Investigation into the circumstances surrounding the death of a prisoner at HMP Gloucester in February 2006

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report of an investigation into the circumstances of the death of a prisoner. The man who is the subject of this report was aged 56 when he died in February 2006 in hospital. At the time of his death, the man was a remand prisoner at HMP Gloucester.

The man who died had been admitted to hospital on 1 February after complaining of 'upper abdominal pain'. Almost immediately, he was diagnosed with terminal cancer of the pancreas.

I would like to add my own condolences to those already expressed by one of my family liaison officers. It is hard to cope with any family loss, but losing someone while they are in custody is especially difficult.

The investigation was led by one of my Investigators. An independent review into the man's medical care and treatment was undertaken by a doctor on behalf of the West Gloucester Primary Care Trust (PCT). I am most grateful to him for his assistance and for the help provided by another member of the West Gloucester PCT. I must also thank the Governor and staff of Gloucester prison for their co-operation during this investigation.

There are no recommendations arising from the clinical review of the man's care, but I make a recommendation of my own related to bed watch management checks and the decisions made in this area. The man who died was unconvicted and in prison for the first time. Yet he was to die while still chained to a member of staff. Leaving aside the lack of dignity afforded to him in his final moments, this must have been extremely upsetting for the member of staff concerned.

I am also critical of the way the prison handled liaison with the man's family and make a further recommendation designed to improve the management of the prison-family relationship in the future.

More positively, I am pleased to commend bed watch staff for the sensitive and professional approach they took to the man's welfare.

This report has been amended to enable this anonymised version to read more easier, however in essence, it is the same report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2008**

CONTENTS

Summary	4
The investigation process	5
HMP Gloucester	6
Key findings	7
Issues	12
Recommendations	16

SUMMARY

The man died in February 2006 in an outside hospital while a prisoner at HMP Gloucester. He had been in custody since 3 November 2005, when he was remanded from Gloucester Magistrates' Court.

The man complained of feeling unwell on 19 January. He was seen by the doctor at the prison who ordered some blood tests and prescribed pain killers. On 25 January, following further consultation with the doctor, it was decided more blood tests were needed and a gall bladder scan was also arranged at the local hospital. On 1 February, an officer took the man to the healthcare centre after he had coughed up blood. He was subsequently admitted to hospital. He was risk assessed before he left Gloucester and it was decided he should have a normal escort of two officers, one of whom would be handcuffed to him at all times.

After spending a few days in hospital, the man was diagnosed with terminal cancer. The man and his family were told of the diagnosis, that curative treatment would not be feasible and that his condition was deteriorating rapidly. Due to the seriousness of his illness, the man's solicitor made an application for release on bail but this was unsuccessful. His condition continued to decline and he died in the early hours the following day. His family were with him at the time.

The clinical review, carried out as part of this investigation, does not identify any specific issues relating to the clinical care the man received. It says that he received nursing and medical care comparable to that which would have been available in the community. However, my report raises important issues relating to the management of the bed watch, the decision to use and maintain handcuffs, and the prison's approach to family liaison.

THE INVESTIGATION PROCESS

1. I was notified of the man's death the morning he died and the investigation was opened the following day. My investigator issued notices to staff and prisoners at Gloucester telling them that an investigation would be taking place into his death, and inviting those who wished to see the investigator to make themselves known.

2. My investigator was provided with the man's prison record, and copies of the notices, reports and other records associated with his death. She also visited HMP Gloucester and informally interviewed staff involved in his care.

3. As part of her enquiries, my investigator made contact with the Coroner's office to inform him of our investigation and request a copy of the Post Mortem report. She also spoke to the man's solicitor.

4. A doctor from West Gloucester Primary Care Trust conducted a clinical review of the man's medical care.

5. My investigator gathered details of the man's next of kin and one of my Family Liaison Officers, contacted his family. His brother was concerned that he had not received appropriate care in the prison. He said the man who died had been complaining for a long time and was not given painkillers. The family was also upset that the man was handcuffed throughout his hospital stay right up until he died. I hope this report goes some way in responding to the family's concerns.

