Investigation into the circumstances surrounding the death of a man at Queen Elizabeth Hospital, Woolwich, in December 2005, whilst a prisoner at HMP Belmarsh

Report by the Prisons and Probation Ombudsman for England and Wales

August 2007

This is the report of an investigation into the death of a man in December 2005. He died at Queen Elizabeth Hospital, Woolwich, having been admitted a week earlier from HMP Belmarsh.

The post mortem gave the cause of death as multi-organ failure and septic left shoulder. The man was 57 years old at the time of his death.

My colleagues and I would like to extend our condolences to the family and all those touched by his passing.

The investigation was started by my colleague and concluded by my deputy ombudsman. An independent clinical review into the man's care was carried out by Greenwich Teaching Primary Care Trust, and I am grateful to the PCT for its assistance. The review concludes that the clinical care provided by the prison fell below acceptable standards. I make seven recommendations to the Governor and to the PCT, which I hope they will see as an opportunity to improve the standard of in-patient care.

I must apologise for the delay in completing this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2007**

SUMMARY

The man arrived at HMP Belmarsh on 2 December 2005. Reception staff were sufficiently concerned by his mental and physical health that he was admitted to healthcare. Over the following days, his physical health deteriorated considerably. Regrettably, insufficient attention was paid to his needs, which were inadequately monitored, and he was not referred to hospital as early as he should have been.

The man was sent to Queen Elizabeth Hospital, Woolwich, in the early hours of 8 December, and was initially admitted to a ward. His condition continued to deteriorate and on 14 December he was moved to Intensive Care. He suffered a cardiac arrest within 24 hours, and was successfully resuscitated. Sadly, he died less than an hour later.

The cause of death was given as:

1a	Multi-organ failure
1b	Septic left shoulder.

THE INVESTIGATION PROCESS

1. One of my colleagues requested a copy of the man's prison records including the medical record. My colleague reviewed all the available evidence.

2. Notices of the investigation and the Prisons and Probation Ombudsman's terms of reference were sent to the Governor of HMP Belmarsh. These informed staff and prisoners of the investigation, and asked them to make themselves known to the investigation team if they had information that might be of help.

3. When prison health services are commissioned by a Primary Care Trust (PCT), I am required to involve them in the investigation process. Accordingly, a clinical review was commissioned from Greenwich Teaching Primary Care Trust. The aim of each clinical review is to assess and advise on the quality of care provided by the relevant healthcare services. I am grateful to the PCT panel review team for their comprehensive report.

4. One of my Family Liaison Officers made contact with the family to outline how the investigation would be conducted, and to identify any areas of care they would like explored. I hope that my report answers the family's concerns. Some of their concerns are beyond the remit of my office, but those which are relevant are as follows:
    - Were prison staff aware that the man had recently been in hospital?
    - What did the man tell staff about his health?
    - What information was known to reception staff about the man's previous mental and physical health?
    - What medication did the man receive whilst in prison?
    - Was he on a methadone programme?
    - Did the man have any medication with him when he arrived at the prison?
    - The family believe that the man had septicaemia and ask whether there was a link between the condition and his existing health problems.
    - Whether the man was in hospital in the prison?
    - Why was he not moved to outside hospital any sooner?
    - Why were the family informed that the man was in hospital by a friend, rather than the prison?
    - Why was he handcuffed in hospital and accompanied by two officers?
    - Why did the prison governor not tell the family that assistance with the funeral expenses was available?

5. At the time of issuing this report, there remains an issue over the offer of financial assistance to the family for funeral expenses. The family have not been offered financial assistance as laid down by the prison service order and I urge the Governor to give due consideration to offering such assistance as a matter of urgency.

6. In response to the draft report, HMP Belmarsh have accepted all the recommendations and will be taking steps to address the identified learning.

HMP BELMARSH

6. HMP Belmarsh is a core local high security prison situated in Plumstead in South East London. The operational capacity (maximum crowded capacity) of the prison is just under 1,000. Belmarsh holds mainly male adults, although in 2005 there were a number of high security young adults. There are four residential units, a high security unit, a segregation unit and a healthcare centre with a number of in-patient beds for people requiring 24 hour nursing care. The majority of patients have mental health needs, but a small number have chronic health problems requiring an enhanced level of care and support.

7. Belmarsh was inspected by HM Inspectorate of Prisons in October 2005. This inspection was an unannounced full follow-up inspection. The aim of the inspection was to establish what action had been taken against the recommendations from an earlier inspection.

8. HM Chief Inspector of Prisons wrote:

   > "An effective and comprehensive induction process was in place, but before prisoners reached that stage, they had to undergo some extremely poor reception and first night procedures."

