The Death in Custody of a prisoner
HMP Bristol – June 2004

Report by the Prisons and Probation Ombudsman for England and Wales

March 2005

This is the report of an investigation into the circumstances of the death of a prisoner in Frenchay Hospital, Bristol on 27 June 2004. The man had been taken to the Neurosurgical Intensive Therapy Unit at the hospital after falling down some stairs on G wing in HM Prison Bristol on 17 June. Despite surgery to remove a blood clot in his brain and ongoing ventilation, the pressure in his brain could not be controlled and he died 10 days after admission to hospital.

The investigation was led by one of my Assistant Ombudsmen. An independent review of the prisoner's medical care in prison was commissioned from a Doctor within Bristol North Primary Care Trust. We would like to thank the management and staff at HMP Bristol for their assistance and co-operation during the course of this investigation.

I am critical of the medical care that the prisoner received whilst at Bristol. His medical history was not appropriately reviewed on his reception nor after he suffered two epileptic fits in November and December 2003. The Doctor's report says there is no evidence of a fit leading to the prisoner's fall. I am much less certain on that point. Indeed, if it is the case that he suffered a further seizure in the moments immediately prior to his fall on G wing stairs, then it is possible that lack of appropriate medication may have contributed to that fact.

We extend our condolences to the family of the prisoner and to those touched by his death.

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Prisons and Probation Ombudsman

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Summary

The prisoner was a 39 year old man who was serving a life sentence at HM Prison Bristol. He died in Frenchay Hospital on 27 June 2004. He had fallen whilst coming down a set of steps on G wing. The prisoner suffered a serious head injury as a result of the fall and was taken to Bristol Royal Infirmary on 17 June. A short while later, the prisoner was transferred to a Neurosurgical Intensive Therapy Unit at Frenchay Hospital where he underwent an emergency craniotomy. Following surgery, the prisoner was ventilated and sedated. Further CT scans over the next few days showed developing brain swelling and areas of infarction. His pupils remained fixed and dilated and after reviewing his scans and clinical condition, the decision was taken to withdraw active treatment. The prisoner was certified dead at 1am on 27 June 2004, 10 days after his admission to hospital.

HMP Bristol is a local prison that generally holds people who are on remand. Once people have been sentenced by a court, they are usually moved to another prison. Bristol does accommodate some long term and life sentence prisoners. The prisoner had arrived at Bristol in January 2002.

It is unclear why he fell as he came down the stairs on G wing. The clinical review by the Doctor draws attention to an officer's statement that the prisoner missed a step on the stairs and concludes that epilepsy did not contribute to the accident. The Ombudsman and his colleagues believe it is most likely that he did suffer an epileptic fit in the moment before he fell. The prisoner fell head first down approximately seven steps. He made no attempt to use his hands or arms to reduce the impact of his fall.

There were no major concerns raised by the clinical review about how the incident was subsequently handled by the prison.

The Doctor states that the resuscitation attempt, the request for an ambulance and transfer to the paramedics, was well handled and I agree with this assessment. The clinical review did pick up that the prisoner's epilepsy should have been reviewed by Bristol prison in November or December 2003, and options for preventative medication discussed. I agree with this comment from the Doctor, but place more weight on the failure of the medical services to carry out this review in December 2003.

My report makes five recommendations.

Investigation Process

My practice in investigations into a death from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My Investigator visited HMP Bristol on 1 July 2004 and met with the Deputy Governor. She was given a full briefing about the circumstances surrounding the prisoner's death and the current situation regarding family contacts and actions instigated by the establishment to deal with the death. My Investigator also met with a Prison Officers' Association representative. A notice to staff and a notice to prisoners was issued by the prison, inviting anyone who might have information relating to his death to make themselves known to the inquiry team. No one came forward from these notices.

