A death in custody at

HMP Bristol in July 2004

Report by the Prisons and Probation Ombudsman for England and Wales

May 2005

This is the report of an investigation into the circumstances of a death in hospital on 4 July 2004 of a man who was a remand prisoner at HMP Bristol. The man died from bacterial endocarditis.

A clinical review into the man's treatment was carried out by Bristol North Primary Care Trust.

We would like to extend our condolences to the man's family for their sad loss. I would like to thank the Governor in charge of Bristol Prison, and his staff for their help.

Stephen Shaw CBE **May 2005**
Prisons and Probation Ombudsman

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Summary

The man arrived at HMP Bristol on 29 June 2004. He was a remand prisoner awaiting a court hearing to face a number of charges relating to relatively minor offences. On arrival at Bristol, a reception doctor examined the man and noted that he had a rapid pulse which was attributed to drug withdrawal and he was taken into the prison's Healthcare unit.

On 30 June, test results for the presence of drugs in the man's urine proved negative and it was realised that his symptoms were due to another cause. The man was transferred to outside hospital the next day, but despite treatment he died on 4 July from bacterial endocarditis. He was 33 years old at the time of his death.

The investigator spoke to one of the man's sisters by telephone.

This report makes recommendations relating to the taking of clinical observations of prisoners being monitored in the Healthcare unit. Also the need to avoid delay in obtaining urine samples for testing purposes, and the need to act promptly once urine test results are available. However this investigation raises questions as to how far an equivalent level of care can be offered by a prison's Healthcare unit compared to outside hospital.

Investigation process

My practice in cases of apparent deaths from natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator visited HMP Bristol on 5 July 2004 when he was given copies of relevant records, including the medical records. The investigator spoke informally with the Deputy Governor and with a prison chaplain who had visited the man in hospital, when she met the man's mother and one of his sisters.

The investigator spoke to the Chair of the Independent Monitoring Board (IMB), who did not have any issues that he wished to draw to our attention.

The investigator telephoned the man's sister. She wanted to know whether her brother had received adequate care and treatment. She said that she particularly wanted to know whether there had been any delay on the part of Healthcare staff at HMP Bristol in recognising the seriousness of her brother's clinical condition. Also, once her brother was recognised to be seriously ill, she wanted to know whether there been any delay in sending him into hospital.

Bristol North Primary Care Trust carried out the clinical review.

This report is based upon a thorough review of all relevant paperwork, upon the clinical review and upon informal discussion with Healthcare staff.

HMP Bristol

HMP Bristol is a local prison, which first opened in 1883. In recent years the prison has been extensively refurbished and renovated.

In-patient beds in Bristol's Healthcare unit are located within individual cells, and are subject to the same level of security as standard prison cells. At night-time, for reasons of prison security, clinical observations of patients are not conducted: the term 'clinical observation' means the measurement of several objective clinical signs, for instance measurement of pulse rate, temperature and blood pressure. Similarly, fluid balance charts are not maintained: fluid balance charts are used to record fluids consumed, and urine passed, by a patient. The only 'observation' of patients at night-time, is a visual check made from the cell door observation hatch. Only in the case of an emergency, will a Healthcare cell door be opened at night.

Events Leading up to the Man's Death

The man was received into Bristol in June 2004, when he underwent a first reception health screen including examination by a reception doctor. During screening, the man reported that he was an illicit drug user: specifically he usually used heroin on a daily basis and had last used this drug two days earlier. He also reported that he used cocaine or crack cocaine on a daily basis and had last used this drug a week earlier.

The reception doctor recorded that the man had tachycardia (a rapid heart rate). Based on his symptoms, and on his reported use of illicit drugs, the reception doctor concluded that the man was suffering the effects of drug withdrawal and that he should be monitored in Healthcare. The reception doctor made a note in the man's records that four-hourly observations should be carried out: that is, that temperature, pulse rate, respiratory rate, and blood pressure should be measured and recorded. The reception doctor also noted that a fluid balance chart should be maintained.

On the morning of 30 June, the healthcare nurse made a note in the man's records: *'Had a shower and exercise. Seen by [the healthcare doctor]. No problems raised.'* Later that morning, the healthcare nurse made a further note that the man had refused lunch.

