The death in custody of a prisoner

HMP Bristol – 6 April 2004

Report by the Prisons and Probation Ombudsman for England and Wales

June 2004

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Bristol on 6 April 2004.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task. However, during a transitional period during which I am building up sufficient staff trained in the relevant skills for this task, Prison Service senior managers, with the necessary operational experience, are being co-opted onto investigation teams.

In this case, the investigation has been carried out by a Prison Service senior manager working for the Prison Service's South West Area Office, and a member of the PPO's staff. An independent clinical review was commissioned from a doctor of Bristol North Primary Care Trust.

This investigation is into the death of a prisoner, who died in hospital in Bristol, during the course of a surgical operation to remove a brain tumour. The man was serving a three-year prison sentence at Bristol Prison at the time of his death.

My colleagues and I would like to extend our condolences to the prisoner's family for their loss. We would also like to thank the acting Governor in charge of Bristol Prison at the time of our visit, and the other members of his staff who assisted us for their help. We found staff generally helpful. In particular, all the documentation we might require had already been gathered together for us.

Stephen Shaw
Prisons and Probation Ombudsman

June 2004

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Summary

The prisoner died at the age of 47 at Frenchay Hospital, Bristol, while undergoing surgery for the removal of a brain tumour, while he was serving a three-year prison sentence at Bristol Prison. His death was not connected to the fact that he was in prison or to the level of care that he received there.

The prisoner was a person with multiple social, medical and psychiatric problems, including learning difficulties, a troubled childhood, alcoholism, thyroid disease, eye disease, intermittent psychotic illness and a brain tumour.

He played truant from school and was a persistent petty offender against the law from his teenage years onwards. He was familiar with prison life, having served many short to medium sentences, and had as good access to medical services in prison as he would have had outside, and better than he would have had at times when he was living rough with no regular home.

I do not believe there are particular lessons for the Prison Service to be learn from the prisoner's death, other than to note the good practice of the acting Governor in visiting the prisoner's mother, and this report does not make any recommendations.

Background

The prisoner was born in July 1956 and was 47 years old when he died on 5 April 2004. He was one of a large family and seems to have had a troubled childhood. He said his father used excessive physical punishment on him. He did not do well at school, played truant and left without having learned to read and write. He was apparently given a statement of special educational needs, but this does not seem to have resulted in any special provision being made for him. He had subsequently been diagnosed as having mild learning difficulties.

His first custodial sentence was imposed in 1976, when he was given 3 months in a Detention Centre. This was followed by two terms of Borstal Training and fifteen prison sentences, including the one he was serving when he died but not counting a technical one day sentence for a breach of conditional discharge. His previous sentence lengths varied from 14 days to 15 months. He also had numerous community penalties imposed on him, including fines, probation orders and community service orders.

He was married, and had three children, but was subsequently divorced. Two of the children have been adopted and the other is in foster care. He was not in touch with his ex-wife or his children, and gave his mother's name as his next of kin (his father is dead), but when contacted about his death she was not aware that he had been in prison for the past seven months. After the break up of his marriage, he appears to have lived rough a good deal of the time.

At the time of his death, he had been in custody in Bristol Prison since 3 September 2003, when he was remanded for trial on a charge of armed robbery. On 16 February 2004 he was given a three-year prison sentence for this offence, which consisted of trying to rob a petrol filling station by holding his fingers inside his shirt to look like a gun.

He was well known to the staff at Bristol Prison as a result of the numerous times he had stayed there, and particularly to the healthcare staff who had dealt with many of his physical and mental problems. He had a long-standing addiction to alcohol and said many of his offences were committed to obtain money for drink.

The prisoner also had a thyroid problem, as a result of which he had part of his thyroid gland removed, and he should then have taken regular medication to keep up his thyroid level, but he probably did not remember to take this regularly when he was drinking and living rough. The thyroid disease had in turn led to trouble with his eyes, and he had been treated for a corneal ulcer. He was almost blind in one eye.

In November 2002 the prisoner was admitted to a psychiatric unit with a diagnosis of paranoid psychosis, possibly caused by his alcohol abuse, and remained as an inpatient for seven months. While there, he was diagnosed with a brain tumour and he underwent surgery for its removal in January 2003.

After his psychiatric symptoms had settled down, he was eventually discharged to lodgings where he could receive some supervision in July 2003.

His admission to the psychiatric unit followed an attempted robbery at the same filling station as the one for which he was eventually sentenced. He repeated the same offence despite the fact that it had not succeeded the first time. On the first occasion, the police did not proceed against him because he was mentally ill and he was admitted to hospital for treatment. On the second occasion, following treatment, he was fit for trial (but only just) and the criminal justice system took its course.

