

**Investigation into the death of a man whilst in the custody  
of HMP Ford in January 2009**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**August 2009**

This is the report of an investigation into the death of a man, a 55 year old prisoner at HMP Ford. The man died in January 2009 in hospital from natural causes. He had been admitted to the hospital on 17 November 2008.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by my Acting Senior Family Liaison Officer.

A post mortem examination was not carried out as the Coroner was satisfied that there were no suspicious circumstances surrounding the death.

This investigation was undertaken by one of my investigators. In addition, the clinical reviewer was asked by the local Primary Care Trust to undertake a review of the man's clinical care. I am grateful for the assistance they received from staff at HMP Ford and would ask the Governor to pass on these sentiments. I must apologise for the delay in issuing this report which was caused by the late receipt of the clinical review.

The clinical reviewer concludes that the man's care was of an equivalent standard to that he would have received in the wider community. I hope that the man's family are reassured by the conclusions of my report. The clinical reviewer's clinical review raises a number of learning points that the prison health partnership will need to consider. He has made one recommendation which I endorse.

I make no recommendations of my own.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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

**August 2009**

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## **SUMMARY**

The man was born in 1953. He was 55 years old when he died in hospital in January 2009. The man's death was from natural causes as a consequence of liver failure following a transplant just under 12 months earlier.

The man had been sentenced to nine years and six months imprisonment on in September 2006 at Crown Court. He was received into custody at HMP Exeter on the same day. He transferred to HMP Ford on 13 August 2008 after previously being held at HMP Guys Marsh, HMP Erlestoke, HMP Bedford and HMP Peterborough.

At his first health screening interview after conviction, it was recorded that the man had history of hepatitis C virus and cirrhosis of the liver. As a result of the problems with his liver, the man had a transplant on 12 January 2008. Whilst the man was in hospital the initial security risk assessment concluded that handcuffs were to be used with two officers present at his bedside.

On 17 November 2008, as the man appeared jaundiced and was complaining of nose bleeds and lethargy, he was taken to hospital. He was admitted to the hospital and remained there for the next seven weeks. The man was released on temporary licence (ROTL) by Ford. This meant that restraints were not used and prison staff were not required to be at his bedside.

The man was pronounced dead at 2.00am on 3 January.

After the man died, the prison activated its death in custody contingency plan. The police were informed and visited hospital. They found no suspicious circumstances and the man's body was released to the undertakers who removed him to the mortuary for post mortem examination. The Coroner's officer informed the Head of Offender Management, who was managing the prison's response following the man's death, that the man had died from natural causes.

The clinical review has identified a number of issues relating to the care provided for the man. The review highlights areas of practice that could be improved, and makes one recommendation for service improvement.

I make no recommendations of my own.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 5 January 2009 by one of my investigators. He issued notices announcing the investigation to both staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the man's death to make themselves known. In the event, no one came forward. My investigator also studied all relevant prison records, which included the man's main prison record and his medical records.
2. My investigator visited Ford on 14 January and 1 April, and discussed aspects of the man's treatment with staff. He interviewed a Prison Officer and Senior Officer. My investigator also interviewed two members of healthcare staff.
3. The local Primary Care Trust commissioned a Quality Commissioning Governance Manager to carry out an independent review of the man's clinical care. I am grateful to him for undertaking the review.
4. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner.
5. My Acting Senior Family Liaison Officer contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. The family told my Acting Senior Family Liaison Officer that they were concerned that the man had remained handcuffed and under two officer escort when he had his transplant operation in January 2008. The man's family chose not to raise any concerns at that time about the care he received at Ford. Indeed, they spoke very positively about the help and support they received from staff at Ford. I hope that this report provides the family with a better understanding of the events leading up to the man's death.

## **HMP FORD**

6. HMP Ford is a category D open prison with an emphasis on resettlement. It stands on the site of a former Fleet Air Arm station and was converted to an open prison in 1960.
7. Further buildings have been added including a gate complex, chapel, education and probation. There are two main sites for the accommodation blocks – A and B wing. A wing has six residential blocks of single rooms. B wing has 24 billets of single and shared rooms. The prison has an operational capacity of 557.
8. Healthcare at HMP Ford is provided by the local Primary Care Trust. The healthcare unit is open from 7.45am until 5.30pm, Monday to Friday. It provides a good range of nurse-led clinics, including mental health support. There are two General Practitioners (GPs) at the prison whose duties are split to provide cover five days a week. The PCT has commissioned Harmoni HS Limited (a national provider of primary care services) to provide out of hours cover, including at the weekend. A dentist also holds weekly clinics and an optician attends once a month
9. My investigator reviewed my reports into earlier deaths from natural causes at Ford. He found no common issues with his own investigation into the death of the man.

