

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Preston,
in March 2006**

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

April 2007

This is the report of an investigation into the circumstances of the death of a man in March 2006. At the time of his death he was a prisoner at HMP Preston. The post mortem report indicates that the man died from pneumonia and complications arising from his general poor health. He was 60 years old.

I would like to extend my condolences to the man's family and friends for their unexpected and sad loss.

The investigation was carried out on my behalf by one of my investigators. One of my family liaison officers provided liaison with the man's family. An independent review into the man's medical care and treatment was undertaken by the Head of Operations at Salford Primary Care Trust (PCT). I am most grateful for her assistance. I am also grateful to the Governor and staff of Preston for their ready co-operation with this investigation.

This report makes four recommendations. I am critical of the way the prison handled liaison with the man's family, and make a recommendation designed to improve the management of the prison-family relationship in the future. Two other recommendations are concerned with clinical record keeping. I also draw attention to an area of good practice.

This report has been slightly amended to provide an anonymised version however, it is, in essence the same as the final report.

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Prisons and Probation Ombudsman

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SUMMARY

The man who is the subject of this report was sentenced to five years and four months imprisonment in May 2005 and sent to HMP Preston. He had not been in prison before. He went through the usual first night in custody procedures without reporting any concerns, besides those related to his health. The man was taking several medications and used a wheelchair, so was automatically allocated to the healthcare unit.

Once settled, the man formed several friendships with other patients and the many staff members who looked after him. Although his health was changeable, he tried to maintain his independence and was provided with a daily carer.

In both February and March 2006, the man experienced choking fits. Following the second fit, he was transferred to the Medical Assessment Unit at the local Hospital. He was diagnosed with a chest infection and was treated with intravenous antibiotics.

The man was visited by both his mother and a friend during a day at the end of March. The next day, a doctor explained the seriousness of his situation to him. Following a further decline, he died at 6.00pm. The chaplain was present at the time, as was the man's next of kin.

The clinical review, carried out as part of this investigation, does not identify any specific issues relating to the clinical care the man's 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 related to the prison's approach to family liaison.

THE INVESTIGATION PROCESS

1. This investigation was formally opened in March 2006 when one of my investigators, issued notices to staff and prisoners at HMP Preston. The notices invited anyone who might have information relating to the man who died to make themselves known. In the event no-one came forward. My investigator was also provided with copies of the man's prison files, including his main prison record and his medical records.
2. Salford Primary Care Trust identified their Head of Operations, to lead a review of the man's clinical care. I am grateful for her assistance in this investigation.
3. The investigation team visited Preston prison in September 2006. They met with one of the prison governors, and also informally interviewed staff on the healthcare wing who had known the man and been involved in his care.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.
5. One of my Family Liaison Officers contacted the man's family to inform them of this investigation and to provide an opportunity to contribute. Subsequently, he and my investigator visited the family. The family raised a number of concerns, some regarding the healthcare their father received while in Preston. I hope this report, particularly the comments made by the clinical reviewer, will go some way in providing reassurance on this matter. The man's daughters were also upset about how they were informed of their father's death and subsequently dealt with by the prison. These concerns are examined further in this report.
6. A draft version of this report was sent to the Prison Service. An action plan was provided which indicated whether they accepted the recommendations or not and how they intend to deal with the recommendations. The responses can be found under the recommendations section of this report and have been reproduced in verbatim.
7. The man's family were also given the opportunity to respond to the draft.

MR RONALD HODGES

8. The man was born into a farming family and, despite being diagnosed with multiple sclerosis at the age of 20, he was able to work until his late thirties.
9. He was sentenced to five years and four months imprisonment in May 2005. On reception at HMP Preston, he reported that he had been married but was now a widower. He said he had two daughters, although he had not been in contact with them since his arrest. He gave the name of a friend, whom he described as "his carer", as his next of kin. Before his imprisonment, the man was also in daily contact by telephone with his 90 year old mother.
10. In prison, the man was friendly with others on the healthcare unit. He was often visited in his room by other prisoners who helped him out when they could. He developed friendships with both prisoners and staff and had settled well into life in Preston.
11. Multiple sclerosis had left the man dependent on the support of others for the activities of daily living. He had had a leg amputated in 1988 and had suffered two heart attacks. Coupled with the associated problems of multiple sclerosis, his health was far from good.

