

**INVESTIGATION INTO THE DEATH OF A MAN
AT A HOSPITAL ON 1 APRIL 2006,
WHILST IN CUSTODY AT HMP BELMARSH**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN
FOR ENGLAND AND WALES**

October 2006

This is the report of an investigation into the circumstances of the death of a man. He died at a hospital in London on Saturday 1 April at 9.30am. At the time of his death, he was a sentenced prisoner at HMP Belmarsh and was aged 48 years.

I offer my condolences to those touched by this man's passing.

A post mortem was carried out by a Home Office forensic pathologist on 3 April. The pathologist concluded that death was due to: (1a) Intracerebral Haemorrhage, and (2) Hypertensive Heart Disease and Diabetes Mellitus.

This investigation was carried out by one of my colleagues. A clinical review was also commissioned to examine the medical care and treatment this man received at Belmarsh. This has been carried out by the Head of Clinical Governance at Greenwich Primary Care Trust, to whom I am most grateful.

I would also like to take this opportunity to thank the Governor of Belmarsh and her staff for their full co-operation and assistance with this investigation.

Finally, I would also like to place on record my thanks and appreciation for the dedication shown by prison staff in attempting to locate this man's relatives. Sadly, despite their efforts and those of police, no family member has been traced.

Stephen Shaw CBE
Prisons and Probation Ombudsman

October 2006

Contents

Introduction
Summary
Investigation Process
HMP Belmarsh
The deceased
Events leading to the man being taken into hospital.
Conclusions
Recommendations and Good Practice

Summary

The man arrived into custody on remand in July 2004. He had previous convictions and had served other custodial sentences. He was sentenced in December 2004 to five years imprisonment.

Whilst in HMP Belmarsh, he was located in the healthcare centre due to his complex medical history. He suffered from renal and liver failure along with cardiac problems. He required out patient appointments three times a week to receive dialysis. On reception at Belmarsh, he also admitted to having a substance misuse problem and underwent a methadone detoxification.

This man's health deteriorated over the following two years. He was reliant on a wheelchair, and needed oxygen day and night. He had several admissions as an inpatient to hospital for recognised complications with his dialysis.

On 31 March 2006, he attended hospital as usual for his dialysis. On his return to the prison, nothing abnormal was noted. However, during the night it became apparent that this man was not well. Staff sought advice from the on call doctor and manager. A 999 call was put out for an ambulance to attend the prison.

The man was taken as an emergency to a nearby hospital by a blue lighted ambulance. On arrival he was seen and admitted. A bedwatch log was then started. His prognosis was poor.

The following morning, after the consultant's ward round, a decision was made to turn off his life support. He died at 9.25am on Saturday 1 April.

No next of kin have been identified for this man. A solicitor has been the point of contact.

The Prisons and Probation Ombudsman's office was notified of the man's death on 7 April. The delay in notification appears to have been an oversight by the National Operations Unit, as the Incident Reporting System was up to date and the relevant details were sent on the day he died.

I make five recommendations in this report and identify three examples of good practice.

Investigation Process

This investigation was opened on 12 April 2006, when two of my colleagues visited Belmarsh and met with a member of staff from the secretariat office. She handed over the man's prison documents including his medical records. Original copies of Notices to the Governor, staff and prisoners were given to her. These notices were displayed around the prison. No members of the Prison Officers' Association (POA) or the Independent Monitoring Board (IMB) were present or had expressed a wish to see my investigators.

My investigators were taken to the healthcare centre and shown around. They also visited the cell that the man had occupied. No formal interviews were carried out during this investigation.

A clinical review was undertaken by the Head of Clinical Governance and a medical reviewer from Greenwich Primary Care Trust (PCT). The reviewers ascertained the level of care given to this man whilst he was in Belmarsh. They also examined the medical records, the quality of the entries made within them and any other matter relating to his care.

HMP Belmarsh

Belmarsh is a high security local prison which became operational on 2 April 1991.

The healthcare centre offers facilities for inpatients and outpatient clinics, and has a purpose built therapy unit. The centre has an operational capacity of 32 beds, mainly used for psychiatric care. There is also an Intensive care suite and special observation room, both of which are single occupancy. The accommodation consists of 20 single cells and 12 ward spaces. A clinical manager heads the staff complement which comprises nursing grades, healthcare officers, discipline officers and nursing assistants in conjunction with the psychiatric team. Outpatients facilities include daily GP clinics and nurse led clinics (asthma, coronary care, diabetes, HIV, hepatitis). All new patients receive a comprehensive health screen.

