

**Investigation into the circumstances surrounding the
death of a man at HMP Gloucester in June 2005**

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

November 2005

This is the report of an investigation into the death of a man at HMP Gloucester in June 2005. He was 51 years of age. The post mortem indicates that he died as a result of intra-abdominal haemorrhage, splenic lacerations and cirrhosis of the liver.

One of my Investigators conducted this investigation. The local Primary Care Trust has undertaken a clinical review into the care and treatment given to the man. The clinical review is comprehensive and includes relevant general observations in relation to healthcare at Gloucester.

I would like to extend my condolences to the man's family for their loss. I am grateful to the Governor of HMP Gloucester, and his staff for their help and co-operation during this investigation.

I make four recommendations in this report, two of which are based on observations made by the Primary Care Trust. I also make one recommendation about the notification of death by the prison to the Coroner as well as informing the next of kin. The final recommendation is concerned with the need for contemporaneous statements taken from prison staff in the event of a death. Although addressed to Gloucester, this recommendation may also be relevant to other establishment. Following a review of the draft report, the Prison Service have acknowledged and accepted my recommendations.

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November 2005

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Summary

On 31 May 2005, the man was sentenced to 21 days imprisonment by the Magistrates' Court for driving with excess alcohol and failing to surrender. His only other term of imprisonment was in the early 1970s. He had a history of chronic alcohol abuse and was in poor health when he went into prison. Whilst in custody, the man was put on a detoxification regime. He died on his second day in custody at HMP Gloucester.

At about 1.30pm on 2 June 2005, a fellow prisoner alerted prison staff that the man had collapsed in his cell and was in pain. The man had reportedly collapsed twice during the day although there were no witnesses to confirm either incident. The man was guarding his abdomen and complained of pain all over. He was conscious and sweating but in a confused state. He was also vomiting and had been doubly incontinent. Healthcare staff, including the prison doctor, attended the man's cell and after a period of observation and assessment decided that he should be taken to hospital as an emergency case. At the time, the man was not considered to be critically ill and appeared to be suffering the symptoms of alcohol withdrawal. However, after a further review, his condition appeared to be deteriorating and the doctor decided to call 999. As he was about to make this telephone call, the emergency ambulance arrived. The man was taken to hospital by ambulance under escort and restraint. At the hospital, it was quickly established that he had an internal bleed and was seriously ill. He was not expected to live and, in view of this, arrangements were made to remove his restraints. Arrangements were also made to contact his next of kin to tell them of the situation. Unfortunately, neither the prison nor the police were able to contact the man's nominated next of kin, his wife. At 7.52pm, the man was pronounced dead.

The post mortem carried out on 6 June, indicated that the man died as a result of a massive intra-abdominal haemorrhage, splenic lacerations and cirrhosis of the liver.

The investigation process

1. The investigation was opened at HM Prison Gloucester on 9 June, when my investigator visited the establishment. The Governor and his staff produced the man's core record, his Medical Record and a number of other documents for examination. Notices were issued to staff and prisoners informing them of the investigation. The investigation began in the week commencing 4 July, when my investigator was able to interview staff who had known the man.
2. Following a visit to HMP Gloucester, the man's wife contacted this office on 22 July and spoke to my investigator regarding the man's death. She raised three concerns that she wanted to be addressed and explored. I hope this report answers the questions she raised.
3. My Investigator contacted Her Majesty's Coroner to request a copy of the Post Mortem report. The Coroner was also contacted at a later stage in order to confirm how the man's was informed of her husband's death.
4. The local Primary Care Trust was contacted. They have produced a comprehensive clinical review into the care and treatment that was given to the man whilst he was in custody.