HMP PRESTON

12. Preston is a local prison for adult male prisoners. Its function is to hold prisoners who have been remanded by the courts and those on short sentences. The daily population is about 650.
13. The provision of healthcare within the prison is the commissioning responsibility of Preston Primary Care Trust. It is essentially a primary care led service, but does provide some secondary out-patient clinics. There is a small in-patient facility which provides care for patients with primary mental health needs and those with primary physical health needs. Twenty-four hour nursing care is available with an on-call GP service to support the nursing staff.
14. The prison was last inspected by HM Chief Inspector of Prisons in July 2004. The inspection found that Preston, like most local prisons, struggled with a history of under-investment and rising numbers of prisoners. However, it had made some headway since its last inspection, with a clear vision of what needed to be done to provide positive outcomes for those in its charge.
15. Mr Hodges's death is the fourth death, all from natural causes, to have occurred at Preston since April 2004. I have identified no common themes between this investigation and the other three.

KEY FINDINGS

16. The man was sentenced to five years and four months imprisonment in May 2005 and sent to HMP Preston. He arrived at the prison with a warning from the court probation officer who said that the author of the pre sentence report felt him to be a potential suicide risk. He also highlighted the man's medical needs, noting he was a wheelchair user and had many health problems.
17. The First Reception Health Screen remarks that the man had been registered with a doctor in the community who had seen him regularly. He said that he had not been in prison before, and the healthcare worker completing his form wrote that he was "frail and wheelchair bound". The man reported that he had been diagnosed with multiple sclerosis at the age of 20. In 1988, he had had his lower left leg amputated. He had apparently taken an overdose a year earlier, and also reported that he had previously had two heart attacks. He also had a urinary catheter.
18. After further discussion, the man said he had no thoughts of suicide or self harm although he was concerned about his own physical health. His past self harm was explored in detail and the healthcare worker, who asked very specific questions, judged him not to be at risk of self harm or suicide. The healthcare worker then recorded that the man would need full assistance, in his daily life.
19. As he had such extensive health needs, the man was appropriately admitted directly to the prison's healthcare unit.
20. A few days later, a Custody and Care Plan was instigated for the man. This is a local plan particular to HMP Preston. The aim is to ensure "a continuity of care involving the whole prison responding to the personal, social and emotional needs of the offender while in custody." Part one of this process is an assessment to identify and target the immediate needs of the prisoner. Again the complications of the man's medical needs were identified and his previous self harm was noted. His induction to the prison's rules, regulations and regimes was also completed on this day.
21. The man was using a manual wheelchair provided by the prison. However, it was decided that his mobility and independence would benefit from the use of his own electric wheelchair. This was eventually delivered to the prison seven months after the man had arrived there. Neither my investigator nor the clinical reviewer has been able to establish the reason for this unacceptable delay.
22. Referrals for both occupational therapy and physiotherapy assessments were made. As a result, new equipment to aid the man was purchased, including a hoist for the bath which all staff members were trained to use. Owing to his limited mobility, the man had regular assessments to ensure he was not suffering from sores on his skin. Staff also encouraged him to shower daily to maintain the good health of his skin. A pressure relieving mattress was provided.

