

**The Death of a man on 9 January 2005
in a Hospital whilst a serving prisoner at
HMP Acklington**

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

September 2005

This is the report of an investigation into the death of a man. He was transferred from HMP Acklington to a nearby Hospital where he died of pneumonia on 9 January 2005.

My office investigates the death of all prisoners in custody, including those due to apparent natural causes. In this case the investigation was carried out by one of my investigators. He commissioned an independent Clinical Review from the Prison Lead for the Northumberland Primary Care Trust. The Clinical Reviewer has assisted with a number of my investigations and I am again very grateful to him for his assistance.

I extend my condolences to the man's brother and family on their sad loss. I would like to thank the Governor at Acklington and his staff for their ready assistance throughout this investigation. I am satisfied that the man received good medical treatment during his time at Acklington. However, this investigation ends with some significant recommendations for strengthening procedures when prisoners are moved from Acklington to nearby hospitals for ongoing inpatient treatment.

STEPHEN SHAW CBE
Prisons and Probation Ombudsman
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SUMMARY

1. The man was received into custody at HMP Holme House on 25 February 2004 when he was 61 years old. On 27 February 2004, he was sentenced to six years imprisonment for serious sexual offences committed between 1964 and 1977. He had no previous convictions. On reception at Holme House, the man reported that he was suffering from hypertension and he also indicated a family history of diabetes. He was a smoker who was considerably overweight.
2. He was transferred to HMP Acklington in mid March 2004 and shortly afterwards routine screening identified that he was diabetic.
3. In November 2004, he suffered temporary left-sided weakness and the doctor who saw him considered it likely that he had had temporary interruption of the blood flow to his brain.
4. On 17 December 2004, he became unwell on A Wing at Acklington and was transferred to a nearby Hospital where he was admitted as an inpatient. His condition deteriorated at the hospital and he died on 9 January 2005. The cause of death reported to the coroner by the pathologist was firstly pneumonia and secondly cerebral and myocardial infarction.
5. The medical care he received whilst a prisoner at Acklington was good, but I make three recommendations in relation to the quality of support he received from the prison after his transfer to Hospital.

CONDUCT OF THIS INVESTIGATION

6. My investigator studied all the man's relevant prison records. These included his main prison record, Medical Record and the nine Bedwatch Logs covering the period spent by him in Hospital between 17 December 2004 and 9 January 2005. My investigator also studied instructions at Acklington on the arrangements to be followed when prisoners are escorted outside the prison.
7. A Clinical Review was commissioned from Northumberland Primary Care Trust and I am very grateful to the Care Trust's Prison Lead for undertaking that review. He is an experienced observer of prison clinical practice and he has undertaken several Clinical Reviews for me in a number of different prisons.
8. My investigator visited Acklington and discussed aspects of the man's treatment with a range of senior staff at the prison. These included the Governor, Deputy Governor, Head of Operations and the Clinical Team Leader.

PERSONAL INFORMATION ABOUT THE MAN

9. He was born in December 1942 and at the time of his death he was 62 years old. He was born in Middlesbrough and the address he gave when he was first received at HMP Holme House in February 2004 was also a Middlesbrough address.
10. He was received at Holme House on 25 February 2004 at the beginning of his trial at Teesside Crown Court. On 27 February 2004, he was sentenced to six years imprisonment for a number of indecent assaults on two young females committed between 1964 and 1977. He had never been in prison before and, although he was sentenced to a lengthy term of imprisonment, no pre-sentence report was written. It is normally possible to find a good deal of written information about a man, like the deceased, who was serving a long-term of imprisonment. But in this case, such information was not available.
11. My investigator made contact with the man's brother who told him that the man had worked for British Steel until taking early retirement around the age of 55. He then became a night watchman. According to his brother, the man spent much of his time in the local British Legion Club. He never married and, when his parents died, he continued to live in the family home. The man apparently suffered from angina before going to prison and he was deaf in one ear due to an industrial injury. The man was described by his brother as being a "big lad" who weighed 18 to 20 stones.

