular surgery service.

34. On 9 January, the vascular surgeon at Southmead Hospital reviewed Mr Brown. The surgeon advised that an urgent intervention was needed due to Mr Brown's symptoms and the rapid enlargement of his aneurysm.

35. Meanwhile, on 10 January, a prison GP reviewed the results of a prostate cancer screening test. He noted that Mr Brown's results were abnormal, and made a fast-track referral to the urologist at the hospital to check for urological cancer. The GP noted that the situation was complicated due to Mr Brown's imminent AAA surgery, but advised that there was a good chance he did not have cancer. On 24 January, the urologist reviewed Mr Brown, but Mr Brown declined further investigations.

36. On 30 January, Mr Brown was taken to Southmead Hospital. He was taken under restraint and accompanied by two officers. Later that day, he had emergency surgery to repair his AAA. The restraints were removed and never reapplied.

37. Mr Brown experienced complications during the operation including a blood clot, pneumonia and respiratory failure. Surgeons also suspected that he had a perforated bowel and so performed a further operation to resolve this. However, Mr Brown's condition deteriorated following this operation, and on 10 February, the hospital took the decision to withdraw treatment. At 1.56pm on 10 February, Mr Brown was pronounced dead.

Contact with Mr Brown's family

38. Mr Brown's next of kin was his daughter, with another daughter also listed. On 3 February 2018, an officer contacted Mr Brown's daughter after her father experienced complications during an operation. The prison then appointed the officer and a prison manager as Mr Brown's family liaison officers. They continued to liaise with Mr Brown's daughter, and facilitated visits for her and other members of his family.

39. On the morning of 10 February, the decision was taken to withdraw Mr Brown's treatment. The prison manager ensured his family were informed and they made their way to the hospital. Mr Brown's treatment was withdrawn shortly after their arrival, and they were with him when he died. The prison manager continued to offer support. Mr Brown's funeral was held on 21 February. The prison contributed to the cost in line with national guidance.

Support for prisoners and staff

40. After Mr Brown's death, the acting Director offered support to the staff involved with him to ensure they had the opportunity to discuss any issues arising. The staff care team also offered support.

41. The prison posted notices informing other prisoners of Mr Brown's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Brown's death.

Post-mortem report

42. The post-mortem concluded that Mr Brown died from liver failure caused by bowel infarction (an irreversible injury to the intestine caused by insufficient blood flow). This was a consequence of the abdominal aortic aneurysm repair.

Findings

Clinical care

43. The clinical reviewer concluded that, generally, the care Mr Brown received at Ashfield was equivalent to that which he could have expected to receive in the community. Mr Brown had several serious health concerns, which were well managed during his time in prison. He was appropriately monitored by healthcare staff, and referred to external specialists as and when necessary.

44. We agree with the clinical reviewer that the management of Mr Brown's AAA was appropriate. When Mr Brown's AAA was first observed at 37mm, the decision to review him three years later was in line with the European Society of Cardiology Guidelines. Once it became clear, in July 2017, that his AAA was enlarging, the prison took the advice of the consultant cardiologist to review him at three-monthly intervals. When the prison GP became concerned on 4 January, she immediately tried to consult a specialist and, on failing to do this, she arranged for an urgent scan. When this showed that Mr Brown's AAA had increased in size to 53mm, a prison GP immediately referred him to the vascular surgeon. He was then appropriately referred for emergency surgery.

Contact with Mr Brown's family

45. Prison Rule 22(1) states that when a prisoner becomes seriously ill the Governor shall inform the prisoner's next of kin at once.

46. Under Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* "prisons must ensure that an appropriate member of staff engage with the next of kin of prisoners who are seriously ill". The PSI adds: "where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, they must be encouraged to engage with their families or nominated person where it is appropriate to do so. "…and that the prison should record "attempts to contact the family or their representatives, including those without success or which were refused or declined and any reasons given."

47. Although Mr Brown was not suffering from a terminal illness he was scheduled for very serious surgery. A review into open AAA surgery conducted by the European Society of Cardiology, found that the average mortality rate for such an operation was a little over 1 in 20 people. Despite this, Mr Brown's family were not officially informed about this emergency operation until a few days after it had taken place. The prison has subsequently informed us that Mr Brown had himself told his family about the operation prior to him going to hospital. While we accept that this may well have been the case, we would have expected formal family liaison contact to have been initiated as soon as the seriousness of the operation was clear, and for that contact to have been recorded. We are concerned that Mr Brown's family was not informed sooner, and make the following recommendation:

The Director at Ashfield should ensure that the prison complies with Prison Service policy about contacting the families of seriously ill prisoners

48. We are satisfied that the prison conducted its contact with Mr Brown's family appropriately once initial contact had been made.

Escorts and security

49. 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 a 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 medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

50. On 29 January, Mr Brown was risk-assessed prior to his transfer to hospital. The risk assessment considered him to be a risk to the public, and there were no medical objections to the use of restraints. The Assistant Director agreed with the risk assessment and authorised the use of restraints due to Mr Brown's offence, and the size and population of the hospital.

51. We acknowledge the historic risk factors but are concerned that the decision to use restraints did not properly consider the proportionality of doing so and, in particular, that there was no proper consideration given to Mr Brown's health and risk of escape. The High Court judgement makes it clear that a prisoner's health and mobility must be considered as part of any risk assessment. We make the following recommendation:

    The Director and Head of Healthcare at Ashfield should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

52. We are satisfied that once the prison removed Mr Brown's restraints prior to him having surgery, they were not applied again.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141