23. As acknowledged at reception, the man needed daily personal assistance. A nurse from a local agency was identified and it was agreed she would become a carer for the man, visiting the prison every morning to help him wash and dress and to deal with any nursing needs. Staff reported that he liked things done “just so”. The use of an identified named nurse helped him retain his dignity and a degree of pride.
24. Staff were also imaginative in dealing with the particular challenges presented by the man’s health needs in a prison setting. For example, when they realised that due to his immobility he could not reach the call bell in his room, staff arranged for a baby monitor to be provided. In this way they could respond quickly if he required help.
25. A few weeks after the man’s reception, he was allocated to HMP Wymott with a view to undertaking an offending behaviour course. However, a note in his core file suggested that healthcare staff should be consulted before a transfer was agreed. The man told staff that he did not want to move as he had become settled at Preston. In the end, the move did not take place. The notes say that nowhere suitable for his needs could be found.
26. In February 2006, the man expressed concern to staff that he was alone in his cell. Healthcare staff responded to this anxiety and, by mutual consent, another prisoner soon moved to share the room with him.
27. The man’s wing file shows that he had settled in well at Preston, and was generally cheerful and sociable. However, his health remained unstable, and his condition started to deteriorate in February 2006. He began to experience increased pain, and was described as becoming unsteady and weak. The clinical reviewer notes that his condition was appropriately reassessed. The spasms associated with his multiple sclerosis worsened, and his doctor sought advice from other colleagues within the acute hospital sector. Following this consultation, the man’s medication was also reviewed. His medical records show that an increase in nursing care during these episodes afforded him the opportunity to maintain independence and his daily routine.
28. In late February, following an increase in his muscle spasms, the man suffered a choking episode. Although there appeared to be no ill effects, in early March he had a second episode of choking. On this occasion he required oxygen, and a liquid diet was ordered as were blood tests. Night staff later accessed the man cell and ensured he was comfortable. At this point, consideration was given to transferring him to hospital.
29. In mid March, the man was transferred to the Medical Assessment Unit at the Hospital. The accompanying letter explained his condition and cited slurred speech, extreme weakness and difficulty in swallowing. The admission assessment carried out at the hospital shows that the man had a chest infection (aspiration pneumonia), and was treated with intravenous antibiotics.

30. The man's younger daughter had not been in touch with him since he had been arrested and charged. However, she told my investigator she was often worried about him, especially because of his poor health. She said she was anxious to know that he was being looked after properly in the prison environment. She told my investigator that she contacted the prison on the day he had been admitted to hospital, and spoke to someone there. She did not know their name or the part of the prison they were speaking from. She was told that her father was "still with them". His daughter said she left her name and a telephone contact number, should anything happen to her father.
31. Initially, the man was handcuffed while at the hospital. However his position was reviewed later that evening. It was agreed that, given his ill health, there was little risk of escape and the cuffs should therefore not be used.
32. Some improvement was noted a few days later, but in mid March it was recorded that the man had further deteriorated. During this time, prison healthcare maintained telephone contact with the hospital, checking on his condition and well-being.
33. A week after the man had been admitted to hospital the prison chaplain visited him and took details of his next of kin. He returned later that afternoon to say he had managed to contact them, and had given information to them about how to book a visit. At about the same time, the man's named next of kin, arrived to visit with a friend.
34. The man was visited by both his mother and a friend the next day. He was later seen by a consultant who predicted that he would be in hospital for another week.
35. The next day, the bed watch log shows a doctor visited the man and explained the seriousness of his condition to him.
36. The man's younger daughter was contacted by a male chaplain from the prison the same day (she could not remember a name). He told her that her father was in hospital and gave her the details should she wish to telephone or visit. She phoned the hospital at 4.15pm that day and spoke to the officer who was carrying out the bed watch. She asked about her father, and the officer said that he was "doing alright".
37. The man's younger daughter then contacted her older sister who lives in Portugal. When they spoke they agreed to contact the hospital again.
38. Following a further decline in his health, the man died at 6.00pm that evening. The chaplain was present, together with the man's next of kin.
39. Staff who were on bed watch duty at the hospital contacted the control room at Preston prison to say that the man had died. The control room log shows that the contingency plans for a death in custody were activated and followed

appropriately. The relevant staff were contacted and informed and the staff involved were debriefed and supported.

40. The death in custody incident log shows the Governor, Deputy Governor, Area Manager and Prison Service National Operations Unit (NOU) were informed within an hour of the death. The Coroner's officer was informed, as were the police. The incident reporting form shows the man's nominated next of kin as his sister, contrary to the facts. The man had given his previous carer as his next of kin when he came to Preston and this remained the same until he died.
41. The man's older daughter said that when she phoned the hospital, as agreed with her sister, she was told by a bed watch officer that she could not speak to her father. When she asked why this was, she said the person on the other end of the telephone replied, "well he is dead". There was no further contact from the prison that night.
42. The bed watch log notes that at 7.20pm the man's "sister rang from Portugal, informed of death". This entry is incorrect, as the call came from the man's daughter and not his sister. It is signed by the bed watch officer.
43. After the man had died, his next of kin left the hospital to inform the man's mother of the loss of her son.
44. Four weeks after the man's death, the Governor of Preston, wrote to both his daughters. He offered himself and a family liaison officer (FLO), should the family need to contact the prison for any reason. My Investigator was given copies of these letters, however when she spoke to the family they were adamant that they had not received them.