THE MAN'S PRISON HISTORY

12. As already indicated, he first entered HMP Holme House on 25 February 2004. On that date a standard First Reception Health Screen was conducted by a nurse. He was asked if he was currently receiving medication. The nurse recorded that he was confused about the medications or what they were for. However, the nurse found a recent prescription from his doctor and was therefore able to record the medication that was currently being prescribed. He was asked if he suffered from a number of conditions including asthma, diabetes and chest pains. He answered 'No' to all these questions, with the exception of chest pains where he spoke of suffering panic attacks.
13. A Secondary Health Assessment was also completed by the same nurse on 25 February 2004. His weight was recorded as being 123 kilograms and he said that he smoked but did not wish to give up. When asked if there was any history of illness running in his family, he referred to diabetes. He answered 'Yes' to the question "Do you have any problems with your heart, high cholesterol or high blood pressure?" Although the nurse did not tick any of the Planned Action boxes at the end of the Secondary Health Assessment form, he was seen by the Medical Officer at the prison on 2 March 2004.
14. On 16 March 2004, he was transferred from Holme House to HMP Acklington. Acklington is in Northumberland near the seaside town of Amble. It is a Category C adult male training prison with an operational capacity of 882. He remained at Acklington continuously until his transfer to Hospital on 17 December 2004.
15. An Initial Reception Healthcare Assessment was conducted at Acklington on the day of his arrival. He was again asked a number of questions about his health. The nurse recorded that diabetes was not an issue, but his high blood pressure was highlighted. Acklington was one of the first prisons in the country where clinical care is directly commissioned by the National Health Service. The objective is that the standard of healthcare received by prisoners should be as good as that received by citizens in the community. The Clinical Review cites an example of good practice at Acklington as follows:

"The computerisation of medical records at Acklington made (my) Medical Review simpler (and the entries legible). It is possible to see at a glance the summary of care which makes it much less likely that key issues are overlooked when organising patient care."

THE MAN'S MEDICAL HISTORY AND TREATMENT IN PRISON

16. The Clinical Review states in the opening summary that he was overweight when received at Holme House and he was also suffering from hypertension for which he was receiving treatment. Shortly after his transfer to Acklington in mid March 2004, routine screening also identified that he was diabetic.
17. The medical history section of the Clinical Review provides more detail about his medical condition. The doctor notes that, at the time of the man's arrival at Holme House, his blood pressure was not properly controlled. He was taking anti-inflammatory drugs and analgesics following a road traffic accident which caused him back pain. The Clinical Reviewer writes that a family history of diabetes was identified and the man was a smoker who was considerably overweight.
18. Arrangements were made to monitor his blood pressure. He was advised to stop smoking and had blood tests to check his blood fats. The Clinical Reviewer describes all these actions as appropriate in view of his hypertension.
19. In relation to diabetes, the Clinical Reviewer writes:

“Surprisingly, the possibility that he might be diabetic does not seem to have been considered, despite his positive family history and the fact that he was significantly obese.”
20. Monitoring of the man's blood pressure showed it to be sustained at an unacceptably high level and so his anti-hypertension medication was increased and more satisfactory control was achieved.
21. Once he had been transferred to Acklington, he was referred to the GP, the Well Man Clinic and the Chronic Disease Management Clinic at the prison.
22. Further blood profiling confirmed that he was suffering from Diabetes Mellitus. The Clinical Reviewer observes it is probable that this condition had been present for some time. The man's medical record indicates that the diagnosis of Diabetes Mellitus was made on 13 April.
23. The Clinical Reviewer notes that the man had lost weight since entering prison and further weight loss was encouraged. He was given medication to help control his diabetes and regular monitoring of both his hypertension and diabetes was undertaken.
24. There is an entry on 1 October in his medical record which states that he collapsed at work and that his right leg and arm went numb. His speech had been slurred but, when he was examined in the GP surgery at the prison later that day, he had full feeling in his leg and his speech appeared to be normal, although he still had some numbness in his right side.
25. On 12 October, he commenced Simvastatin as a preventive measure to reduce his blood lipid levels. The Clinical Reviewer explains that the man

was at risk of a heart attack as he had diabetes, hypertension and was a smoker. The Clinical Reviewer also writes that in such circumstances raised blood lipids should be controlled if possible.