## **Independent Monitoring Board**

10. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The most recent annual report by the Ford IMB was published in November 2008. The IMB drew attention to the impact of the lack of investment in Ford. The IMB report summarised the prison in the following way:

“HMP Ford is based on the accommodation provided for the Fleet Air Arm, during the Second World War. This accommodation was erected as a short-term measure to provide much needed space during the war. The prisoners are still living in these units, albeit somewhat refurbished, 63 years later. The Ablutions, provided particularly in the wooden huts, are woefully inadequate. In the twenty-first century, it is hardly appropriate for men to be accommodated 16 to a hut with two showers and two lavatories, many of these out of action much of the time due to age and lack of quality.”

## **Her Majesty’s Chief Inspector of Prisons**

11. The most recent inspection of Ford by Her Majesty’s Chief Inspector of Prisons was an unannounced inspection in October 2008. In her report the Chief Inspector found that: “staff at Ford were caring and committed, but they found their efforts undermined by those who remained negative and obstructive”. The

Chief Inspector said that managers needed to be much more active in supporting the efforts of good staff and challenging those who were disengaged or negative. In relation to healthcare, the Chief Inspector recorded that:

“Prisoners had access to a wide array of health services from in-house and visiting professionals. Doctors were in prison every weekday, and the presence of two nurse prescribers meant that prisoners were seen and diagnosed quickly, resulting in early treatment. Chronic disease management was excellent, and the standard of mental health care provision was extremely good.”

## KEY EVENTS

12. In September 2006, the man was sentenced at Crown Court to nine years and six months imprisonment for the offence of conspiracy to supply drugs. He arrived at HMP Exeter the same day. The man was later held at HMP Brixton, HMP Guys Marsh, HMP Erlestoke before he transferred to HMP Peterborough on 22 November 2007.
13. During the man's first reception health screening interviews, it was recorded that he had a history of hepatitis C virus and cirrhosis of the liver.
14. In August 2007, a report written by a Professor of Hepatology, mentioned that the man's health had deteriorated to such an extent that his life expectancy was less than two years.
15. In his letter dated 22 October 2007, a Consultant Hepatologist wrote that as the man was persistently jaundiced and encephalopathic he was to be placed onto a liver transplant waiting list. (Encephalopathy is degenerative disease of the brain. The severity of the condition can vary from minor alterations in the ability to perform movements, mild confusion with impairment of attention and concentration through to loss of consciousness. As a result a sufferer may be able to concentrate for a period of time and then may be confused within hours and vice versa.)
16. At the Court of Appeal on 2 November 2007, the man's appeal against his sentence was dismissed.
17. On 12 January 2008, the man had a liver transplant operation. Whilst the man was an in-patient at the hospital, a bedwatch was carried out by prison staff. The security risk assessment said that an escort chain should be used and two prison officers should be in attendance. Staff on bedwatch duty maintained a log of activities whilst the man was an in-patient. He was discharged from hospital on 29 February and was received at HMP Bedford.
18. From 3 April, the man was working full time as an orderly on the healthcare wing at Bedford. Staff noted in the wing record that he was a calming influence on other prisoners. A Prison Officer wrote:

"The man may be discharged this week. So far the man has taken on the role as No 1 orderly in the HCC [healthcare centre], his calming influence and humour has a good effect on the patients especially those with mental health issues. The man commands a sound knowledge of bio-hazards and cross contamination. The servery area has been the focal point of cleanliness and hygiene thanks to the man's dedication to his work. The man has been an asset to myself and the nursing staff and will be missed once transferred. I would always recommend the man to another prison if requested."

19. On 3 July 2008, the man was seen by a Consultant Hepatologist. The Consultant noted that the man had gained 15 kilograms of weight in three months and there was some suggestion of type 2 diabetes.
20. The man transferred to HMP Ford on 13 August.
21. On 2 September, the man attended an appointment with a Consultant Hepatologist. In her letter the Consultant Hepatologist wrote:

“He looked fantastically well and I was quite taken aback not having seen him since he was deeply jaundiced during his hospital admission. He has been working out for an hour a day and looks extremely well on it, he has lost a lot of weight ... was deeply tanned and we discussed the issues of the increased risk of skin malignancy whilst on immunosuppression and will be asking the prison services to ensure that he has adequate access to sun tan lotion at all times.”
22. The man attended a review at hospital on 14 October. The consultants informed the man that they would be referring him to a Consultant Psychiatrist. The Consultant Psychiatrist is a specialist in the field of the psychological trauma experienced by transplant patients.
23. On 20 October, the man was seen by a nurse who referred him to the prison doctor. The man had a foot which had been swollen for a number of days. The prison doctor recommended that the leg be elevated and tubigrip applied, as well as blood tests on the man's liver function and uric acid levels. When the man was reviewed two days later, it was noted that his foot was less painful. His blood tests showed a normal uric acid level and very mildly elevated liver function tests. In addition, it was noted that his blood sugar levels were quite high. Further tests were carried out on 3 and 7 November as diabetes was suspected.
24. On 2 November, as part of his rehabilitation the man was allowed out of Ford for a visit to a local town.
25. Just over two weeks later (on 17 November), as the man appeared jaundiced and was complaining of nose bleeds and increased lethargy, an urgent referral was made to hospital. He was admitted to the hospital later that same day. The man remained too ill to be transferred back to Ford and remained in hospital for the next six weeks. He was released on temporary licence (ROTL) by Ford. This meant restraints were not used whilst he was in hospital and that prison staff were not required to be at his bedside. Whilst the man was in hospital he was visited by the chaplain from Ford.
26. In her letter to the prison doctor at Ford dated 24 November, the Consultant Hepatologist confirmed that the man was still an in-patient. She wrote that he had become progressively more jaundiced and that a liver biopsy had suggested that he had recurrence of severe hepatitis C. The Consultant Hepatologist confirmed that the hospital were continuing with their investigations but also commencing anti-hepatitis antiviral therapy. The

Consultant Hepatologist wrote: "He is very ill and may not get through this episode. We are going to need to keep him here for some considerable time to try to get him through this."

27. In her letter to the Governor dated 10 December, The Consultant Hepatologist wrote:

"I reviewed the man in the Transplant Clinic today ... In himself he remains well, but his liver function tests are severely deranged .... The man remains fully aware of the predicament that he is in. He has severe hepatitis C recurrence and his only hope is that his current treatment of Interferon and Ribavirin [a drug used in the treatment of hepatitis C] will take effect. He is aware that there is no guarantee that this will be the case. We spent some time alone with the man's family going over the issues. We cannot predict how things are going to go. We explained that he probably has less than 50% chance of getting through this and that it will take several weeks to know whether he is turning a corner. He is going to remain in Southampton until we know which way this is going. We will write again when we have more information."

28. On 18 December, Ford completed and forwarded an application for early release on compassionate grounds to the Public Protection Casework Section of the Ministry of Justice (formerly known as the Early Release and Recall Section). The application asked that the Secretary of State for Justice remit the man's custodial sentence and allow his release subject to licence conditions.

29. The man's condition continued to deteriorate and he died at 2.00am on 3 January. The man's family were with him when he passed away. A nurse from the hospital telephoned Ford at around 8.00pm to inform the prison of the man's death. The nurse was asked why she had not told the prison sooner. She replied that she had attempted to call Ford throughout the day but had been unable to get through.

30. In her letter dated 5 January 2009 to the prison doctor at Ford, the Consultant Hepatologist wrote:

"I regret to inform you that the man passed away on 3rd January 2009. He was admitted with jaundice six weeks ago and liver biopsy taken at that time demonstrated a picture of acute liver injury on the background of severely scarred liver. We attempted to control his hepatitis C virus replication with anti-viral treatment but unfortunately, he developed progressive liver failure. He remained well in himself until the last week of his illness but then became encephalopathic and deteriorated rapidly thereafter. His family remained with him during the last week of his illness and he passed away peacefully on the ward."

31. The prisoners on B wing were told the following morning about the man's death. Staff on the wing asked prisoners whether they required anything or

wanted to speak to a Listener. (Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.)

32. An officer was appointed by Ford as the prison's family liaison officer and Ford gave financial assistance with funeral costs. A memorial service was held at the prison's chapel.
33. In his letter dated 23 January 2009 to the former Governor of Ford and an ex-prisoner raised concerns about the care the man received whilst he was at Ford. The ex-prisoner wrote:

"The man had been suffering from a very painful foot for some time before he asked to see a doctor, a typical trooper and used to being dismissed as we all are. He was told that it could be this or that and that the doctor would contact him. The man was never contacted again and had been ground down. A doctor of even a junior position would have taken any complaint or health issue arising from the man most seriously following his most recent liver transplant but to my greatest disappointment not at HMP Ford. There followed long bouts of sleep and the man withdrew this also failed to capture the attention of the staff employed here at Ford. At various junctures he was encouraged ... to seek further help but he had lost heart and carried on. ... [another prisoner] used to get the man out of his cell and they used to walk the grounds together. It was then that he began to suffer long and incessant nose bleeds which caused the individual who walked with him some concern and distress. The man was waiting and made to wait until he virtually died on his feet. It was only then when his eyes and skin turned yellow with jaundice that he was taken seriously. Shame on you and I hope you can live with the decisions and catalogue of errors that have been made on your watch as I believe you had a duty of care to someone who needed your help. When the man called you didn't listen and like all of us made to wait due to incompetence. Please note my disgust in the first instance whilst I investigate further avenues of complaint not for myself but for the man as I am in all likelihood likely to survive the disgrace that is HMP Ford."