HMP GLOUCESTER

6. Gloucester is a small local prison that serves Gloucestershire and much of the West of England and South East Wales. It is a category B adult local prison and young offender remand centre, situated in the centre of the city. The prison is made up of three wings, each with three landings holding 90-100 prisoners. Gloucester can hold up to 330 prisoners in total.

7. At the time of his death, the Health Care Centre (HCC) was undergoing major refurbishment. The establishment now has a small HCC on two floors. Healthcare is provided by West Gloucester PCT. They have an 11 bed in-patients facility predominately for patients with mental health problems and those undergoing detoxification. This is staffed by mental health nurses (RMNs) and healthcare assistants during the day and a trained nurse (RGN) and healthcare assistant at night. Six GPs from a local practice in Cheltenham provide clinics daily and are on call 24 hours a day. They also have several RGNs who operate an out-patients clinic and provide reception cover. They also provide nurse led clinics for phlebotomy, hepatitis B vaccinations, and health promotion. Dental provision is one session per week and an optician is provided as necessary. There is also a mental health in-reach team (MHIRT) consisting of two RMNs and an occupational therapist, with support from a consultant psychiatrist.

8. In Autumn 2003, Gloucester was inspected by Her Majesty's Chief Inspector of Prisons. Her report indicated that there had been noticeable improvements at the prison since the previous inspection in 2002.

9. The man's death is one of seven I have investigated at Gloucester since I became responsible for all such investigations in April 2004. Only one of these deaths was from natural causes. I have found no similarities between that case and the death of the man who is subject of this report.

KEY FINDINGS

10. The man was remanded to HMP Gloucester in November 2005. On arrival, there was no information of note on his Prisoner Escort Record (PER), a document which accompanies all prisoners travelling between police stations, courts and prisons. The PER indicated that no known risks had been reported by the man or about him.

11. At his reception interview, the man was asked various questions relevant to someone coming into custody from the courts. He was asked whether anyone knew where he was and whether he had any pressing problems regarding housing or legal issues. He was told of the emergency procedures at Gloucester, and it was also explained what would happen to him during the next 24 hours. At this point the man gave his brother as his next of kin.

12. At the same time, his Cell Sharing Risk Assessment (CSRA) was completed. He said that he had no concerns about sharing a cell and was assessed as presenting a low risk. (This means that there was no indication or evidence that he would be a risk to himself or others and was therefore suitable to share a cell.)

13. The man was seen by healthcare staff on the same day for an initial assessment, and it was recorded that there was nothing to note. His follow up health appraisal (this is a more comprehensive and wide ranging health screening) took place the next day. It recorded that this was his first time in custody, but nevertheless he felt he had settled in well and felt 'A1'. A note was made regarding some difficulties he had experienced after being bitten by a dog. It was agreed this should be reviewed as necessary.

14. Later that day, the man completed a legal aid form which said that he was working prior to arrest and was due back in court in a weeks time. He also made an application to Nacro Housing, saying that he wished to use their services as he needed help with housing on release.

15. An Officer on A wing had a lot of interaction with the man during his induction. He told my investigator that the man did not mention any concerns he had with his health. Nor did he look unwell. He added that the man 'did not moan' and kept himself to himself.

16. There are various entries in the man's file**,** many by his personal officer. It is noted that he was attending education daily, was seen as a 'good prisoner', conformed to the regime and was quiet and polite to all. There is no mention of his health or other concerns.

17. When the man appeared before the court again he was further remanded pending medical reports from his solicitors. A week later, he was examined and found fit for travel to court for a further appearance.

18. The first record of the man asking to be seen by Healthcare was in mid January 2006, when he was seen by the prison doctor. He reported experiencing upper abdominal pain. Several blood tests were arranged. In the meantime, he was

prescribed a painkiller with a plan to review the situation when the test results were available. A week later, he was again seen by the prison doctor who then had the test results. The doctor found the man had a slightly raised temperature and still complained of pain. The doctor reviewed the blood tests and prescribed Co Amoxiclav 375mg three times a day. He was due to return to court on soon, but was told that an ultrasound scan of his gall bladder had been arranged at the hospital. It was also decided that further blood tests were needed when he returned from court. The man was advised that he should see his GP should he was released on bail. In the event, he was returned to HMP Gloucester having been further remanded.