In October 2004, a letter was received from the Prisoners' Advice Service stating that a man wished to send a statement to the investigation team. My office requested that he send in his statement, but none was forthcoming. Whilst my Investigator was making arrangements to speak directly with him at Dartmoor prison, the coroner's officer advised that he had made a statement to the coroner, and informed my investigator about the contents of that statement.

A clinical review was commissioned from a Doctor within Bristol North Primary Care Trust. My Investigator returned to Bristol in November and spoke with staff who worked on G wing and who knew the deceased.

My family liaison officer contacted the prisoner's aunt. She did not have any specific concerns about his death. She did not know of any history of epilepsy but thought a fit might have been related to drug use or withdrawal. She subsequently contacted the Ombudsman's office in order to gain assistance in sorting her nephew's financial affairs whilst at Bristol prison.

Background

The prisoner was born on 25 February 1965 and was an only child. The relationship between himself and his step father was not harmonious. Sadly, his stepfather committed suicide in 1993 and left debt problems for the family. The prisoner misused both drugs and alcohol and these problems, along with difficulties controlling his anger, appear to have been closely linked to his offending.

The prisoner was convicted and given a life sentence in March 1999, with a tariff of five years. He was in a relationship at the time of being sentenced and the couple had a daughter. Unfortunately, the relationship with his child's mother broke down. After an unsettling start, he made good progress whilst at Brixton prison and completed the Enhanced Thinking Skills course. As a result of his progress he was transferred to a lower security prison, Channings Wood. This establishment is in Devon, closer to his mother.

The prisoner's main support whilst in custody was his mother. He also had contact with his daughter via the telephone. Sadly, the prisoner's mother died in July 2001 after abdominal surgery. Understandably, he went through a period of great emotional turmoil following his mother's death and struggled to maintain his previous behaviour and motivation levels to progress through the prison system. He dropped out of the Cognitive Self Change Programme (CSCP), despite having made good early progress and reportedly began taking drugs again.

The prisoner was received into Bristol in January 2002 on a regressive move from Channings Wood. He went through a period of counselling with CRUSE during 2003. In May 2004, he was informed that his first Oral Hearing before the Parole Board was scheduled for 4 or 5 August 2004. The appropriate papers had been prepared by staff at Bristol, ready for this review to take place.

The papers prepared for the Parole Board review indicated that lifer management, prison officers, the psychologist and probation staff all felt that the prisoner had much work to do in addressing the causes of his offending, before consideration could be given to an open prison or release. They felt that he needed to address his drug addiction and complete further cognitive behaviour programmes.

Bristol prison noted that the prisoner spent much time in his cell. He had not shown much determination to find gainful employment after losing his job in the prison workshop. His drug problem seemed to return and he had several adjudications for drug misuse since being at Bristol. His personal officer noted that the loss of his mother had affected him very deeply. The prisoner had been moved from B wing (the lifer unit) to G wing in February 2004 after information was received that he was manipulating and bullying other prisoners for their medication.

The Events Leading Up To The Prisoner's Hospital Admission on 17 June

The prisoner suffered from epilepsy. The epilepsy seemed to have been brought on by a head injury that he suffered in 1983. It was well controlled during his periods in prison custody prior to his transfer to Bristol by preventative medication.

Whilst in Bristol, the prisoner was not prescribed any preventative medication for his epilepsy. For 22 months, there is no record of him having any sort of epileptic fit or seizure. Records indicate he then suffered an epileptic fit on 26 November 2003 and again on 30 December 2003. The medical team at Bristol did not review his previous history in relation to epilepsy nor did the doctor appear to consider prescribing any preventative medication. No review of the medication that he was taking at that time was carried out either.

At some time between 11:45 and 12:00 on Thursday 17 June, the prisoner who died came out of cell G2-23, following his cell mate. The prisoner was on his way to the servery, on the ground floor, to collect his lunch. His cell mate remembers the prisoner looking around. He remembered the prisoner saying before unlock that someone owed him ½ ounce of tobacco, but that he could not remember who it was. It seems as though he was looking around in order to try to remember who it was who owed him the tobacco. A third prisoner was walking behind the man who fell on their way to collect lunch.