9. HM Chief Inspector of Prisons also referred to healthcare standards, writing that:

   > "Healthcare, too, had made little progress, with most of our recommendations not implemented, although prisoner perceptions had improved."

10. Belmarsh is situated in the geographical area served by Greenwich Teaching Primary Care Trust. Responsibility for commissioning healthcare services at the prison transferred to the PCT on 1 April 2005.

11. Greenwich Teaching PCT has carried out a number of clinical reviews on behalf of my office, and has analysed the findings of this review and the others. A pattern has emerged that a more holistic approach to care is required. Of particular concern is the conclusion that, "patients with apparent mental health problems or addiction problems are treated for these problems and physical health needs come second if they are identified at all."

KEY EVENTS

12. The man was taken into police custody on 1 December 2005. He was seen by the Forensic Medical Examiner (FME) at 9.45am. Unfortunately, the record of the contact is illegible, but it is clear that he was deemed fit to be detained and was interviewed with an appropriate adult. The man was seen by another FME later that day at 3.05pm. This time he was not considered fit to be interviewed until he received his medication. Just over two hours later, the same doctor made contact with the man's own doctor and issued his medication. He was again considered fit to be re-interviewed.

13. At 3.17am the next day (2 December), the duty FME was called to the police station to see the man who was given pain killers and some of his asthma medication. At 7.14am, the FME saw him again and assessed that he was fit for transfer to court. The custody officer at Bexleyheath Police Station completed a Prisoner Escort Record which indicated the man had physical and mental health conditions. There is no significant further information available on the document. At 8.15am, the man was received into the care of the prisoner escorting services, and taken from the police station to Bexley Magistrates' Court. He appeared in court just after 11.15am, charged with a number of counts of deception and theft, and was remanded into prison custody at Belmarsh. His next court appearance was scheduled for 8 December 2005. He left Bexley Magistrates' Court around 1.45pm, arriving at Belmarsh at 2.40pm.

14. When the man arrived at the prison, he was assessed by various members of staff who carried out the various reception processes, including the Cell Sharing Risk Assessment (CSRA), initial interview and healthcare assessment. The Prisoner Escort Record and copies of the FME report, along with his warrant, were with him when he arrived at Belmarsh. He told staff that he was married, and named his brother as his next of kin giving full contact details. He said that he was retired, but gave no indication of his former occupation.

15. The CSRA noted that he abused alcohol or drugs, and was currently dependent on them. No other risk factors were identified and he was assessed as suitable to share a cell.

16. The man was also interviewed by a member of the healthcare team for completion of the 'First reception health screen'. The purpose of the interview was to gather a brief confidential medical and psychiatric history, and identify any suicide or self harm risks and any medical help that might be required. The man advised the interviewing member of staff that he had been an in-patient at a psychiatric unit more than five years previously. He also advised them of all the medications that he was taking. He made no reference to either the healthcare worker or the medical officer of a recent hospital admission. Although the form is incomplete, he was appropriately referred to the doctor and for a mental health assessment. It is not recorded anywhere that the man had any medication with him on his arrival into prison. Due to his mental and physical health needs, he was to be admitted to healthcare as an in-patient.

17. The man was seen next by a doctor, who carried out a further assessment and also requested that he should be admitted to healthcare. The man was later admitted to healthcare where he was allocated a single cell. He was to be monitored intermittently, and have his baseline observations checked. (Baseline observations are the patient's blood pressure, pulse, temperature and breathing.) A psychiatric review was booked for the following Monday.

18. After his assessment by a doctor, he was prescribed:
    - Paroxetine 40mgs, once daily for his depression.
    - Buspirone 10mgs, three times a day for his anxiety.
    - Procyclidine 5mgs, three times a day to manage any side effects from the psychiatric medications he was taking.
    - Haldol 100mgs, every two weeks as an intra-muscular injection.
    - Ibuprofen 400mgs, three times a day as a pain killer.
    - Salbutamol inhaler, to be kept in his own possession for use when needed.

19. The section of the CSRA to be completed by the admitting member of the healthcare team is also incomplete. However, the member of staff did note that he was slow on his feet and breathless. The man was allowed to keep his asthma inhaler so that he could use it whenever it was required. No nursing care plan was prepared, and no baseline observations were recorded.

20. The next day (3 December), the man again saw the doctor who recommended that tramadol (an opiate based painkiller) should be avoided, and that he should continue with ibuprofen (a non-steroid painkiller). A brief standard care plan was prepared. It did not refer to the patient's individual needs.

21. The following day, the man was apparently in a lot of pain and required some assistance to look after himself. He saw a doctor again the next day (5 December). The doctor diagnosed that he was suffering from Chronic Obstructive Pulmonary Disease. Chronic Obstructive Pulmonary Disease is a progressive disease of the lungs and respiratory system that results in the narrowing of the airways and difficulties breathing. The following day, the man was referred to a consultant at Queen Elizabeth Hospital, Greenwich.