ISSUES

The man's Medical Care

45. In accordance with procedures agreed with the Department of Health, my investigator advised Salford Primary Care Trust (PCT) of the man's death. The PCT then arranged to undertake a clinical review of the healthcare provided to him while in prison. The Head of Operations at Salford PCT, undertook the review. She examined the man's medical notes and visited the healthcare unit at Preston to carry out joint interviews with my investigator.
46. As noted earlier, when the man was received into prison in March 2005, he was wheelchair bound, suffered from multiple sclerosis, had had two previous heart attacks and had various difficulties associated with being in a wheelchair and limited movement. The post mortem report shows he died from a pulmonary embolus, recumbency, aspiration pneumonia due to stem cell infarction and generalised degenerative arteriopathy.
47. Staff reported that the man was cheerful and well liked by prisoners and staff alike. Other prisoners seemed to have developed a protective attitude towards him and were constantly in and out of his room, helping and supporting him. The design of the healthcare unit means prisoners are able to move freely between the bathroom, TV room and the servery. Staff said that, despite his disability, the man tried to maintain his independence. With his electric wheelchair, a full time carer and the help of other prisoners and staff, he was able to do this.
48. The clinical reviewer judges that the bathroom facilities were unsuitable for disabled access and believes that they discriminate against those reliant upon a wheelchair. Whilst I acknowledge that Preston is a prison of Victorian design, it is a requirement under the Disability Discrimination Act that facilities are accessible or that reasonable adjustments are made. I note, however, that a transfer was arranged to place the man in a prison more suitable to his needs but he said he had settled in at Preston and did not want to move.
49. In reviewing the bed watch log, it is clear that the staff involved behaved with compassion and sensitivity. The security arrangements in the hospital seem to have been appropriate, striking a good balance between public protection and sensitivity to the man's condition.
50. In light of the clinical review and my own investigation, I am satisfied that the man's care was appropriate. However, the clinical reviewer does raise concerns about the completion of medical records. Not all entries were signed, dated or legible. There was no chronological order to the entries and there were separate medical and nursing records. The clinical reviewer also considers that there was evidence of laziness when completing such records, with staff members compressing their entries onto the bottom of a page, instead of starting a new sheet.

The record keeping policy should be revised. All staff should then be made aware of the renewed policy and receive a copy to sign, confirming that it has been read and understood.

A record keeping audit should be developed and undertaken within six months of the publication of this report to assess adherence to appropriate standards of records and record keeping.

51. All that said, there is ample evidence that healthcare staff met the man's identified nursing needs very well. They thought imaginatively and addressed some of the specific challenges, for example, providing the baby monitor. Equally, the use of a dedicated pool of staff gave him the support and dignity to manage his condition.

The healthcare team should be commended for their management of the man and the innovative ways they enabled him to maintain his independence.

Family Liaison

52. I am concerned that, when the man's younger daughter first contacted the prison, it does not appear that she was put in touch with anyone dealing with her father or who had knowledge of him. I note that this was the very day her father was admitted to hospital, but no mention was made of this at the time. Nor was any effort made later to contact her and let her know where her father was. Equally disappointing is the fact that, when she did talk to an officer at the hospital on the day her father died, the conversation did not reflect the seriousness of her father's condition. Had she been made aware of how ill he was, she could have travelled to the hospital and spoken with him before he died.

53. If the account of the man's older daughter is correct, I am appalled that a family member could be told of the death of a loved one in such an insensitive way. When my investigator contacted the officer involved, he said that he remembered the phone call very clearly. He explained that he believed that the man's relatives had already been informed about his death. The officer said he felt sure that he was not rude or abrupt on the phone, however he said he did feel uneasy at having to break such news. He thought he had said 'I'm sorry to tell you but he has just died' and said he was sorry if the man's daughter was offended. He offered his apologies and said he could understand how the family felt. Whatever may actually have been said at that time, it is clear that there was no further contact from the prison that night.

54. Having still not heard anything a few days later, the man's younger daughter telephoned the prison to arrange to collect her father's personal effects. She said this proved to be very difficult, and the person who seemed to be responsible could not be contacted. Again, without noting the name, she said she was told by a staff member that she should travel to the prison the next day.