When the man who fell was two or three steps down the stairs he was greeted by a fellow prisoner. They started walking down the stairs together and then the prisoner who fell stopped approximately half way down and looked back up the staircase. The other prisoner didn't see anything, so continued to walk down the stairs. He took two or three steps and was down on the one's landing when he heard a noise and turned to see the man who died falling towards the floor and hitting his head as he landed. An Officer saw the prisoner walking from the two's landing to the one's landing and reports that, as he was walking down the stairs, he missed a step and then fell down approximately seven steps to the ground. Another Officer's account says that he was half way down the stairs when he started to shake. He then turned around and fell down the remaining steps, landing on his head. He had not used his arms to try to break the impact of his fall in any way. There are no reports indicating anything was on the stairway that may have caused him to fall. The Orderly Officer states in his report of the incident that the prisoner suffered what appeared to be an epileptic fit, lost consciousness, fell and then hit his head at the bottom of the stairs. The Orderly Officer was not a witness to the fall.

The Senior Officer in charge of the wing at the time immediately called a code 'red' and asked for healthcare staff to attend. Another prisoner ran to him and felt for a pulse and was about to start mouth to mouth when he said "It's alright he's breathing". An Officer and the two prisoners put him into the recovery position and monitored his airway and breathing until nursing staff arrived. One of the prisoners used a rolled up green towel to try to stem the bleeding from his head. The prisoner who fell began to make noises from the back of his throat, clamping his teeth together and shaking as if he was

having a fit. The other prisoner put his fingers into the man's mouth in order to prevent him biting / swallowing his tongue.

The medical staff arrived and attended to the prisoner who had fallen. He stopped breathing twice, but was successfully resuscitated. One nurse took the lead in resuscitation efforts and inserted an airway in order to help the prisoner breathe. A nurse who had grabbed the emergency bag en-route to the incident, and another nurse were also present.

When the paramedics arrived they transferred the prisoner into the ambulance and took him to hospital. He was breathing when he left the prison.

The Prison Response following the prisoner's hospital admission on 17 June and his death on 27 June.

Statements from all those staff who had been involved as a witness or in the medical care of the prisoner on 17 June were taken.

There is evidence in his medical record that nursing staff kept in regular contact with hospital and bedwatch staff as to the condition of the prisoner. There is at least one entry (and frequently more) every day covering his admission on 17 June until his death on 27 June. This is good practice.

The prisoner was found to have a fractured skull, a subdural haemorrhage and intracerebral bleeding. An emergency craniotomy was performed and the prisoner was subsequently ventilated and sedated. Unfortunately, he subsequently developed brain swelling and infarction. Following review, active medical treatment was withdrawn and the prisoner died in the early hours of 27 June.

The contingency plan for a death outside hospital describes the actions to be taken by staff. It was only partially completed and did not indicate who had informed the prisoner's next of kin of his death.

The local notice to staff that was issued and signed by the governor stated that the prisoner "died today, 28 June 2004". This notice is inaccurate in two respects. The spelling of the prisoner's surname is incorrect and he died at 00:55 hours on the morning of 27 June, not 28 June. Given the sensitivity of these notices, it is disappointing that these inaccuracies were not spotted.

A post mortem was carried out by a doctor on 28 June 2004. The doctor summarised the events on 17 June and said that the prisoner was reported to have 'had a fit and fallen down the stairs, hitting his head on the concrete floor'. The cause of death was given as 'head injury'.

Issues considered during the investigation

Accidents and near misses – slips, trips and falls within Bristol prison

An accident investigation into the prisoner's fall was carried out by a Health and Safety Adviser. In carrying out this review, he sought assistance from the Area Health and Safety Advisor. Both men visited the scene of the accident and inspected the stairs. The Health and Safety Executive were notified of the prisoner's fall by telephone and fax on 21 June. At this time, he was still alive and so the notification records the outcome of the injury as 'a major injury'. The Health and Safety Advisor wrote to the Governor of Bristol with his report on 29 June and said in this letter that he would update the H&S Executive about the prisoner's death.