HMP Gloucester

5. 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 prison that was first built in 1782 and substantially rebuilt in 1840. An additional wing was constructed in 1971.
6. Gloucester has three main wings. A and B wings are located in the older part of the establishment and are of the traditional Victorian style. Both A and B wings have integral sanitation and accommodate two prisoners per cell. C wing is the newer of the wings and has night sanitation. It also houses the prison's voluntary drug testing unit. Gloucester can hold up to 330 prisoners.
7. The establishment also has a small, stand alone Health Care Centre on two floors that can hold a maximum of 14 prisoners, with treatment rooms and other outpatient facilities. At the time of the man's death, the Health Care Centre was undergoing major refurbishment.
8. In autumn 2003, Gloucester was inspected by Her Majesty's Chief Inspector of Prisons (HMCIP). Her report indicated that there had been noticeable improvements since the previous inspection in 2002. However, an issue was highlighted in respect of the number of staff dedicated to deal with prisoners undergoing detoxification from drugs.

Events prior to the man's death

9. On Monday 30 May, the man was arrested on an outstanding warrant for failing to surrender to the courts on a charge of driving with excess alcohol. He was kept in police custody to appear before the Magistrates' Court on 31 May 2005.
10. Whilst in police custody, the man stated that he was an alcoholic and that he would suffer withdrawal symptoms. He was subsequently seen by a Police Medical Examiner and prescribed appropriate amounts of Chlordiazepoxide at stipulated intervals. Police also ensured that the man was observed every 30 minutes. His Prisoner Escort Risk (PER) form was annotated with this information and he was considered fit to be detained.
11. After sentence, the man was taken to Gloucester. On arrival at the establishment he underwent an initial health screen, where it was determined that he had suffered ruptured blood vessels in his stomach in the months preceding his arrest, which had required a period in hospital. It was noted that he was not in receipt of any prescribed medication and that he had been experiencing circulatory problems in his legs. It was also determined at the health screen that he was an alcoholic who drank six litres of strong cider per day. The man had been diagnosed with cirrhosis of the liver some years previously.
12. During the medical screen, the man denied any thoughts of self-harm and stated that he had not received any past psychiatric treatment. He also said that he did not have any concerns about his imprisonment. In light of his alcohol abuse, he was referred to the prison doctor for advice. The PER form initiated by the police was used as a source of information for treatment by the prison.
13. On 31 May, the man commenced the alcohol detoxification regime following discussions with the prison doctor. He was prescribed appropriate medication at regular and specific times. The man was not considered to be at risk, despite the fact that he was withdrawing from alcohol, and in view of this he was not placed on any specific observation. There was no particular concern about the man withdrawing from alcohol.
14. On the afternoon of 31 May, the man made a telephone call to his wife to tell her that he was in prison. He sounded well and appeared to be in good spirits.
15. On 1 June, the medical record indicates that the man was still withdrawing from alcohol. His induction to A wing was completed and he was allocated to a double cell, A1-6. However, he was the sole occupant of the cell as the other prisoner had been transferred to court during that morning.
16. It is not possible to determine whether the man took the top bunk bed in the cell and it seems that when he entered cell A1-6 as the sole occupant

he had a choice of beds. The man's wife maintains that, because he was unsteady on his feet, it is somewhat of a surprise that he would have elected to take a top bunk. The prison does not keep records of which prisoner takes which bed.

17. At about 1.30pm on Thursday 2 June a prisoner on A wing, who was also the wing cleaner, alerted a member of staff that the man was lying on the bottom bunk bed in his cell and appeared to have difficulty with his breathing. The prisoner had been in the process of collecting the dinner time trays from each cell on the wing. According to his police statement, the prisoner asked the man what had happened. The man stated that he had fallen off the top bunk bed and that he was hurting all over. The prisoner alerted staff. In the meantime, an officer and the prisoner placed the man in a chair beside the washbasin as he had been vomiting. The man was described as weak, incoherent and unable to support his own weight.
18. The man was seen by the prison doctor and was administered painkillers some time after 2pm, although this was not recorded on the medical record. He was exhibiting the extreme signs of someone who was withdrawing from alcohol. He was not displaying signs of shock and his vital signs were satisfactory and not considered to be a cause of immediate concern. It was decided to review the man in one hour or call the doctor if his condition deteriorated further.
19. Whilst in the cell, the man wanted to use the toilet and the officer and prisoner tried to lift him onto the toilet. However, the man could not support his own weight and he was put into the recovery position on the floor where he defecated several times, unable to control his bodily functions. The man was conscious although he was in distress and disorientated. He was guarding the left side of his body and complained of a pain in his chest.
20. At 3pm, the medical record indicates that the man vomited again in his cell. By this time he was doubly incontinent. He was described as confused and disorientated. The doctor decided to send him to hospital and phoned for an ambulance at approximately 3pm. The man continued to exhibit the signs of extreme alcohol withdrawal. Although his vital signs were considered to be satisfactory, the doctor decided to call for an ambulance. It was felt at the time that the man's condition did not warrant a 999 response. It was established that the ambulance could take up to 30 minutes to arrive.
21. Whilst awaiting the arrival of the ambulance, the man continued to want to use the toilet but he was unable to muster the strength. An officer attempted to provide cover for him in order to provide as much privacy and dignity as possible. However, the man who was still in the recovery position continued to pass loose faecal matter. He was provided with clean clothing and healthcare staff attempted to clean him. The clinical review indicates that the doctor was about to phone for a 999 response as