26. On 20 November, the man “suffered a transient left-sided weakness” which resolved spontaneously. On 22 November, he was seen by a doctor who considered it likely that the man had had a transient ischaemic attack (temporary interruption of cerebral blood flow).
27. On 17 December, the man suffered a further episode of left-sided weakness and the nurse who attended him on the wing could not record his blood pressure. The Clinical Reviewer notes that she correctly decided to refer him to the Accident and Emergency Department at a Hospital near the prison. He was diagnosed as having had a left-sided stroke so was admitted to the hospital and investigated by CT scan.
28. In the ward, he developed a chest infection and his condition deteriorated. According to the Clinical Reviewer, “this was attributed to an extension of his original cerebral vascular accident”. On 9 January 2005, the man deteriorated rapidly with a falling level of consciousness and increasing sepsis from his chest infection. A Senior Officer recorded in Bedwatch Book 9 that the man passed away at 8:22pm on 9 January.
29. He appears to have died from natural causes with the pathologist reporting the cause of death to the coroner as:

1A pneumonia
1B cerebral and myocardial infarction.
30. The Coroner for North Northumberland has kindly made available to me a copy of a letter sent to him on 11 January 2005 by the Specialist Registrar in Elderly Medicine at the Hospital where the man was a patient. He reported to the coroner that the man was admitted to hospital on 17 December 2004 with left-sided weakness and slurred speech. He also informed the coroner that the man’s past medical history included diabetes, hypertension and hypercholesterolaemia.
31. After the Clinical Review had been completed, the coroner sent me a copy of the post-mortem report he had received from the Home Office pathologist for the North Eastern region based at the Royal Victoria Infirmary in Newcastle. The pathologist’s commentary at the end of his report to the coroner is as follows:

“The post-mortem in this case has shown that this man has probably died as a result of a terminal infection involving the substance of the lungs, pneumonia. This infection has arisen as a result of debilities imposed upon the patient because of extensive damage to the brain and the heart brought about by degenerative vascular disease. These conditions between them are thus properly considered the underlying cause of death in the case. There were no marks of violence.”

FOLLOW-UP TO THE MAN'S DEATH

32. Bedwatch Log Book 9 indicates that his condition began to deteriorate markedly during the afternoon of 9 January 2005. The consultant at the Hospital asked the officer who was accompanying the man that day for information that would enable contact to be made with the man's family in Middlesbrough. An entry in the Bedwatch Log at 18:10 shows that by that time his brother had been contacted by the hospital authorities. He explained that the family would be unable to get to the hospital.
33. The Duty Governor at the prison that day was the Head of Operations. The man's brother in Middlesbrough had already received news of his death from the Hospital by the time the Head of Operations telephoned him. The Prison Service Order on Follow-up to a Death in Custody states that ideally the news of a prisoner's death should be conveyed in person, but I am entirely satisfied that in this case it was appropriate for the Head of Operations to make telephone contact instead. In the first place the man was a patient in Hospital at the time of his death and the hospital authorities therefore correctly took on primary responsibility for breaking the news of his death to his next of kin. Secondly, the significant distance between Acklington and Middlesbrough would have led to the man's household being disturbed in the very late hours of 9 January or the very early hours of the following morning for the news to be given in person by the Duty Governor.
34. The Governor sent a prompt letter of condolence to the family and he also ensured that staff and prisoners were quickly informed of the man's death.
35. A senior Governor at Acklington made suitably early telephone contact with the man's brother and the prison offered to send a representative to the funeral. This offer was declined by the family.
36. The prison also offered to contribute towards the cost of his funeral, but his brother told my Family Liaison Officer that the man's solicitor was dealing with a number of issues, including funeral costs, and the family had therefore not accepted the prison's offer in relation to funeral expenses. A number of items of clothing were sent by the prison to the man's brother and safely received by him on 24 January 2005. My investigator has also seen an exchange of correspondence between the prison and a Law Firm in Middlesbrough in relation to a sum of money and two bags of property belonging to the man. I take the view that the prison has behaved professionally and sensitively in its handling of matters after the man's death.