The ground floor conditions on the stairs on G wing are noted as being "Good, clean and free from obstructions" and the lighting as "good". The final point that the Health and Safety Adviser makes in his report is that there was no evidence at present that the prisoner suffered an epileptic fit prior to falling down the stairs and that all the evidence supported that it was an unforeseen accident.

In his letter of 29 June, the Health and safety Adviser stated that both himself and the Health and Safety Executive had watched the video footage of the prisoner's fall. He reported that they could not establish whether he had suffered an epileptic fit prior to his fall, but that an Officer had said that the prisoner had been shaking and leaning on the stair rail.

My Investigator obtained details of other reported slips, trips or falls in Bristol prison over the previous 12 months. There were seven recorded incidents, two involving staff and five involving prisoners. Both of the staff incidents involved slipping on wet floors. Of the prisoner incidents, three involved slipping on floors (some of which were described as wet floors). There are no witness reports about the fall of the prisoner to indicate that the stairway was wet or slippery on 17 June. The remaining two prisoner incidents involved stairs. On 22 November 2003 there is a record of a prisoner coming to the wing office with a cut ear and bruising to his eye and cheek area after reportedly falling over on B wing stairs. There were no witnesses to the fall and unfortunately the paperwork describing exactly what happened is incomplete. On 11 May 2004 a prisoner was heard to have stumbled on the stairs coming from the IT room in the education area. When the member of staff asked the prisoner if he was okay he told her that he was fine, but that he already had a weak ankle from an earlier injury. She noted that the prisoner showed no signs of discomfort for the duration of that 30 minute session. A doctor saw the prisoner the next day and said there were no injuries to note.

It seems clear from the Health and Safety report that G wing stairs did not represent a particular danger in themselves. The record of slips, trips and falls across the prison indicates that wet floors are the most likely hazard to result in a slip or fall. There is one incident of a prisoner falling on some stairs

that resulted in facial injuries, but it is not clear exactly what happened and there were no witnesses.

I do not think that the stairs on G wing were themselves the cause of the prisoner's fall. However, the fact that the fall occurred on the stairs clearly did have an impact on the seriousness of the injuries he suffered.

The prisoner's epilepsy

It is apparent from reading the prisoner's medical record that he suffered from epilepsy after a serious head injury in 1983.

During most of his time in prison custody, the prisoner was assessed as being epileptic and was prescribed preventative medication. Whilst on remand in HMP Exeter, he was prescribed carbamazepine (Tegretol). Whilst the prisoner was in Brixton prison and Channings Wood he continued to take carbamazepine. This medication controlled his epilepsy successfully. The prisoner arrived at Bristol in January 2002. His reception entry does not indicate that any consideration was given to continuing the prison's carbamazepine medication or even that any history indicating epilepsy was considered. Whilst at Bristol, I can find no prescription chart that indicates he was given any drugs to prevent epilepsy. However, for the first 22 months the prisoner did not suffer any fits and it was not inappropriate that he took no anti-epilepsy medication during this time.

On 14 October 2004, a doctor made the decision to prescribe the painkiller Tramadol, instead of Tylex, which the prisoner had been receiving for back pain. The doctor noted in the prisoner's clinical record that he wished to change to Tramadol because *"his mother had seen good reports about it on the internet*". A friend of the prisoner, and another prisoner at HMP Dartmoor, made a statement to the coroner that he had heard that Tramadol was linked to epilepsy. This information was passed on to my Investigator by the coroner's officer. She looked at some information about Tramadol. Several websites indicate that it is not suitable for a patient who has a history of epilepsy, nor a history of alcohol or drug abuse, as it may bring on seizures. There is no indication in the prisoner's medical record that the doctor asked the prisoner whether he had any history of epilepsy, nor that he reviewed past prescriptions or notes regarding him.

