Investigation into the circumstances surrounding the death of a prisoner from HMP Camp Hill in September 2004

Report by the Prisons and Probation Ombudsman for England and Wales

July 2005

This is the report of an investigation into the circumstances of the death of a prisoner in September 2004. The man - a prisoner at Camp Hill - had been admitted to hospital with abdominal pain on 28 August 2004, and undergone an operation for a perforated sigmoid colon. He never recovered from the operation, and died in hospital, in September 2004.

I would like to extend my sincere condolences to the man's family and friends for their loss.

I thank the Governor at Camp Hill Prison at the time of our investigation. I would also like to thank the other members of his staff who assisted us.

Whilst I do not feel anything could have been done to prevent the man's death, there are several lessons to be learnt in the clinical management of patients in prison. The clinical record keeping was particularly poor in this case.

I make five recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The man who died moved to Camp Hill in August 2003. He quickly settled in and was well liked by both prisoners and staff. He was described as being a real character, always with a smile on his face, and being sadly missed.

On 28 August 2004, the man went to see the Medical Officer (MO) with abdominal pain and was appropriately taken to hospital for further investigations. He underwent an operation for a perforated sigmoid colon. Following the operation, he suffered multiple organ failure and died in September. He was 65 years old.

The Deputy Governor acted sympathetically by facilitating the man's release on temporary licence on compassionate grounds.

He suffered from many medical problems including Chronic Obstructive Airways Disease, emphysema and fibrosis of the lungs. He also had a duodenal ulcer and was doubly incontinent. Although the healthcare staff had good intentions, there was a lack of evidence of further investigation to ascertain the root of the man’s symptoms and ailments. The record keeping of the healthcare staff is also difficult to follow, and poor in quality.

At the time of our visit to Camp Hill, the paperwork relating to the man had not all been gathered together, and it was difficult to ascertain a picture as to the events prior to his admission to hospital.

He was known to staff, and well liked. He was treated compassionately by the prison authorities. However, I am concerned by the lack of any documented investigation and follow up to health concerns relating to the man. I therefore make five recommendations to be acted upon locally.

Investigation process

All the indications were that this was a death from natural causes. In these circumstances, 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 the man's case, I decided that the circumstances did not require a full investigation.

My investigator, visited Camp Hill and met with the Deputy Governor. Notices were issued to staff and prisoners asking them to contact my investigator if they had any questions or information to bring to the investigation.

The investigator offered to meet with representatives from the Independent Monitoring Board (IMB) and the Prison Officers' Association (POA).

Access to the man's prison records, including his medical records, was provided to the investigation. However, my investigator was unable to view the man's wing record, as this could not be located.

A nurse employed by my office, conducted a review of the man's clinical care.

One of my family liaison officers, contacted the man's family and kept them updated on the investigation and report.

The events leading up to 28 August

The man suffered from several medical problems. He had Chronic Obstructive Airways Disease (COAD), emphysema and fibrosis of the lungs. He also had a duodenal ulcer. After arriving at Camp Hill he had a bad back for which he needed physiotherapy and a T.E.N.S machine. He also briefly lost consciousness in his cell in October 2003. This was something the man reported as having occurred before. He was treated for a cut to his ear that he sustained during the fall, but no further investigations as to the cause of his temporary loss of consciousness were conducted.

During 2004, healthcare staff saw the man on a regular basis due to his deteriorating health. In January, healthcare staff comment in his Inmate Medical Record (IMR) that he was doubly incontinent. He appropriately remained on the residential units, as his condition did not necessitate a clinical admission to a healthcare bed. Incontinence pads were suggested, but no further investigation as to the cause of the incontinence was conducted.

In February, he was suffering chest pain, and the doctor felt he was suffering from a chest infection. Again, there is no evidence of tests being conducted to confirm the diagnosis.

A member of staff in the library, described the man as “a real character, always with a smile on his face”. She also said that from July, he had seemed unwell. He had the odd day off work and looked “grey”.

On 16 August, the man saw the Medical Officer (MO). He was short of breath, and the MO suggested blood tests. There is no evidence that these took place or of the results if they were undertaken.

Events from 28 August

On 28 August, the MO saw the man because he was suffering from acute abdominal pain. On examination, the MO felt that it was likely that his duodenal ulcer had perforated and he was promptly admitted to hospital for further investigation.

In light of the man's poor health, the deputy governor re-categorised the man to category D status. He also arranged for the man to be released on temporary licence on compassionate grounds. This meant that he could be in hospital without handcuffs or prison staff present

On 8 September, the hospital contacted the prison to obtain details of the man's next of kin. This is the only recorded contact between Camp Hill and the hospital.

He died in September. The post mortem identifies the causes of death as:

a) Multiple Organ Failure
b) Complications of Faecal Peritonitis (Operation)
c) Stercoral Ulceration of the Sigmoid Colon

Findings and Conclusions

Healthcare issues

The man suffered from several ailments including COAD, emphysema and fibrosis of the lungs. He also had a duodenal ulcer and was doubly incontinent. There are several occasions in the man's medical records where the clinical reviewer was unable to find evidence of further investigation into problems, evidence of tests being performed or results of any tests. Specific examples of this relate to him suffering from blackouts, being doubly incontinent, and having a chest infection in February 2004.