THE MAN'S ESCORTS AT HOSPITAL

37. As a result of good work both by prison officers and nursing personnel, he was transferred rapidly to Hospital from Acklington on 17 December 2004. The gravity of his medical condition on that date meant that he was admitted to the hospital. He was serving a relatively lengthy sentence for sexual offences and the prison conducted a risk assessment on 17 December to establish the appropriate level of escort. The decision by the then Head of Operations at Acklington was that the man should be escorted by two prison officers and that he should be handcuffed up to and immediately following any consultation, examination and treatment. If he was admitted to Hospital, an escort chain was to be used at all times. The risk assessment stated that ROTL (Release on Temporary Licence) could not be granted.
38. A further seven days went by and then a second risk assessment was conducted on 24 December 2004. Bedwatch Log No. 3 indicates that on 23 December the man had been complaining about his handcuffs and "kept asking for them to be removed". The previous entry in the Bedwatch Log at 14:15 on 23 December made by one of the escort Officers states:
- "Remove cuffs, allow staff to put the man in hoist then on to toilet. Now sat up in chair. Reapplied cuffs."
39. On the morning of 24 December, a Principal Officer made a management check at the hospital. As the Security Principal Officer he had both the authority and expertise to review the man's escort conditions and make recommendations. At Part 2 of the Risk Assessment for Escorts form, the Security Principal Officer wrote that he had discussed the patient's condition with the ward sister. The prisoner was immobile due to paralysis on his left side. The revised Risk Assessment indicated that the escort should be reduced from two prison officers to one. At Part 4 of the same form, the then Head of Operations agreed that the staffing should be reduced to one officer and he also instructed that restraints should no longer be applied. He wrote that the Duty Governor should be advised immediately if there was any indication of increased prisoner mobility or any event indicating difficulty in managing the man with a single escort.
40. This second Risk Assessment again indicated that ROTL could not be granted.
41. There are two aspects of the time that the man spent at Hospital which require further comments:
- (i) contact between the Healthcare Centre at Acklington and the Hospital;
 - (ii) the quality of some entries made in the Bedwatch Log while the man was an inpatient at Hospital.

CONTACT BETWEEN THE HEALTHCARE CENTRE AND THE HOSPITAL

42. On 17 December 2004, a nurse attended the man on the wing and noted in his medical record that he was complaining of left-sided weakness. His mouth was drooping, his arm had little grip, he was complaining of pins and needles, and his leg was heavy. An Officer wrote in the A Wing Observation Book on the same date that the man had had a stroke down his left side.
43. The man spent three and a half weeks in Hospital between his admission on 17 December and his death on 9 January. During that period there was just one recorded contact between the HCC at Acklington and the Hospital. On 4 January 2005, two and a half weeks after his transfer to hospital, a nurse called Ward 9 at the Hospital to ask about him. The medical records do not indicate any information about what the nurse was told when she asked about his condition.
44. To Acklington's credit, my investigator discovered when he visited the prison in late February 2005 that arrangements are in hand to improve systems of contact. He discussed existing arrangements with the Clinical Team Leader at Acklington. She said there were no written systems at the time of the man's death, but showed my investigator a draft document which requires much more regular contact by a member of the nursing team once a prisoner is in outside hospital.