About six weeks after starting on Tramadol, a nurse responded to a call from visits stating that the prisoner had suffered an epileptic fit in the visits holding room. He was reported to be very disorientated but denied having had a seizure. B wing staff told the nurse that they thought he may have taken an illicit substance. There is a note in his medical record that the incident would be followed up on sick parade, but there is no further entry to indicate that this was done. A memo written on behalf of the prisoner (on 26 November) states that he refused to go to the healthcare centre to see the doctor.

The second seizure was on 30 December 2003. An officer reported to healthcare staff that the prisoner had suffered a fit lasting approximately two minutes. The prisoner said he had no recollection of the fit. The entry in the prisoner's wing file states that healthcare told staff that no further action was

required. The entry in the medical record reads “to be seen by doctor on the next sick parade.” There is no evidence that he was seen by the doctor, or that any review of his recent seizures took place. A medical review of the prisoner’s condition might have led to decisions regarding preventative medication, a change in his current prescription, or a change in the prisoner’s cell allocation in the prison (whether he should be restricted to cells on the ground floor of wings).

The reports by those prisoners and staff who observed the prisoner falling down G wing stairs on 17 June differ as to whether he simply ‘missed his step’ or whether he might have suffered an epileptic fit in the moments just prior to his fall. However, all reports agree that he fell head first down the stairs and made no effort to try to break his fall by putting his arms out in front of him. My advice from medical staff at Prison Health is that putting one’s arms out is an automatic reaction and would be done by anyone who was conscious at the point of falling. I therefore conclude that it is very likely that the prisoner did suffer a fit in the seconds just prior to his fall. This is contrary to the opinion of the primary care trust doctor in his clinical review.

I am critical of the fact that the medical team at Bristol did not review the prisoner’s medical history and consider a change in his prescription and a ground floor cell after the first or second apparent ‘fit’ that he suffered at the end of 2003.

Conclusions and Recommendations

No-one can say with certainty what caused the prisoner's fall. I have carefully considered the clinical review in which there is no evidence that the prisoner suffered a fit. However, my own view is that the most likely cause of the prisoner's fall on G wing stairs was an epileptic fit in the moment just prior to him falling. The stairway was of no particular danger in itself. Whilst the prisoner had been fit and well in the days and weeks prior to his fall on 17 June, there were two recorded episodes of epilepsy fits or seizures within the previous seven months. No review of the prisoner's medical history (which would have shown that epilepsy had been a factor for the prisoner since 1983) or his medication (which would have indicated a prescription history of anti-epilepsy medication at every other prison he had been to and potential problems with his current prescription of Tramadol) was carried out at that time, despite two commitments in his medical file to do so. Evidence provided by officers is contradictory as to whether the prisoner was shaking before he fell.

After the fall down the stairs the prison responded quickly and appropriately. The nursing staff twice resuscitated the prisoner prior to the paramedics arriving. They are to be commended for their efforts. The two prisoners who came immediately to the prisoner's assistance, are also to be commended.

I make five recommendations.

Recommendation 1 – LOCAL When a prisoner arrives at Bristol a full review should be carried out to ascertain a patient's previous medical history and their prescriptions whilst at other prison establishments (or with their GP).

Recommendation 2 – LOCAL Medical staff at Bristol should be reminded that commitments to carry out reviews written in medical records should be followed up in a timely way.

Recommendation 3 – LOCAL Medical staff should be reminded that a patient's medical history should be ascertained and considered prior to changes being made in their prescription drugs.

Recommendation 4 – LOCAL The governor should remind senior colleagues that, when issuing sensitive notices, factual information should be double checked for accuracy.

Recommendation 5 – LOCAL I recommend that a copy of this report be sent to the Primary Care Trust to consider the implications for clinical practice at HMP Bristol in light of future commissioning arrangements.