19. Another Officer who worked on the man's landing, and was also one of his personal officers, described the man as a pleasant person but whom, in the main, kept himself to himself. He said they often had chats but he did not go into any personal detail. Nevertheless, the Officer was aware the man had plenty of family support and lots of visits. He said the man spoke to some of the older prisoners and often popped in and out of their cells for a quick smoke.

20. He said the man attended education in the mornings and was always the first to arrive there. He often attended association in the afternoon, restricting himself to a small group of friends. He spent most evenings reading in his cell, especially reading magazines about model airplanes in which he had a real interest.

21. The Officer said he was on early duty on the morning in early February. He said the man was usually one of the first up and waiting to be let out. But that morning he was not, so he went into his cell. He noticed something spilt in the sink and, when he asked the man about it, he replied that he had spilled some coffee. The Officer was not convinced by this and, when he asked him again about it, he said that he had had a nosebleed. The Officer told my investigator that he was not convinced by the man's responses and became worried that something was wrong.

22. On the same day, the man's personal record shows that he was taken to the Healthcare Centre by an officer after coughing up blood. He was also still complaining of abdominal pain. He was admitted to Healthcare at about 8.10am and placed on half hour observations. His case was reviewed later that morning and his medical record shows he was in pain and looked unwell. The man was subsequently admitted to the surgical assessment unit at Gloucester Royal Hospital.

23. The PER shows that the man left Gloucester prison at 10.30am after a full search. He arrived at the hospital at 10.50am. The hospital risk assessment was completed by a senior officer. It shows that it was a normal escort with two officers attending the prisoner. An officer was to be handcuffed to the man at all times. The form indicates that the restraints should not be removed for medical treatment but could be removed in emergencies with the duty manager's authority. The form was signed by the duty governor that day. It was countersigned by the deputy governor. A bed watch management check carried out at 4.00pm that day noted that the man was undergoing tests and was expected to be at the hospital for a further two days.

24. The next day, a nurse informed the officer who was conducting the bed watch, that the man was quite ill and would be at the hospital for 'at least a week'. The healthcare manager at HMP Gloucester contacted the hospital later that day. He was told that they had no plans to discharge the man at that time. He maintained regular contact with the hospital throughout the man's stay there.

25. The hospital contacted HMP Gloucester again the following day. They were told that the man might be suffering from cancer and confirmation was awaited. The principal officer completed a review of hospital assessment form later that day. It said that the man had been diagnosed with cancer of the pancreas, and that visits would be allowed at the hospital during normal hospital visiting times. The prison subsequently contacted his visitors to let them know. It was also noted in the management check log for that day that the man was expected to stay in hospital for another week.

26. Two days later, them man received a visit from members of his family. The same day he had a scan and was seen by the care team at the hospital. It was noted in his medical record that he had also been seen by the palliative care team. He received further visits on each day of that week and near the end of the week he was seen by a consultant who told him he would be discharged the next day. An officer carrying out bed watch duties noted in the bed watch log that the man was "very emotional after being given the bad news re condition, family to contact solicitor re bail app."

27. The duty governor that day spoke to the Officer about his entry in the log and made a further note in the management checklist log saying 'consultant says ready for discharge. Dr wants to keep him until Monday (bail app). Perhaps 2 months left.'

28. The man was seen by doctor the next day and he told him he would be seen by the palliative care team before he was discharged. The palliative care team also spoke to the man's solicitor who confirmed he would apply for bail the coming Monday morning.

