The death in custody of a man at HMP Ford on 23 September 2004

Report by the Prisons and Probation Ombudsman for England and Wales

February 2005

This is the report of an investigation into the circumstances of the death from pneumonia on 23 September 2004 of a life sentence prisoner at HMP Ford.

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.

The investigation was carried out by one of my Senior Investigators. A clinical review into the man's care and treatment was commissioned from Western Sussex Primary Care Trust.

Just one, relatively minor, matter has arisen from this investigation.

We would like to extend our condolences to the man's family for their loss. I would like to thank the Governor of HMP Ford and her staff for their help.

Stephen Shaw OBE **February 2005**
Prisons and Probation Ombudsman

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Summary

The man died from pneumonia on 23 September 2004, at the age of 71, at outside hospital. At the time of his death he was serving a life sentence at HMP Ford.

The man had a number of age related clinical conditions that were managed appropriately and enabled him to lead an independent life in prison. That included day release from the prison when he worked part time in a nearby town. On 21 September 2004, the man consulted prison Healthcare with an upper respiratory tract infection (URTI), which the doctor treated with paracetamol. This was appropriate for the man's presenting symptoms at that time. Within 24 hours, the man's condition deteriorated significantly and he was transferred to hospital, where he died two days later.

One of my Family Liaison Officers spoke by telephone to the man's next-of-kin, his adopted daughter.

This report makes a recommendation in relation to record keeping practices by doctors who work in the prison.

Investigation Process

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

My investigator visited HMP Ford on 30 September 2004 when he spoke informally with the Governor, the Head of Residence, a representative from Healthcare, and two of the prison chaplains. The investigator was given access to the man's records, including his medical records. The investigator also met the Deputy Chair of the Independent Monitoring Board (IMB). He said that he had no concerns either about HMP Ford in general, or about the man's care and treatment in particular.

The man's next-of-kin, his adopted daughter, was contacted by telephone and letter. She raised no specific concerns, but was interested to learn about her adoptive father's cause of death.

Western Sussex Primary Care Trust carried out a clinical review.

No formal interviews with staff were conducted. This report is based upon a thorough review of all relevant paperwork and upon the clinical review.

The Man

The man was sentenced to life imprisonment in 1986 with a recommendation that he serve a minimum of 20 years. He served time at a number of different prisons before being transferred to HMP Ford. The purpose of moving the man to Ford was to prepare him for his future release back into the community. As part of this process, the man worked at a number of different community based placements, both carrying out community work and working in paid employment. The man had also had regular weekend release on temporary licence.

HMP Ford

HMP Ford is a category D open prison with a regime that includes a community service department to help life sentence and long term prisoners work towards their release.

Healthcare at Ford is staffed from 7.45am to 5.30pm each day and has two full time nurses, supplemented by agency nurse support. Healthcare operates as would a GP surgery, with GP consultations being arranged on an appointment basis. There are no permanent GPs on site. Instead, GP support is provided four mornings per week through an agency based in Brighton. Although most appointments are made for between 24 to 48 hours ahead, Healthcare nurses will ensure that prisoners with more significant clinical conditions are given priority. Prisoners presenting with significant conditions will, if necessary, be referred to the out-of-hours GP service, or direct to hospital. There are no in-patient beds in the prison Healthcare unit.

The Events Leading up to the Man's Death

The man's records reveal that he had a number of clinical conditions. These were largely age related and were being monitored through regular hospital appointments. For instance, he had had a mild heart attack in 1996 and he was being regularly reviewed by a consultant cardiologist at a London hospital.

In the final months leading up to his death, the man had several consultations with Healthcare doctors in connection with symptoms of sleeplessness, for which he was referred to an outside hospital for investigations. On 2 September 2004, the man consulted Healthcare complaining about an exacerbation of his symptoms of angina and a note was made in his records that a further cardiological opinion should be sought.

On 21 September 2004, the man consulted Healthcare about a condition wholly unrelated to any of his chronic conditions. His consultation that day concerned a throat infection – clinically, an upper respiratory tract infection – and he also reported that there was some blood staining in his sputum. The Healthcare doctor noted that the man's chest was clear and that his respiration was normal. The Healthcare doctor prescribed paracetamol, advised the man to take fluids and told him to rest from work for four days. In the early afternoon of the following day, 22 September, the man returned to Healthcare complaining that he was coughing blood. On examination, he was found to be having difficulty in breathing. He was also found to have a rapid pulse and was sweating. Pneumonia was the tentative diagnosis and a 999 call was made to the ambulance service for the man to be rushed to outside hospital.