the man's condition appeared to be deteriorating. Just when the doctor was about to make a 999 call, the ambulance arrived at approximately 3.50pm. The clinical review suggests that the arrival of the ambulance was hampered to a degree by Gloucester's security arrangements. However, the paramedics were escorted by the doctor to the man's cell and any delay was not considered to have affected his treatment or the outcome.

22. Because the man was leaving Gloucester to go to hospital, a security risk assessment was completed by the Security Unit. The assessment determined that he should be put on a closeting chain and that the removal of this device by staff at the hospital for medical or emergency treatment should only be done on the authority of the duty governor. In light of insufficient information about the man, this was a standard precaution and in line with Prison Service Regulations.
23. The man was taken from Gloucester to the ambulance by a wheelchair. On entering the ambulance, he was immediately connected to monitoring equipment. Paramedics stated to the escorting officers that he had very low blood pressure and that they suspected an internal bleed. The ambulance left Gloucester at about 4.10pm.
24. The man was taken to hospital by ambulance, arriving at the hospital at about 4.15pm. He was escorted by two prison officers and restrained by a closeting chain. On arrival at the hospital, he was taken straight to the resuscitation area. At 4.20pm, the man was seen by an A&E doctor who suspected that he had an internal bleed. His condition was considered to be very serious. Medical staff asked that the man be released from his closeting chain. The prison escorts were reluctant to take this decision until they had received authority from the duty governor, as per the man's security risk assessment. A telephone call was made to Gloucester by one of the escorting officers to update them of the situation and seek the duty governor's authority to remove the chain.
25. At 4.45pm, the man's closeting chain was removed in order to afford effective medical treatment and a degree of dignity to him. He was taken to the Intensive Treatment Unit (ITU) although medical staff stated that the prognosis for recovery was poor. The man continued to be observed by the two prison officers although there was no direct interaction. He was described as semi conscious and very confused. However, during the course of the early evening the man appeared to be a little brighter and at one stage he tried to get off of the bed. This may be attributed to the drugs he was being given or confusion due to his toxic state.
26. In light of the man's deteriorating condition, the Deputy Governor at Gloucester contacted the police so that the man's wife could be informed of her husband's condition. He was not expected to survive. Although the prison had noted her address they did not have a contact telephone number. Police attempts to contact her were also unsuccessful. At 7.52pm, the man was pronounced dead.