29. The man remained in hospital over the weekend and received more visits from his family. Late on the Sunday evening, an entry in the bed watch log records that the man was very ill and was vomiting up blood. Early the next morning, another Officer carrying out bed watch duties contacted HMP Gloucester's control room. He noted in the bed watch log that he had spoken to 'senior staff there re [the man's] status on the cuffs'. He also mentioned that the man seemed 'confused and his health was fast deteriorating and that it is now a concern for staff who are with him.' Later that day, a further entry in the bed watch log records that the man seemed to have 'perked up'.

30. The man had more visits that afternoon. At 2.25pm, the officer who had earlier raised concerned about the man remaining cuffed, noted in the bed watch log that 'staff feel very awkward being cuffed to up to a dying man. I intend to request removal during management visit.' The deputy governor carried out the management check that afternoon and noted in the management check log that

the man was 'very ill and not expected to last very long. Consideration could be given to reducing escort strength.' This entry was timed at 2.40pm.

31. The man had another visit that afternoon and 'seemed very happy'. However, at 7pm it was recorded that he was very worried about the bail hearing the next morning. At 7.30pm, the nurse was called by the bed watch officers after the man became unstable and did not seem to know what was going on.

32. The next morning, the doctor saw the man again and said that he was too ill to go home. Half an hour later, the doctor returned with the news that the bail application had been denied. It had been decided that, as the man did not have a fixed release, he was deemed at risk of absconding if released. The court also asked for further reports to be compiled and agreed to look again at the man's case when this was done.

33. A hour later the officer again noted in the bed watch log that he was still uncomfortable that the man was handcuffed despite being so ill. He later asked deputy governor if the handcuffs could be removed and was told, 'no … not at this stage', but with a promise that the matter would be raised later at a security meeting. The officer said that both he and the medical staff at the hospital made several requests for the handcuffs to be removed, but were informed repeatedly that this would not be permitted.

34. Later that evening, another officer took over the bed watch duties and he recorded that the doctor had asked for the handcuffs to be removed due to the man's deteriorating condition. This officer told my investigator that, at the doctor's request, he contacted the prison and spoke to the deputy governor. He said he would not agree to the request for the handcuffs to be removed, but said he would review it the next day. This officer than noted in the bed watch log that he was awaiting a decision from prison control about removing the handcuffs. Some family members visited that evening, including the man's two sons who stayed with him during the night.

35. A principal officer carried out the management bed watch checks the next day. He signed the check log at 4.10pm. On the management checklist log he noted that, 'the prisoner's condition is causing concern for the hospital staff.'

36. The doctor saw the man again in the early hours of the morning and said that he was unlikely to last another 12 hours. At 4.00am, it was noted by a third bed watch officer that he was breathing very slowly. He called the nurse to the man's bedside at 5.31am, the handcuffs were removed and it was noted that there was no movement. The nurse then reported that the man had died. The doctor confirmed death at 5.40am.

37. According to the clinical review conducted as part of this investigation, the 'treatment and care provided to the man whilst he was in HMP Gloucester, from the time of his admission in early November 2005 until his death, was both appropriate and satisfactory and the same as that he would have received had he been in the community. Once he complained of pain and symptoms associated with this problem the healthcare team acted appropriately and arranged blood

tests and emergency admission to hospital.' The clinical reviewer noted that pancreatic cancer is very difficult to diagnose and the man had became unwell very quickly.

Events after the man's death

38. One of the escort officers telephoned the prison and told the duty governor that the man had died. Gloucester opened and followed its contingency plan in the event of a death in custody.

39. The death in custody incident log shows the Governor was informed at 6.40am. The Area Manager and the Prison Service National Operations Unit (NOU) were informed at 6.55am and 6.57am respectively. The Coroners' officer was informed at 7.30am. The man's nominated next of kin, was called at 7.45am. Staff on duty at the hospital were provided with the support of the care team who attended to speak with them.

40. The same day, the governor wrote to the man's next of kin expressing his condolences. He offered himself and deputy governor as contacts, should the family need to contact the prison for any reason.

41. One of man's sons and his partner visited the prison and spoke to a member of the management team. They raised the issue of handcuffing but the management team member told them that the hospital had not contacted the prison to ask for them to be removed. They also talked about funeral expenses.