A nurse from Healthcare telephoned the hospital later in the afternoon of 22 September and made a note that the diagnosis of pneumonia had been confirmed and that, although stable, the man was gravely ill. At 4.30pm on 23 September the nurse telephoned the hospital for an update and was told that the man was still stable. However just after 9pm that evening, the hospital telephoned Healthcare to say that the man had serious respiratory problems and had been moved to the intensive care unit. The hospital had informed the man's relatives of this development.

When the Healthcare nurse telephoned the hospital for a further update on the morning of 24 September, she was told that the man had died at 10.30pm the previous night.

After the Man's Death

In compliance with its contingency plan relating to deaths of prisoners, HMP Ford notified the Coroner, the IMB and other official parties of the man's death.

The prison's Head of Residence was the Duty Governor on 24 September and she heard of the man's death when she came on duty that morning. When she contacted the outside hospital she discovered that news of the man's death had been passed to the partner of the man's adopted daughter. The Head of Residence asked one of the prison chaplains to make contact with the man's next-of-kin.

The chaplain made contact and advised the man's next-of-kin about the processes involved in dealing with a death and making funeral arrangements. At the next-of-kin's request, one of the prison chaplains subsequently conducted the man's funeral service. Prisoners at Ford made a collection to purchase a wreath.

When the PPO investigator visited Ford on 30 September, all the necessary information had been gathered together for the purposes of the investigation. Arrangements were made for the investigator to speak to relevant members of staff.

Level of Compliance with Prison Service Requirements

Standards of clinical care in prison are intended to mirror those available in the outside community. The clinical aspects of the man's care are described in the clinical review. This indicates that while in prison the man's clinical needs were recognised and adequately dealt with, in particular there was no unreasonable delay in transferring him to hospital upon the development of his final illness.

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

Findings

The man was transferred to Ford open prison in April 2000, with a view to his future release. Towards that end, the man worked in the community and had periodic weekend leave on temporary licence. At 71 years-of-age, the man seems to have been a reasonably active man and he self-described his health as good. The clinical review refers to a relatively straightforward medical history, albeit including a number of age-related clinical conditions for which the man was receiving appropriate treatment and medication.

The man's consultation with Healthcare on 21 September 2004 was unconnected to any of his pre-existing clinical conditions. Instead, his consultation that day was to report a throat infection. The man also reported blood staining in his sputum. The doctor's examination revealed that the man's chest was clear and that his respiration was normal. The doctor prescribed paracetamol, advised the man to drink extra fluids, and also suggested he stay off work for four days.

The man returned to Healthcare the following day with symptoms indicating a significant deterioration in his clinical condition. He was noted to be having difficulty in breathing and it was also noted that he was coughing blood. A tentative diagnosis of pneumonia was made and he was rushed to outside hospital. Although it is recorded that the man's condition stabilised in hospital to some extent, he died less than 36 hours after his admission.

The question to be asked in this case is whether the seriousness of the man's developing clinical condition could have been identified sooner, specifically whether it should have been recognised at his consultation on 21 September. The clinical review of the man's care and treatment, has explained that production of blood stained sputum is not necessarily a sinister symptom as it can occur in acute upper respiratory illness. The clinical review goes on to conclude that there is nothing in the man's records to indicate that he should have been referred to hospital on 21 September.

The review does refer, however, to the doctor's failure to note whether he advised the man to return to Healthcare if his condition were to deteriorate or fail to improve. The man was very knowledgeable about clinical matters so I am certain he would have needed little advice on how he should proceed, but in this regard he was an exception.

Conclusions

The man was well cared for in HMP Ford. There was no indication on 21 September that he needed to be sent to hospital that day.

Recommendations

I recommend that Healthcare staff ensure that they always advise prisoners to return to Healthcare if they fail to respond to the prescribed treatment. I also recommend that a brief note be made in the medical record that such advice has been given.