22. On 7 December, the night nurse, recorded that the man did not have a good night and appeared to be disorientated. The nurse asked the doctor to review him in the morning. When the man saw the doctor, a set of observations (including urine testing and a number of blood tests) were requested. The doctor prescribed antibiotics to treat his foot as it was red and inflamed. The next entry later in the day states that the man should be "Put on observation", but there is no documentary evidence that this happened.

23. At 10.30pm that evening, the healthcare worker on night duty recorded the man's blood pressure and pulse. (This was the first record of any baseline observations.) It was also noted that he was very thirsty, shaky and mildly confused. At 1.30am, his condition deteriorated. The healthcare worker was concerned and contacted the clinical manager and duty doctor, after which the man was sent to the Accident and Emergency Department of Queen Elizabeth Hospital for further assessment.

24. The man was admitted to the hospital for on-going investigations, after which a risk assessment was carried out in order to establish the risk he presented to the public and the level of escort which was required. The assessment decided that he should be escorted by two bedwatch officers at all times, and that handcuffs should be used. The bedwatch officers began a log of all occurrences and interactions.

25. At 5.15pm, the man had an hour's visit from his brother, who had found out about the hospital admission from the prison chaplain. This followed information received from a police officer based at Bexleyheath Police Station, that the man was in prison.

26. The man remained in the ward at Queen Elizabeth Hospital. At about 7.30am on 14 December, the bedwatch officers noted that they telephoned the duty governor to ask permission to remove the handcuffs as his condition had deteriorated. The duty governor gave permission for the handcuffs to be removed. The man was transferred to the Intensive Care Unit at about 9.00am.

27. A second risk assessment was carried out later that day, which noted that no handcuffs were to be used whilst he was in the Intensive Care Unit. The assessment authorised visits from his family and friends, provided that they were in accordance with any hospital restrictions.

28. His brother visited that afternoon, and remained with him until just after 8.00pm. When he left, the bedwatch officers noted his telephone number in case they needed to contact him. He asked to be contacted if his brother's condition changed.

29. The man had a cardiac arrest during the night. Hospital staff successfully resuscitated him, although he was clearly very poorly. The hospital contacted his brother at about 6.00am, and told him about his brother's deteriorating condition. At 6.47am, the prison's Night Orderly Officer asked the bedwatch officers to withdraw to a side room if the family arrived in order that they should have privacy. Two minutes earlier, at 6.45am, the man was pronounced dead.

ISSUES CONSIDERED IN THE INVESTIGATION

Clinical care

30. When the man arrived at Belmarsh, reception healthcare staff were concerned about his physical and mental health and decided (appropriately) to place him as an in-patient in the healthcare centre. The man was supposed to be observed and baseline observations were to be taken. There is no evidence that the observations were carried out for the next five days. Because the observations were omitted from reception onwards, when they were taken on 7 December no comparisons could be made nor any change in his condition identified.

31. As well as failing to take the observations, healthcare staff did not carry out a physical examination until three days after the man was admitted as an in-patient.

Patients admitted to healthcare should undergo a thorough physical review. The exact nature of the review should be agreed with the PCT and set as a prison policy. It should include routine observations and a visual examination of the patient.

32. Five days after the man's arrival at the prison, a doctor requested regular observations and a number of blood tests. Again, there is no documentary evidence that the blood tests were carried out. It seems that only the observations of his blood pressure and pulse were carried out as requested.

33. It was the opinion of the clinical review panel that healthcare staff did not recognise the seriousness of the man's physical condition. Their apparent disregard was further compounded by their failure to use the range of routine observations. The outcome was that the man's condition was not diagnosed, his symptoms were not acted upon in an appropriate and timely manner, and transfer to hospital was delayed.

All patients admitted to healthcare should be monitored routinely and appropriately for their condition. Where clinically indicated, this should include routine measurements of temperature, blood pressure and pulse. If a decision is taken not to undertake such observations, the rationale for such a decision must be recorded in the medical record.

34. The failure properly to monitor his health was compounded by inadequate nursing records. There is no evidence of continuous nursing notes or of an appropriate care plan to identify and meet his nursing needs. The clinical review panel could find no evidence of a named doctor or nurse who should have taken responsibility for co-ordinating care.

Existing policies for a "named nurse" and "named doctor" should be further developed in line with normal NHS arrangements and fully implemented. These should include that the named nurse writes a formal nursing plan that assesses, plans, implements and evaluates evidence based nursing care.

35. The clinical review panel concluded that the man died of multi-organ failure and a septic left shoulder that could have been diagnosed while he was at Belmarsh. I concur with their opinion that the care afforded to the man was below acceptable standards.