Also on 30 June, the healthcare doctor, made a note in the man's records to say that, due to what still seemed to be withdrawal symptoms, he should remain under observation in the healthcare unit and that this plan should be reviewed the following morning. The man provided a urine sample at some time on 30 June and a computer print-out, produced at 3.42pm, showed that the urine sample proved to be negative for various drugs tested.

The man was seen by the detoxification team on the morning of 1 July. The record made of this review showed that the man had a rapid heart rate, that he felt hot to the touch and that he was slightly dehydrated. The record went on to say that, with these continued apparent symptoms of withdrawal, but given the negative urine result, the man needed to be seen by a doctor.

At 3.50pm on 1 July, the healthcare doctor reviewed the man and noted his symptoms to be moderate to severe dehydration with a feeling of weakness and lethargy. His observations showed him to have a rapid heart rate, rapid pulse, rapid respiration and a high temperature. The healthcare doctor noted that the man's condition had deteriorated compared to how it had been the previous day and

that he was also having difficulty holding down fluids. As the man's symptoms were clearly due to a cause other than drug withdrawal, the healthcare doctor decided that he needed to be transferred to outside hospital urgently. The man was taken to hospital, where he was taken into the intensive care unit and later diagnosed with bacterial endocarditis.

Over the following days, the man's condition deteriorated further and that led to him being transferred to another hospital just after midday on 4 July 2004. The man's condition continued to deteriorate and that evening he was taken into the operating theatre for surgery to be considered. The man died at around 9.30pm that evening during surgery.

Discussion with healthcare and other Staff

The Senior Medical Officer (SMO) told my colleague that, when a prisoner reports at first reception that he is a drug user, a urine sample should be taken for testing. Sometimes a prisoner will be unable to pass urine, perhaps because he is dehydrated or suffering urinary retention. In such a case, the prisoner will be given water to help him urinate.

The SMO explained that monitoring of a prisoner through four-hourly clinical observations and maintenance of a fluid balance chart was not possible overnight in a prison setting. Nor was such monitoring very practical even during the day. The SMO said that, if a prisoner's condition is such that observations are necessary, it would be more appropriate to send him into hospital rather than keep him in Healthcare.

The reception doctor said that he had worked at HMP Bristol, in a locum capacity, from February 2004 to August 2004 and had worked day-time shifts only. The reception doctor said that when he examined the man upon his arrival at Bristol on 29 June, he concluded that the man was suffering the effects of drug withdrawal. Ordinarily, prisoners suffering from withdrawal would be allocated to a standard prison location, however the man seemed to be having a more difficult time in withdrawal than usual, which is why the reception doctor decided he should go to the healthcare unit. The reception doctor did not know that the SMO did not regard it as feasible for clinical observations and maintenance of fluid balance charts to be carried out at night. The reception doctor added that his role in the man's care was only for preliminary examination and preliminary planning. Once the man was in the healthcare unit, it was for the doctors there to take forward his care and treatment.

The healthcare doctor said that on 30 June, the man was weak, but he was able to sit out of bed that day and had also been able to collect his food. The man was drinking fluids and able to converse. There were no indications that the man should be transferred to hospital. On 1 July, the man was clearly worse than he had been the day before and transfer to hospital was appropriate then.

The detoxification doctor saw the man in the clinic on 1 July. Ordinarily, prisoners in drug withdrawal were seen by the detoxification team on the morning immediately following their arrival into prison. They would be reviewed in the clinic even if urinary analysis was still awaited. The detoxification doctor could not, therefore, understand why the man was not seen on 30 June. The detoxification clinic was held during the late

morning so the detoxification doctor surmised that he would have seen the man at around 11am on 1 July. The detoxification doctor thought that the man looked unwell and he mentioned his concern to the healthcare doctor. The healthcare doctor said that healthcare would keep the man under observation. This conversation would have been at around midday.