34. A post mortem did not take place as the man died of an existing condition and there were no suspicious circumstances surrounding his death. His cause of death was liver failure caused by severe recurrence of hepatitis C virus following his liver transplant. On 8 July 2008, the Consultant Hepatologist sent additional information to the Coroner. She wrote:

"I write with some further information regarding the man who sadly passed away on the 3rd January 2009. He had had a liver transplant for hepatitis C related cirrhosis and was known to have recurrent hepatitis C infection within his new liver. His condition deteriorated towards the end of 2008 and a liver biopsy showed a severe reaction to a hepatitis virus. The further information that has become available is that, at some point towards the end of 2008 he

acquired a second hepatitis virus, hepatitis E. This is a virus that you acquire via the oral route and is therefore most likely picked up by contaminated water or food. It causes an acute short lived illness in most cases but occasionally it can be severe and occasionally can cause death. The man had severe liver disease at the time he acquired this virus. It is impossible to say whether his clinical course was affected by this virus as the hepatitis C was severe enough to account for his demise. It does remain possible however that the super added hepatitis E infection virus contributed to the severity of his final illness.”

My investigator confirmed that no other cases of hepatitis E had occurred at Ford.

## ISSUES CONSIDERED

### Clinical care

35. As noted above, a review of the man's medical care was undertaken on behalf of the local Primary Care Trust by a clinical reviewer. In his review, the clinical reviewer records that staff at Ford carried out regular reviews and monitoring of the man's condition and medication.
36. The clinical reviewer has investigated the allegations raised by the ex-prisoner. The ex-prisoner had suggested that the man had suffered in silence and that his complaints about his health were not acted upon. The clinical reviewer interviewed the prison doctor about the allegations. The prison doctor denied any problems of interaction with the man and said that they always had a good relationship. The prison doctor said that he had received no complaints from either the man or his wife about his medical care. The clinical reviewer recognises that a diagnosis of diabetes could have been made sooner, but that this would not have changed the eventual outcome in any way.
37. In her written response to my investigator about the ex-prisoner's allegations the Head of Healthcare at Ford, wrote:

"I am surprised at his [the ex-prisoner's] comments as the man was always very complimentary about the care he received from our healthcare department, as was his wife. The man was seen eleven times in healthcare since his arrival on 13/08/08 before he was admitted to hospital on 17/11/08. He also had a review appointment on 15/10/08 ... re his liver transplant. He did attend healthcare with a swollen left foot on 20/10/08 and was seen by a nurse who referred the man to the doctor on that day. The doctor saw him and recommended he elevate his foot and gave him tubigrip. He also advised blood tests be done, which subsequently were. He was seen again on 22/10/08 by a nurse to check on his foot which was reported to be less painful at that time."

38. When interviewed as part of this investigation, a healthcare nurse confirmed that the man was quite independent and felt that issues raised by the ex-prisoner were taken out of context. The healthcare nurse said:

"I think in that sense I don't think it was about his care, I think this was more about the man would have been left alone as I say he was a bit stubborn. But I think that people were looking after him and he had certainly, didn't have any problems if he wanted to come down to the healthcare he did and he didn't always have an appointment and we are supposed to be very strict and yes I'm aware that other offenders were encouraging him and spoke to him which I think you know they do you know it's the community. So actually I don't think that's a negative I think that's just quite a positive and I'll be honest if he wasn't well people would have come you know and other offenders would come down and which they have done and tell us and say, look."

39. When interviewed as part of this investigation, a second healthcare nurse confirmed that the man was someone who would not cause a fuss but was also not afraid to approach healthcare if he had any concerns. The second healthcare nurse said:

“Very rarely we lock the gates at lunchtime and when the last patient has been since we tend to lock the gate because a lot of the prisoners do tend to just wander in but we do try to stick to an appointment basis. But there were certain prisoners that you knew you were going to see regularly with ongoing health issues, serious health condition such as the man had. So he would quite often, as far as I could tell he was quite happy to walk in and just knock on the door and we would have a chat, you know and see how he was and we’d have a chat about the football. So I honestly can’t say that he would have felt worried about coming down and knocking the door and having a chat because we used to have a bit of a laugh. You know I never felt that he would be worried about coming down to see us or that we wouldn’t want to see him.”