36. It is the clinical reviewer's opinion that the standard of record keeping does not meet the standards laid down by the relevant professional bodies. The medical record is difficult to decipher, and this could have reduced its usefulness as a communication tool for healthcare professionals. Many entries were unsigned or signed illegibly and only two entries included the time.

    Training in record keeping standards expected at the prison, in line with professional guidance from the Nursing and Midwifery Council and the General Medical Council, should be made mandatory for all healthcare staff, including contracted doctors.

    All healthcare staff making entries in the medical record must sign and print their name, as well as note their professional role.

37. The panel also considered clinical reviews of earlier deaths at Belmarsh and found a pattern emerging of the need for a holistic approach to patient care. In view of the delay in producing this report, I do not propose to make a formal recommendation. But I hope that the PCT has taken action and redressed the apparent imbalance between attention paid to mental health problems and physical health needs.

Bedwatch logs

38. The bedwatch log is a comprehensive document which provides the bedwatch officers and their managers with clear guidance about their roles and responsibilities. The manager's check list has clear prompts to ensure that appropriate checks are made and it is a well documented audit trail. The majority of entries in the log are informative and give a clear picture of the man's time in hospital.

Communication with the man's brother

39. The man's brother found out that he had been admitted to prison from a friend who was a serving police officer. He then contacted the prison for verification of this information. The man's brother was later contacted by the prison chaplain to inform him that he had been admitted to hospital.

40. When his brother arrived at the ward, he was initially stopped from visiting until security checks were carried out. I appreciate that these measures are necessary, but advance information would have reduced his frustration

    The Governor should consider adding a prompt to the bedwatch instructions regarding any visiting restrictions and security measures.

Use of restraints

41. When the man was first admitted to hospital, the initial risk assessment was appropriately completed. His security record was checked and there was no information about his behaviour at Belmarsh which was a problem. He had no history of attempting to escape or of violent behaviour. Risk to the public, likelihood of escape, outside assistance to escape, risk to hospital staff or of hostage taking, were all considered to be low. Furthermore, the man had no relevant pre-convictions. The initial assessment, which is the usual level of bedwatch security, was that handcuffs were to be used at all times and were not to be removed for treatment or consultation except in the event of an emergency. This initial assessment seems to have been right.

42. However, the man was evidently poorly and confused. He was asleep most of the time and his condition was worsening. It is somewhat surprising, therefore, that the restraints were not reviewed for the next six days until he was transferred to the Intensive Care Unit. When the duty governor was asked to review the level of restraint, the request came from the bedwatch officers rather than the visiting managers.

    The Governor should consider an additional prompt to all managers' check lists to ask them to consider if the current level of restraints is appropriate to the clinical condition or should be reviewed.

CONCLUSION

43. The man was only at Belmarsh for a short period of time. After less than six days, he was admitted to Queen Elizabeth Hospital with multi-organ failure and a septic shoulder from which he did not recover. However, whilst it might not have altered the eventual outcome, the less than satisfactory standards of care meant that a timely diagnosis did not occur. There was an apparent imbalance between the attention paid to his mental health problems and physical health needs, resulting in delays in referring him to hospital.

44. I have made seven recommendations which I hope the Governor and Greenwich Teaching Primary Care Trust will see as a further opportunity to improve the standards of in-patient care.

RECOMMENDATIONS

Since issuing the draft report the prison have accepted all the recommendations and will be taking action to address them in a timely manner.

1. **Patients admitted to healthcare should undergo a thorough physical review. The exact nature of the review should be agreed with the PCT and set as a prison policy. It should include routine observations and a visual examination of the patient.**

2. **All patients admitted to healthcare should be monitored routinely and appropriately for their condition. Where clinically indicated, this should include routine measurements of temperature, blood pressure and pulse. If a decision is taken not to undertake such observations, the rationale for such a decision must be recorded in the medical record.**

3. **Existing policies for a "named nurse" and "named doctor" should be further developed in line with normal NHS arrangements and fully implemented. These should include that the named nurse writes a formal nursing plan that assesses, plans, implements and evaluates evidence based nursing care.**

4. **Training in record keeping standards expected at the prison, in line with professional guidance from the Nursing and Midwifery Council and the General Medical Council, should be made mandatory for all healthcare staff, including contracted doctors.**

5. **All healthcare staff making entries in the medical record must sign and print their name, as well as note their professional role.**

6. **The Governor should consider adding a prompt to the bedwatch instructions regarding any visiting restrictions and security measures.**

7. **The Governor should consider an additional prompt to all managers' check lists to ask them to consider if the current level of restraints is appropriate to the clinical condition or should be reviewed.**

ANNEXES

1. Clinical Review
2. Clinical Record
3. Documents considered as part of the investigation