55. When the man's daughter arrived at the prison the next day, she says she was kept waiting for over half an hour. Eventually she was seen by the designated family liaison officer, who said that she was unable to release the man's personal effects, as neither daughter was the nominated next of kin. The FLO explained that she and the chaplain would visit the man's daughter at her home, and would discuss what had happened, including what would happen to her father's belongings.
56. The man's daughter told my investigator that, on the day of the arranged visit, she was contacted by the chaplain who apologised that he could not attend. He thought that the FLO was still going to attend, but this did not happen and she did not telephone to explain. A few weeks later the FLO telephoned, and said she was sorry she had not been able to make the visit. The man's daughter told her that she was angry, and the FLO said she had thought it best to give the family time to grieve. The man's daughter said she found this attitude condescending, and it was hardly an apology for the upset that had been caused.
57. When my investigator put these concerns to the governor, he was rightly concerned and offered to meet the family to offer his personal apologies. However, the man's daughters felt that it was too late, and did not want to meet with any representatives of the Prison Service personnel.
58. Subsequently Preston prison has met all the funeral costs, and the man's personal effects have been returned to his daughters, albeit after some considerable time.
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 requires a contact log to be kept recording all contact between the prison's Family Liaison Officer and the family. It requires the prison to consider the complete family and other interested parties, not just the person nominated as the next of kin. Additionally, Preston has a detailed local policy for dealing with a death in custody, with direction given about procedures for notifying the family and providing follow-up support. I consider that the standard of family liaison offered by the prison in this case was poor and failed to comply with PSO 2710.

The Governor of Preston should review, with immediate effect, the prison's policy on responding to the needs of families after 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.

Following the publication of the draft version of this report, the prison service offered the following comments.

“There are clearly issues about the contact with the family, and in particular *the man’s* daughters. It is also understood that some confusion arose over the status of the ‘next of kin’, in relation to the release of *the man’s* property. It is understood that the establishment took legal advice about this matter which confirmed that *the man’s* belongings should only be released to the next of kin ... Notwithstanding the issue of the status of the next of kin, the criticisms of the contact with *the man’s* daughters are accepted; it was regrettable that *his younger daughter* was, when she attended the prison, kept waiting and that the subsequent meeting which had been arranged did not go ahead. This would appear to have arisen because of a misunderstanding following the Chaplain’s telephone call to *the man’s older daughter* as it was understood that the daughter would contact the prison to arrange a further date for that meeting, given that she lives in Portugal. *The FLO*, who subsequently contacted *his younger daughter* when the family had not been in touch does not believe her attitude to have been ‘condescending’, and but would again offer her apologies if this is how the call was perceived.”

The man’s daughters commented that the bed watch officer had been put in a terrible position and they felt that this confusion was an example of the wider problem of poor communication which existed. They also reiterated their regret at not having received the letters of condolences from the prison. Perhaps if they had been received, the communication between the family and the prison would not have been so disconcerting. The governor may wish to consider if such letters, designed to open up communication with a family, should not be sent by way of registered or guaranteed post.

RECOMMENDATIONS

- 1. The record keeping policy should be revised. All staff should then be made aware of the renewed policy and receive a copy to sign, confirming that it has been read and understood.**

Accepted. A Preston PCT record keeping policy is in place, however with the recent reconfiguration of the PCT now Central Lancashire PCT a review of all Clinical Policies is taking place. A training session on record keeping was delivered to staff in November 2006

- 2. A record keeping audit should be developed and undertaken within six months of the publication of this report to assess adherence to appropriate standards of records and record keeping.**

Accepted. The record keeping audit now forms part of the Healthcare Audit Calendar. A sample of five records per month is audited against the Policy requirements and Nursing and Midwifery Council Standards. These findings are reported to the PCT and Clinical Governance Group (joint PCT and HMP)

- 3. The healthcare team should be commended for their management of the man and the innovative ways they enabled him to maintain his independence.**

Accepted. The Head of healthcare (PCT) has conveyed this to staff.

- 4. The Governor of Preston should review, with immediate effect, the prison's policy on responding to the needs of families after 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.**

Accepted. The prison's policy on responding to the needs of the family following a death in custody will be reviewed. The review will include emphasis on the importance of a maintaining a family liaison log. Two Governor Grades have secured placed in a Family Liaison Course in April 2007.