The healthcare nurse was an agency nurse who worked at Bristol for a brief period. The healthcare nurse remembered the man. She remembered that he was dehydrated and was not drinking. She had pushed him to drink and had made up Ribena drinks for him. The healthcare nurse recalled the man being worse on 1 July than he had been the day before. The healthcare doctor had asked her to take observations and the man had been unable to support himself in bed while she took those observations.

Other staff told my investigator that urine samples taken from prisoners were stored in a fridge overnight and taken to the prison's Mandatory Drug Testing Unit (MDTU) at 8am the following morning. Testing of the samples would normally be completed by about 9am. Where a urine sample needs to be tested urgently, this can be done on an ad hoc basis throughout the day. The MDTU does not open at weekends, so a urine sample taken on Friday will not be tested until the following Monday morning.

Bacterial Endocarditis

Bacterial endocarditis is an infection of the valves and inner lining of the heart. It occurs when bacteria from the skin, mouth or intestines enter the bloodstream and infect the heart valves and lining. Although bacterial endocarditis can occur in anyone, people with an abnormal heart valve or other heart defect are at greater risk. Intravenous drug abuse is a risk factor, although there is no evidence that the man was an intravenous drug user. People who are immunosuppressed (those with a lowered resistance to disease) are also at risk. Infective endocarditis frequently presents with vague early symptoms which delays diagnosis. Infective endocarditis can be treated successfully with antibiotics or surgery. The average mortality rate for infective endocarditis is around 20 per cent, with higher rates applying when there are added complications such as fungal infections.

After the man's death

HMP Bristol followed its contingency plans for handling deaths occurring at outside hospitals. A ward sister from the hospital notified the man's mother of her son's death.

One of the chaplains from HMP Bristol had met the man's mother and one of her daughters when she visited the man while he was a patient in hospital. Following the man's death, the chaplain spoke by telephone to the man's mother and to both of her daughters. The chaplain also attended the man's funeral service, which was held at the Baptist church to which the man's mother belongs. The chaplain told my investigator that there had been a great number of mourners at what was a very moving service.

Level of compliance

The post-incident response by HMP Bristol was fully compliant with Prison Service instructions and policies on managing a death in custody.

Findings

At his first reception health screen on arrival at Bristol on 29 June, the man reported that he was a user of both heroin and of cocaine/crack cocaine. The reception doctor examined the man and noted that he had a rapid heart rate. The reception doctor concluded that the man was suffering the effects of drug withdrawal. Normally, prisoners in withdrawal would be sent to a standard prison location, but the reception doctor judged that the man was experiencing a more difficult withdrawal than was typical. For this reason, the reception doctor sent the man to the healthcare unit where his condition could be monitored. The reception doctor noted in the man's medical record that four-hourly observations should be conducted and a fluid balance chart maintained.

When examined by the healthcare doctor on 30 June, it would seem that the man's condition was largely unchanged from how it had been the day before. The healthcare doctor recorded that his plan was for the man to be reviewed the following day.

A urine sample had been taken for drug testing purposes at some time on 30 June, and that afternoon the urine test result was produced showing that the man was negative for various drugs tested.

The man was reviewed by the detoxification doctor on the morning of 1 July. The detoxification doctor made a note that the negative result from the urine test, together with the fact that the man remained unwell, meant that he needed to be reviewed by a healthcare doctor. The detoxification doctor thought that the man looked unwell and he mentioned his concern to the healthcare doctor who said that healthcare would continue to keep the man under observation. This conversation took place at around midday.

The healthcare doctor saw the man at 3.50pm and recorded that his symptoms at that time included a rapid heart rate, rapid respiration and that he was no longer able to hold down fluids. As these symptoms could no longer be attributed to drug withdrawal, the healthcare doctor arranged for the man to be transferred to hospital.

Initially, the man went to hospital and it was there that the diagnosis of bacterial endocarditis was made. Despite treatment, the man's condition continued to deteriorate and on 4 July he was transferred to another hospital. He died at the hospital later that night.

As explained in the clinical review, the man died from a very rare condition that is hard to diagnose. On admission to Bristol, his presenting clinical symptoms were attributed to drug withdrawal and that was not an unreasonable assumption to have made at the time. Later, when it was recognised that the man's symptoms were due to some other cause, arrangements were made for his urgent referral to hospital.