40. No other prisoners approached my investigator to raise any concerns about the care the man received whilst he was at Ford. My investigator was therefore unable to find any supporting evidence to substantiate the claims made by the ex-prisoner. After receipt of the draft report, the man’s family wrote that they were thankful for the comments made by the ex-prisoner. They were grateful for the ex-prisoner “standing up and giving his opinion” but the family felt that Ford sent the man to hospital as soon as they realised something was wrong.
41. The clinical reviewer notes that when, on 17 November 2008, the man presented with increased lethargy, nosebleeds and jaundice, he was immediately referred as an emergency to the liver unit. Neither the clinical reviewer nor my investigator could find any record of the man presenting with symptoms other than lethargy prior to 17 November. The clinical reviewer says that it was difficult to say whether the man volunteered any information on significant symptoms prior to his admission to hospital in November.
42. The clinical reviewer comments that many entries in the medical record were brief and several had no clinical comments written in at all. In the clinical reviewer’s opinion, more comprehensive details of all medical consultations should be entered particularly when a patient has known hepatic problems. In addition, he recommends that it might be sensible to record important negative clinical problems and the results of any team discussion about a patient.

**The Head of Healthcare should ensure that medical records are comprehensive. Issues relating to medical conditions should be recorded so that any deterioration in clinical condition can be monitored.**

43. The clinical reviewer concludes that overall the man received good medical care whilst he was in custody at Ford and other establishments. The clinical reviewer also concludes that the specialist liver services provided excellent

care and follow up treatment. After receipt of the draft report, the man's family commented on the medical care provided when he was located at HMP Peterborough. The family felt that adequate care was not provided by Peterborough and wanted this to be recorded in the report.

### **Use of restraints**

44. As noted above, the man's family told my Acting Senior Family Liaison Officer, that they were concerned about the use of restraints whilst he was in hospital in January 2008. The use of handcuffs for prisoners on escort to hospital has been the subject of recent case law in relation to the issue of decent and humane treatment. (Judgment by Mr Justice Mitting on 23 November 2007 in the case of (1) Graham (2) Allen v Secretary of State for Justice.) I know that the Prison Service is currently drawing up new guidance in relation to this matter.
45. According to the policy for performing hospital bedwatches adopted by Peterborough at the time that the man was in hospital in January 2008, the following options were available to the Governor:
  - i. Escort and bedwatch with two officers or more, with restraints.
  - ii. Escort and bedwatch with two officers or more, without restraints.
  - iii. Escort and bedwatch with one officer, without restraints.
  - iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
  - v. ... exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952).

The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

46. When the man was taken to hospital in January 2008, the security risk assessment was that an escort chain should be used and two officers needed to be in attendance. Although the prospects of the man making a determined escape attempt were frankly remote, this decision was entirely in line with current practice throughout the Prison Service. At the time the handcuffs were applied, the man was conscious and was judged to pose a security risk. The use of an escort chain enabled the nursing staff to have easy access to the man when they carried out their duties. After receipt of the draft report, the man's family felt that the risk assessment was not correct. They wrote that the man "wasn't shown any dignity or respect when he needed it the most".
47. In November 2008, when the man was admitted to Hospital, he was released on temporary licence (ROTL) by Ford. This meant that restraints were not used and that no officers were on bedwatch duty. I conclude that the use of restraints was appropriately revised in light of the man's condition. After receipt

of the draft report, the man's family wrote that "Ford showed the man the dignity and respect that he deserved".

## **CONCLUSIONS**

48. The man arrived in HMP Ford on 13 August 2008. He died in hospital on 3 January 2009.
49. The man came into custody with a serious pre-existing medical condition. In January 2008 he had a liver transplant and just under a year later the failure of that new organ led to his death.
50. Although I judge that the man's care was equivalent to what he would have received in the wider community, the findings of the clinical review and my own investigation offer some learning points for improvements in healthcare practices.

## **RECOMMENDATION**

The Head of Healthcare should ensure that medical records are comprehensive. Issues relating to medical conditions should be recorded so that any deterioration in clinical condition can be monitored.

Recommendation accepted by HMP Ford - Healthcare team has been briefed as to the outcome of the report from the clinical reviewer and its recommendations. All are aware that clinical notes need to be detailed and comprehensive and that if a patient is discussed in a meeting these discussions must also be detailed in the medical records, including decisions and action points. Clinicians' names must be stated fully.