It appears from the medical records that the staff who cared for the man had good intentions regarding his care, and on the whole, had suggested appropriate investigations and tests to ascertain what was causing his symptoms. However, these do not appear to have been followed through.

The clinical reviewer commented on the fact that the man was being treated for a duodenal ulcer and was on Losec (Omeprazole) when he was in HMP Bristol in August 2000. There appear to be no investigations as to whether the treatment for his ulcer had worked and he continued on the same drug until his death in September 2004. He continued to complain of 'ulcer' problems, which indicates that the treatment was not completely effective. His duodenum was noted to be 'normal' during the post mortem.

The clinical reviewer further comments that, although possibly not relevant to the outcome in this case, it is noteworthy that on 30 September 2004, Vioxx, a drug that the man had been prescribed and taking for some time, was withdrawn due to mounting evidence linking it to cardiovascular problems. It is apparently also connected with higher incidences of respiratory, liver and kidney dysfunction. Due to the effects on the man's organs of the peritonitis caused by the perforated sigmoid colon, it is difficult to ascertain what their condition would have been prior to that happening. The clinical reviewer is concerned that some of the symptoms that he was suffering were due to already damaged organs.

She concludes that, although staff intentions appear well meaning, he may have suffered unnecessarily, due to lack of investigation and review of treatment for his various ailments.

The action of the MO in admitting him to hospital was appropriate.

The clinical reviewer makes the following recommendations, which I endorse:

I recommend that all healthcare professionals should be reminded of the importance of legible, accurate and thorough documentation and also about their duty of care to patients, in accordance with their professional bodies.

I recommend that investigations and tests should be thorough and where indicated, organised quickly. Test results should be followed up, documented, filed and acted upon.

I recommend that the treatment patients are receiving should be reviewed within an agreed timeframe (depending on medical history and presenting symptoms) and the timeframe for review documented in the medical record and prescription sheet.

Furthermore, although I understand that the man was visited by the prison Chaplain, there is no recorded contact between healthcare staff and the hospital in regard to the man's condition between 8 September and the day he died. There should be a system where healthcare staff check on the progress of prisoners at outside hospital.

I recommend that the head of healthcare devise and implement a system where healthcare staff check on the progress of a prisoner who is an inpatient at an outside hospital.

Release on Temporary Licence

The deputy governor acted appropriately and sympathetically by releasing the man on a temporary licence for compassionate reasons.

Record management

My investigators were given access to the man's Inmate Medical Record, Sentence Management, Security and Main Records. These did not include his recent history sheets in which staff record significant events. My investigators and various members of staff searched for the documents to no avail.

There were no statements, special logs or debrief report, as we would usually find in the case of a prisoner's death. This is probably because what occurred was that he became ill and was admitted to outside hospital. There would have been no reason at that stage to implement the contingency plans for action following a death in custody.

However, it is regrettable that his recent wing history sheets could not be found. These, with the medical and other records, might have provided a sufficient contemporaneous record of events immediately before his admission to hospital. After his death, I consider that it would have been good practice for those members of staff who were in contact with the man on the day he became ill to have been asked to prepare brief statements of their contact with him that day.

I recommend that in the event of a death, staff who have been involved in the episode leading to the prisoner's hospitalisation, should prepare a written statement.

This would have been helpful to my investigation. It would also assist the inquest at which staff might be required to give evidence, as well as enabling the Prison Service to demonstrate accurately the care they provided to a prisoner who has died.

Since April 2004, when the Ombudsman's office was passed responsibility for investigating deaths in custody, there have been many deaths by natural causes. We have been able to identify a number of lessons that may improve the service to older and terminally ill prisoners. As such, deaths by apparent natural causes in prisons should be treated by prisons in the same way as apparently self-inflicted deaths. All records relevant to the man should have been found and sealed. The investigation team should have been provided with a liaison officer to help facilitate the visit, to enable them to visit parts of the prison and speak to relevant staff and prisoners. In this case, it was felt that the investigators' movement and access to records was hindered by the fact the records were not collated and there was no dedicated liaison officer.

Recommendations

Local

I recommend that all healthcare professionals should be reminded of the importance of legible, accurate and thorough documentation and also about their duty of care to patients, in accordance with their professional bodies.

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I recommend that the treatment patients are receiving should be reviewed within an agreed timeframe (depending on medical history and presenting symptoms) and the timeframe for review documented in the medical record and prescription sheet.

I recommend that the head of healthcare devise and implement a system where healthcare staff check on the progress of a prisoner who is an inpatient at an outside hospital.

I recommend that in the event of a death, staff who have been involved in the episode leading to the prisoner's hospitalisation, should prepare a written statement.