It had been the negative urine result that led clinical staff to question the preliminary, initially reasonable, diagnosis that the man was suffering from drug withdrawal. There was some delay in obtaining this result. First, because the man was dehydrated he was unable to produce a urine sample for somewhere in the region of 24 hours. That delay was compounded by a further delay before the man was reviewed in the light of that result by the healthcare doctor. Having said this, I recognise that the purpose of the urinary analysis was for the purpose of devising a detoxification plan, and not for diagnostic purposes. It is because of this distinction that it is not considered necessary for the Mandatory Drug Testing Unit to operate at weekends.

If urinary analysis is not used for diagnostic purposes, what diagnostic tests or other objective measurements are used? The reception doctor decided that the man should be kept in healthcare where four-hourly clinical observations should be taken and a fluid balance chart maintained. Clearly, the reception doctor thought that such monitoring would be helpful in the management of the man's care and treatment. If he had known that such monitoring would not take place, his approach to planning the man's care might have been different. The SMO has said that the taking of clinical observations and maintenance of a fluid balance chart is impractical in a prison setting. I accept that maintaining an accurate fluid balance chart would be impossible without the prisoner's total co-operation. However, I reject any suggestion that the taking of clinical observations is impractical; it would certainly not be impractical during the day, even if it would be rather more difficult to manage at night.

The healthcare doctor said that, when he examined the man on 30 June, his condition was not such that referral to hospital was appropriate. It was on 1 July that the man's condition had deteriorated to the extent that his condition then, and in light of the negative urine test result, indicated that he should be sent to outside hospital. Had four-hourly observations been recorded, the deterioration in the man's condition might have been recognised at an earlier stage, resulting in an earlier transfer to outside hospital.

It might have been the case, of course, that the man's clinical observations would not have indicated the need for his transfer to outside hospital at an earlier stage. Indeed, the clinical review concludes that "it is very unlikely" that the man's condition would have been picked up any earlier had he been in the community. However, if four-hourly observations had been maintained, the man's records would have contained objective evidence to support the clinical decisions made in his case.

Conclusions

When the man was received at HMP Bristol, his condition of bacterial endocarditis was clearly already developing. Unfortunately, the symptoms of this illness were assumed to be symptoms of drug withdrawal. Given the man's reported history of drug use, and given that the diagnosis of bacterial endocarditis is not an easy one to make, the assumption that he was suffering the effects of drug withdrawal was not, initially, unreasonable.

There was a delay in obtaining a urine sample from the man, and a further delay in the man being reviewed by a doctor once the urine test result was available. Contrary to the advice of the reception doctor, four-hourly observations were not taken and no fluid balance chart maintained. That plan was probably not achievable in a prison setting. It is also possible that even if an earlier, correct, diagnosis had been made, the ultimate outcome for the man might have been the same. Certainly, the clinical review concludes that the man was appropriately looked after during his time in prison. However, the absence of recording of clinical observations means that his care was almost certainly not on a par with what he would have received had he first presented with his symptoms at outside hospital.

Recommendations

I make the following recommendations, all of which are directed to HMP Bristol's Healthcare unit:

Local recommendation 1: All doctors at HMP Bristol – whether locum or permanent – should be made aware of the frequency and regularity of clinical observations that can reasonably be undertaken within the healthcare unit. Where more frequent or more detailed observations are indicated for a particular prisoner, arrangements should be made to unlock the prisoner during patrol periods, or to transfer the prisoner to outside hospital.

Local recommendation 2: Where needed for testing, urine samples should be obtained from prisoners at the earliest opportunity. If a prisoner is unable to provide a sample, on request, at reception, his care plan should include the aim to obtain a sample with a minimum of delay.

Local recommendation 3: When a negative urine test result is returned for prisoners being monitored in healthcare, the prisoner should be reviewed by a doctor with an absolute minimum of delay.

Local recommendation 4: The prison should consider the purchase of voluntary drug testing analysis kits for use in reception and healthcare. These will enable a urine sample to be tested for the presence or absence of drugs within minutes of production of the urine sample. This would prevent unnecessary delay in diagnoses and treatment decisions.