42. The Governor wrote again to the family a few weeks later. He said he was sorry not to have been at the prison when they visited and asked them to contact him again about the issues they had raised.

43. The man's funeral took place in later February. The family said they would be happy for the chaplain and one of the bed watch officer to attend, but it is unclear if anyone actually attended from the prison.

ISSUES

Was the man given the right treatment at Gloucester when he complained of being unwell?

44. The man's next of kin was concerned about the medical treatment he believed his brother had received. He understood from the many phone conversations he had with his brother that he was in considerable pain, but had only been given paracetamol despite telling staff how unwell he was feeling. However, I have not found any evidence to substantiate these concerns. My investigator found the officers on the man's wing to be interested and conscientious in their duties, and they were swift to act when they thought the man might be unwell.

45. It may have been the case that the man had felt unwell for some time, but there is no evidence that he reported this to staff. It appears, from all accounts, that he was a self contained man who went out of his way not to trouble anyone. Even on the morning that officers first suspected he was ill, having found blood in his sink, he pretended it was coffee and insisted he was fine. Furthermore, as evidenced by the clinical review, once the man did see the doctor and reported his aliments he was correctly dealt with.

Release

46. The man who is the subject of this report was held at HMP Gloucester as a remand prisoner. As a consequence, the prison had no authority to arrange his temporary release as it could have done had he been convicted and sentenced.

47. The man's solicitor made a bail application on his behalf, but this was unsuccessful because he did not have a fixed address. The court took the view that the man's offence was a serious one and asked for further reports, in particular a victim interview. The court agreed it would look at another bail application when these reports were made available. Sadly, he died before this process was completed.

48. The decisions of the courts are outside my remit. However, it is manifest that someone who is terminally ill should only be remanded in custody in the most exceptional circumstances. Although I am not in possession of all the details, it is not immediately apparent what those circumstances were in the case of the man who died.

The use of handcuffs

49. The man had not been in custody long before he became unwell. In the short time that he was at HMP Gloucester, staff had little time to form a relationship with him. However, the officers who conducted the bed watch became friendly with him. Several of the escorting officers said they were disturbed to see him handcuffed up until the time he died.

50. The man' son explained that on one occasion a doctor came to see him and asked the escorting officers to wait outside the room. They explained that they

were not in a position to do that and the man's son said they seemed genuinely sorry and embarrassed about the situation. Eventually the doctor became very angry and both officers left the room with one of them remaining handcuffed by the closeting chain so that the man was stretched between his bed and the room door. His son said his father took it in good humour, recognising that the officers were just doing their job. However, his son said he found it very upsetting and unnecessary.

51. Both bed watch officers made requests for the handcuffs to be removed and they were supported in this by medical staff. The officer who relieved them for night duty was told during the verbal handover that they had made a request for the handcuffs to be removed and this request had been denied. He too said he was uncomfortable being handcuffed to the man because it was obvious that he was very unwell.

52. The deputy governor was the duty governor during the weekend just before the man died and on the following Monday. When he was asked about his decision not to remove the handcuffs, he said he was keeping the situation under review. He also explained that, when he conducted the management check at the hospital on the previous Friday, he raised the man's condition at the evening meeting. There are no minutes available of this meeting, but the deputy governor said he told the other staff present of the man's condition. He said consideration was given to removing the cuffs but it was decided not to remove them and to keep the situation under review.

53. When asked why he did not reconsider this decision in light of the requests by both medical and discipline staff at the hospital, he said he could not recall being contacted with these requests. However, he acknowledged that procedures might have fallen down in this case.

54. The man's family were keen to acknowledge that the medical staff and escorting officers were very good and had been concerned about him. His ex-wife said she felt the escort staff did not seem sure about what to do about the issue of handcuffs. This anxiety seems to reflect the difficulty staff were in, as expressed by their comments on the bed watch log.