Events after the man's death

27. One of the escort officers telephoned the prison and told the duty governor of the man's death. On being told that the man had died, Gloucester opened and followed its contingency plan in the event of a death in custody. His cell was sealed to await the arrival of the police and the Coroner's officer. The prison escort officers continued their bedwatch vigil awaiting the arrival of the Coroner at the hospital. There was an assumption that the hospital would notify the Coroner of the man's death. However, it was later learnt that it was the prison's responsibility to notify the Coroner of a death in custody. Once the Coroner's office was informed, it was then ascertained that the Coroner would not attend the hospital because of the nature of the man's death.
28. The Prison Service National Operations Unit (NOU) was informed of the man's death at 8.35pm. The Deputy Governor held a debrief for staff involved at 9.50pm telling them that the prison care team was available if anyone required their support. Staff confirmed that support was available to them. The Deputy Governor also thanked the prisoner who had discovered the man in his cell, for his assistance. The note of the debrief was short and did not indicate who had attended.
29. Following the man's death, the prison contacted the police asking them to inform the man's wife of his death. However, the police were not able to establish contact with her. Following a review of the draft report, his wife stated that she first learnt of her husband's death at about lunchtime on 3 June, when she received a telephone call from the Gloucester Coroner's Office. His wife had taken her husband's mobile phone at the time of his arrest and the Coroner's Officer used this number on the assumption that the man's wife had already been told of her husband's death. The Coroner's Officer who broke the news has confirmed that informing the next of kin is something that the Coroner's Office does not usually undertake and that this is usually left to the police or prison service. It was most unfortunate that she learnt of the death of her husband in this way.
30. The man's funeral took place on 23 June. The prison had not been approached for any financial support for funeral costs by the family and Gloucester has not contributed to the funeral costs. The Governor confirmed that property belonging to the man had been handed to a representative of the man's wife. He will wish now to consider making an offer of financial assistance in line with Prison Service policy.
31. On 21 July, the man's wife visited Gloucester and spoke to the prison's family liaison officer. She visited the cell in which her husband had been found and was concerned that the poor condition of the floor and the fact that he was unsteady on his feet could have resulted in him slipping and sustaining a serious injury. My investigator examined the cell, noting that

although the floor was well worn it did not appear to present a significant trip hazard. She is concerned that her husband might have slipped on the floor and hurt himself against the metal washbasin, thus sustaining an internal injury.

32. The man's wife was also surprised to learn that her husband might have fallen off the top bunk as reported by the prisoner who discovered him. She is concerned that a fall off the bunk bed could have caused the splenic lacerations. There was no reason why the man should have been on the top bunk bed as he was the sole occupant of a double cell and had a choice of beds. However, as there are no independent witnesses to either incident, the cause of his internal injury remains a matter of conjecture. At the time of his discovery, the man mentioned that he had fallen off the bunk bed although he was also described as incoherent and in a confused state.

Clinical review and Post Mortem

33. The post mortem was conducted on 6 June and indicates that the man died from a massive intra-abdominal haemorrhage, lacerations to the spleen and cirrhosis of the liver. The post mortem indicated that the splenic trauma was the cause of the haemorrhage and very likely that the haemorrhage had been exacerbated by a relative failure of blood clotting.
34. The clinical review found that the man's medical care, treatment and referral to hospital were appropriate. However, the review indicates that it was difficult to establish the overall level of nursing care that was provided to him because of omissions and inconsistencies in record keeping in respect of the medical record. The review highlights a number of administrative deficiencies that need to be reviewed by the healthcare team at Gloucester. However, none of these affected what happened to the man and I hope that this offers some reassurance to his family.
35. The clinical review does raise one general issue in relation to the care and treatment of prisoners who are alcoholic in that the dramatic reduction in fluid intake for an individual can have a significant and adverse physical impact, more so than withdrawal from drugs. Such an impact should be monitored more closely to include observations of fluid balance and kidney function and referral to a specialist as appropriate.