A psychiatric report prepared for the court pointed out that he would be vulnerable in prison custody, and requested that this should be drawn to the attention of prison staff. At that time he had already been in custody for some months, and said he did not find it difficult though it was rather boring.

All the indications are that his problems were recognised at the prison (where he was a familiar figure) and his time was spent either in the healthcare centre or in D wing, the prison's "safer custody unit".

He was referred for further investigation of his eye problems, and in the course of this it was discovered that his brain tumour had grown back. It was during the course of a second operation to try to remove the tumour that his death occurred. The prisoner seems to have been quite popular in the prison. Several of the prison nursing staff requested permission to attend his funeral, and some of the prisoners made a collection for flowers.

Investigation process

All the indications were that this was a death from natural causes. The Ombudsman's Terms of Reference permit in these circumstances, that it may be sufficient for a clinical review to be carried out by an independent health care professional, rather than a full investigation. My approach in cases of apparent natural cause deaths has been to conduct an initial review to determine if a full investigation is justified. In this prisoner's case, I decided that the circumstances did not require a full investigation.

I did so after the investigators visited Bristol Prison and had a very helpful discussion with the acting Governor as well as the Safer Custody Officer and the Deputy Head of Healthcare. The investigator recommended to me that a full investigation was not warranted and I agreed that this procedure should apply in this case.

We visited D wing, the "safer custody unit" where the prisoner spent much of his time in prison. We met the Chairman and Secretary of the local Prison Officers Association (POA), also the Chair of the Independent Monitoring board (IMB). Neither the POA nor the IMB had any issues they wished to draw to the investigator's attention.

The investigator's were given access to all the prisoner's prison records, including his medical records, and were given copies of everything they required.

The acting Governor had visited the prisoner's mother, his next of kin, to break the news of his death to her, and explained that there would be an investigation. The prisoner's mother does not have a telephone, but a letter was sent to her by the investigators inviting her to get in touch to make any comments or ask questions if she wished. To date the prisoner's mother has not contacted the investigators.

A doctor of Bristol North Primary Care Trust carried out the clinical review.

The Events Leading up to The Prisoner's Death

The prisoner was admitted to Frenchay Hospital, Bristol, on 4 April 2004. This was for surgery to remove a tumour. He had previously undergone surgery on the tumour in January 2003, but it had re-grown.

The procedure and its associated risks were explained to him, including the possibility of death, and he gave his written consent. Unfortunately he suffered a haemorrhage during the operation, and despite action to stem the loss of blood this resulted in heart failure, and he died on the operating table.

The Specialist Neurosurgical Registrar sent a report to the prison medical officer. An autopsy was carried out and confirmed the cause of death. A medical report was also sent by the prison medical officer to the coroner's officer.

Post Incident Response

The acting Governor in charge of the prison went personally to break the news of the prisoner's death to his mother, whom he had named as his next of kin. This unenviable responsibility seems to have been very appropriately and sensitively handled. I commend the acting Governor's actions.

All the necessary information was gathered together for the purposes of the investigation. Arrangements were made for the investigators to see the relevant members of staff so that we could satisfy ourselves as to the way in which the deceased had been cared for in prison.

Level of Compliance

Standards of healthcare in prison are intended to mirror those available in the outside community. There are also instructions and policies on the management of prisoners like the prisoner who are vulnerable for one reason or another.

The prisoner's prison records indicate that while in prison he was being given an appropriate level of care, and his medical, psychiatric and social needs were recognised and adequately dealt with. The medical aspects of his care are described in the independent clinical review, which concludes that he was well looked after and there were no major areas where his care could have been improved.

The post-incident response was also, as indicated above, fully compliant with Prison Service instructions and policies.

Findings

The prisoner died of natural causes as a result of a surgical operation, which was performed in his own best interests, and with his informed consent. The haemorrhage that led to his death, is, as the autopsy report states, “a well recognised complication of this type of surgery”.

There may have been a short delay in him being referred back to the neurosurgeons who decided on this treatment, but the independent clinical review concludes that this would have made no difference to the outcome.

Conclusions

The story of the prisoner’s life may be thought to raise more questions than that of his death, which could have happened to anyone. But this report is concerned only with his death and the way in which his management in custody could have had a bearing on it.

The prisoner was well cared for in Bristol Prison, and probably received better healthcare when he was there than when he was outside in the community.

Recommendations

There are no recommendations arising from this investigation.

Good Practice

The acting Governor’s decision to visit the prisoner’s mother in person to break the news of her son’s death was good practice.

A full investigation might have revealed other aspects of the prisoner’s treatment that amounted to good practice, but in this case, where the death was clearly due to natural causes, the more limited type of investigation that has been conducted has not brought these to light.