55. The man was taken to hospital in early February and diagnosed with terminal cancer just two days later. It is clear that, from the moment he arrived in hospital, he was very poorly and escort staff became increasingly uncomfortable with the use of handcuffs. Although daily management checks on his condition took place, I have not seen any evidence to show that the level of escort and restraints was reviewed.

56. In the event, the man, a remand prisoner not convicted of any crime, died in chains. This situation must have been deeply distressing for both his family - and for the officer who was required to be handcuffed to a dying man while his family had their last moments with him. I find it particularly unacceptable that this situation was allowed to continue despite requests from both escort staff and medical staff for the restraints to be removed.

The Governor of Gloucester should ensure that, within two months of receiving this report, the local contingency plans for the use of restraints on prisoners on bed watch are reviewed and, where necessary, revised to ensure that decisions show the reasoning behind them and are documented properly.

The Family

57. The man's family received a letter from governing governor expressing his condolences. He gave himself and the deputy governor as contacts should the family need to get in touch. A few days later, one of the man's sons and his partner visited the prison. As the governing governor was not there, they were received by a member of the management team. They asked why the handcuffs had not been removed and she apparently told them that the prison had not been contacted by the hospital to request this. The man's son said they also had a conversation about funeral expenses at this time. He said he was given the impression that they would only receive help with funeral costs if they were in receipt of benefits. He said he was left with the clear feeling the family would not receive any such help from the prison.

58. The governor wrote again to the family after this meeting to say they should contact him if they wished to discuss these matters further. However, after what they had been told, the family felt that this would have been fruitless.

59. PSO 2710 'Follow up to deaths in custody' was implemented on 4 January 2006. In chapter 4, it provides clear guidance on the prison's responsibilities in the matter of liaison with a bereaved family. There is also substantial supplementary advice available on the Prison Service intranet. The PSO says that the prison should offer to pay reasonable funeral expenses, regardless of whether the family are entitled to apply for a grant from the Social Fund. The PSO also requires a contact log to be kept recording all contact between the prison's Family Liaison Officer and the family.

60. I was sorry to learn that the prison did not make any further contact with the man's family. At such a difficult time for the family, I would expect the prison to take the initiative. It is the prison's responsibility to provide a liaison officer for the family. Although the Governor wrote and gave himself and the deputy governor as contacts, the family did not feel he made clear they would have a liaison officer to deal with their questions and concerns. No family liaison log was kept and I am unable to say what, if any, consideration was given to the man's family after his death.

61. The man's funeral took place near the end of February. The family said that they invited the chaplain and an officer, but do not know if anyone from HMP Gloucester attended as no-one made themselves known to them. The prison was not approached by the family for any financial support for funeral costs. The family say that this is because they were given discouraging and misleading information when they visited the prison. I consider that the standard of family liaison offered by the prison in this case was poor and failed to comply with the instructions in PSO 2710. The Governor may now wish to consider making an

offer of financial assistance towards the costs of the funeral in line with Prison Service policy.

The Governor of Gloucester should review, with immediate effect, the prison's policy on responding to the needs of families after a death in custody. Within two months of the publication of this report, he should produce a local protocol explaining what support will be offered to a family bereaved by a death in custody. Specifically he should ensure that bereaved families are provided with trained liaison staff who have a thorough understanding of the provisions of PSO 2710. A family liaison log must be kept in all cases.

RECOMMENDATIONS

The Governor of Gloucester should ensure that, within two months of receiving this report, the local contingency plans for the use of restraints on prisoners on bed watch are reviewed and, where necessary, revised to ensure that decisions show the reasoning behind them and are documented properly.

The Governor of Gloucester should review, with immediate effect, the prison's policy on responding to the needs of families after a death in custody. Within two months of the publication of this report he should produce a local protocol explaining what support will be offered to a family bereaved by a death in custody. Specifically he should ensure that bereaved families are provided with trained liaison staff who have a thorough understanding of the provisions of PSO 2710. A family liaison log must be kept in all cases.

Good Practice

I am pleased to commend bed watch staff for the sensitive and professional approach they took to the man's welfare. The Governor should arrange for my commendation to be shared with the staff concerned.