I recommend that written guidance should be issued and implemented without delay requiring much more regular contact by the nursing team once a prisoner is in an outside hospital.

It is very important for contact to be maintained and documented by HCC staff once a prisoner is being cared for as an inpatient at an outside hospital. This is because of the prison's continuing duty of care to any such prisoner and because decisions about security matters need to be based on reliable, up-to-date information about the patient's condition. Information from the Healthcare Manager is critical for decisions by the Governor about such issues as the use of restraints and whether ROTL may be granted.

The need for appropriate and respectful Bedwatch Log entries

45. My investigator carefully studied the nine Bedwatch Logs completed by Acklington prison officers during the time that the man spent at Hospital between 17 December and 9 January.
46. My investigator was shown a copy of the published guidance made available to staff from Acklington who are undertaking escorts outside the prison. Section 1 of the guidance states that, if the escort develops into a "bedwatch", they should contact the Communications Room at the prison and maintain an Occurrence Log. They are referred to Section 3 of the guidance for requirements about what is to be entered into the log, but when my investigator asked to see Section 3 it was blank. The job description for officers on a bedwatch states that they have three prime functions, the third

of which is “to maintain an Occurrence Log of all events, i.e. visits from prisoner’s family, changes of location and staff, etc.”

47. There is very detailed guidance about how escorting staff are to maintain security, but there is no corresponding guidance about what the Occurrence Log should or should not contain nor about the language and tone of their entries.
48. The job description for the Duty Governor at Acklington sets out a list of general responsibilities. The second responsibility on the list is to arrange for a manager to visit the bedwatch during the course of the day if there are any prisoners in outside hospital. The seniority of the manager who should make such a visit is not specified.
49. The vast majority of the entries made in the nine Bedwatch Logs are appropriate and suitable, but a few are lacking in respect and decency.
50. I accept that officers staffing the bedwatch at Hospital were not to know that the man’s life was nearing its end, but they should certainly know that it is unremarkable for seriously ill patients to lose control over their bodily functions. There are several examples of log entries that I consider disrespectful and lacking in common humanity. They use pejorative language, exclamation marks and refer disrespectfully to incontinence. These entries were made by two senior officers and two officers on 18 and 20 December and 3 and 5 January.
51. I consider a review of procedures should be undertaken to include improved guidance and training for staff on what to write and how to write it when on bedwatch duty. The review should also reflect on the question of who should make management visits and whether any additions are required to the existing Visiting Manager’s Bedwatch Checklist.

I recommend that staff should be reminded of the need to ensure that entries in prisoner records should be accurate, factual, sensitive and respectful.

I recommend that the Governor should review and strengthen existing procedures at Acklington for management checks and the monitoring and support of staff on bedwatch duty.

CONCLUSIONS

52. I conclude that the man had a number of health problems when he was first admitted to prison in February 2004, although his diabetes was not diagnosed until he was transferred to Acklington. He received good medical care at Acklington, then on 17 December 2004 he was referred to the Accident and Emergency Department at a nearby Hospital. According to my Clinical Reviewer that was a correct decision. Although the man remained in outside hospital for over three weeks until the time of his death, there was just one formal contact between the HCC at Acklington and the hospital during that period. Some of the entries made in the Bedwatch Logs by prison staff were lacking in respect and decency.
53. Representations were made to me about my bedwatch logs conclusion in the preceding paragraph when I issued my draft report to the Prison Service for consultation. I decided not to accept these representations.

RECOMMENDATIONS

Written guidance should be issued and implemented without delay requiring much more regular contact by the nursing team once a prisoner is in outside hospital.

Staff should be reminded of the need to ensure that entries in prisoner records should be accurate, factual, sensitive and respectful.

The Governor should review and strengthen existing procedures at Acklington for management checks and the monitoring and support of staff on bedwatch duty.