Findings and conclusions

36. It was known that the man was a chronic alcoholic and had in the months preceding his arrest and imprisonment been in hospital for internal abdominal bleeding. His physical condition was poor and included circulatory problems in his legs. He was not registered with a GP and on reception stated that he was not on any medication. He was described as being very unsteady on his feet and not particularly coherent, exhibiting the signs of an alcoholic.
37. The man continued on the alcohol detoxification regime whilst at Gloucester, but was not considered to be at risk in any way. Indeed, the clinical review confirms that alcohol withdrawal in prison is probably better supervised than in the wider community as there is an increased likelihood of compliance with no access to alcohol. However, the clinical review also points out that prisoners on such regimes should be monitored for fluid balance and kidney function as the reduction in fluid intake can have a dramatic and severe effect on individuals. The man was not subject to any healthcare or prison observations. However, failure to monitor his progress on the detoxification regime did not affect the circumstances or the final sad outcome.
38. The man was only in prison custody for two days before he died. In the short time that he was at Gloucester, staff had little time to form a relationship with him. In regard to the documentation that is available, the medical record is not consistent or continuous and deficiencies have been highlighted in the clinical review. During my investigation, it was suggested that the man may have collapsed twice on 2 June and that healthcare staff attended prior to his collapse at 1.30pm. However, there is nothing recorded in his medical record to indicate that healthcare staff were called to attend and treat him as a result of an earlier collapse.
39. There is some confusion about how the man was found to be collapsed in his cell. The medical record indicates that he had slipped on the cell floor and knocked against the washbasin, whilst other evidence from interviews suggests that the man stated that he had fallen off of the top bunk bed in his cell. There are no direct witnesses to either event as he was in the cell by himself. A police investigation has ruled out any third party involvement. A check of the cell floor as part of the investigation did not highlight any deficiency in the flooring or any work carried out on the cell floor before on or after 2 June. I regret that I am unable to determine how the man sustained the apparent internal injury that led to his death.
40. No contemporary statements were submitted to the Governor by staff who dealt with the man up to the time of his death. In light of this, it was difficult to establish the continuity of events. This has necessitated a series of interviews with healthcare and prison staff and has no doubt caused some anxiety to individuals.

41. The man was allocated a shared cell after his reception although he was the sole occupant. On being discovered in his cell by a fellow prisoner, he complained of pain all over, was vomiting and became doubly incontinent. At the time, the man exhibited the extreme signs of alcohol withdrawal and it was decided to send him to hospital as an emergency case. His vital signs were not a cause for concern. However, a further review of the man by the prison doctor determined that his condition was deteriorating and it was decided to upgrade the emergency call to a 999 call. The ambulance arrived just as the doctor had decided to telephone 999. The clinical review has identified that there was a delay in authorising the entry of the ambulance to Gloucester because of security considerations. Although any delay did not adversely affect the treatment of the man, this suggests a breakdown in communication between healthcare and the front gate.
42. The man was taken to hospital under escort and restraint in compliance with the Prison Service's security and operating procedures. The prison had limited knowledge of him and in view of this the prison escort officers were instructed not to remove the restraints unless it was authorised by a duty governor.
43. At the hospital it was soon determined that the man's condition was very serious and that he was suffering from internal bleeding, complicated by his alcoholism. He was not expected to survive. In light of the situation, arrangements were made to remove his clothing chain but to maintain unobtrusive observation. The time it took to seek authority to remove the clothing chain was not unreasonable and afforded some degree of dignity to the man in the last hours of his life.
44. After the man had been pronounced dead there was some confusion as to who was responsible for notifying the Coroner. It was unfortunate that the two prison escort officers were retained on bedwatch duty at the hospital for quite a considerable time until the administrative details had been clarified.
45. The police were unable to make contact with the man's wife on 2 June and inform her of the death of her husband. It later transpired that she only learnt of the death of her husband the following afternoon when the Coroner's Office made contact with her by telephoning her late husband's mobile telephone. The Coroner's Officer contacted her in the belief that she had already been told of her husband's death. This was most unfortunate as the Coroner's Office is not usually called upon to break such news, relying primarily on the prison service or the police to do so.

Recommendations

46. That all health care staff are reminded to make their own contemporaneous entries in the medical record where they have contact with the patient. This will give a full, accurate and continuous record of the care and treatment given to the patient.
47. That the Governor reviews arrangements to ensure that, where an ambulance is requested by healthcare staff, everything is done to expedite ambulance and paramedic access to the patient.
48. That the Governor reminds staff that, in the event of a death of a prisoner in hospital, arrangements are made for the prison to contact HM Coroner immediately.
49. That the Governor reminds staff that, in the event of any death in custody, a written statement should be supplied by key staff involved. Statements taken at the time or soon after provide a more accurate record and may reduce the need for staff to be interviewed as part of an investigation.