Healthcare is provided by officers and nurses employed by the Prison Service. GP services are provided by Thamesmead Medical Associates (TMA) under a contract arrangement with the prison, and psychiatric services are provided by Oxleas NHS Trust.

Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, reported in an unannounced follow up inspection of October 2005:

“Most of our 2003 recommendations about healthcare had not been addressed, although prisoner perceptions about the quality of healthcare and the service from doctors had improved. There was a very limited regime for inpatients, who had poor access to regular exercise and limited association opportunities.”

The man

The man was born on 29 April 1957 in Bulawayo, Zimbabwe. He was 48 years old when he died. He was a keen artist and had decorated the healthcare centre with some of his work.

He had been in custody since July 2004, first on remand then as a convicted prisoner. He was sentenced on 16 December 2004 to five years imprisonment. He had served two previous custodial sentences in Zimbabwe in 1975 and 1981. He came to London in 1988, under an alias.. He served further custodial sentences in 1996 and 1998.

By the time of his reception to Belmarsh, he was already receiving dialysis three times a week for chronic kidney failure in a hospital with appropriate facilities. In addition, he had poor cardiac function and a past history of hepatitis C. He spent his time in Belmarsh located in the healthcare centre. On his visits to hospital, he was escorted by prison staff. On several occasions, he had been an inpatient at hospital due to his complex medical history.

The chaplain at Belmarsh visited the man on a weekly basis. It appears that he had no contact with any family. No family member was listed on his prison records, and he received no visits and made no telephone calls of a personal nature whilst in prison.

The chaplain believes that the man had been married in Zimbabwe and had a daughter. The marriage ended and the man came to London. It is not known if he ever divorced. After his arrival in London, he had another relationship and another daughter. It is thought that the child was adopted.

Since his death, a firm of solicitors in London have been the point of contact. To date, no family members have been identified. This apparently is in accordance with the man's own wishes.

Events leading to the man's death

The man was arrested on 19 July 2004 and held in police custody at Kentish Town before being remanded to HMP Belmarsh. Whilst in police custody, he was seen and assessed by a forensic medical examiner (FME). The FME recorded that he suffered from liver failure, hepatitis C and congestive cardiac failure (CCF). He was being cared for as an out patient at a London hospital (under the care of a consultant nephrologist), where he received dialysis three times a week.

The man arrived at Belmarsh as a remand prisoner on 20 July 2004. Due to his complex medical history, he was located in the healthcare centre. He was seen and assessed on his arrival where the doctor noted that he suffered from liver and renal failure. It was also noted that the man received dialysis on Monday, Wednesday and Friday of each week. He also required the use of oxygen day and night.

He smoked, and was encouraged to reduce the amount of tobacco he consumed, especially whilst receiving his oxygen. His first visit to hospital for dialysis occurred the day after his arrival at Belmarsh. On his return, his condition was recorded as satisfactory.

Whilst in Belmarsh he commenced a methadone detoxification programme on 22 July. On his first reception health screen, he admitted to previously being an intravenous drug user and currently abusing methadone. There was no history recorded of self harm or mental health issues.

However, on 27 July a Form 2052SH (self harm monitoring form) was opened on him. An officer was concerned after a search of the man's property. During this search, the officer came across a letter that stated "if things don't improve I will ease the pressures myself". This letter was assessed in conjunction with the fact that, if convicted, he would be facing a lengthy sentence. When the man was asked about this, he said that he would "speak to his solicitors to ease the pressures". The F2052SH form remained open until 7 September 2004. Throughout that time there were no incidences of self harm, and the man maintained that was never his intention.

Over the next two years, he remained on the healthcare centre at Belmarsh. He received his dialysis three times a week. The level of escort changed over a period of time. Initially, it was felt that restraints should be used for public protection. During the last months of his life, he attended a London hospital under escort but without the use of restraints. It was felt that this was appropriate due to his poor prognosis and his failing health which required him to resort eventually to using a wheelchair.

The man was a quiet prisoner who kept himself to himself; on the whole he did not cause the staff any concern. A care package was in place to assist him with daily routines, for example cleaning his cell and attending to his personal hygiene.

He had several admissions to hospital for short periods and these were due to infections in his Hickman line (a fine plastic canula inserted into a vein to allow

administration of drugs). Infections are a recognised complication of these lines. The man was usually noted as being compliant with his medication. Over a period of time his health deteriorated and his care plans were adjusted accordingly. Towards the end of his life, he was extremely poorly.

On Friday 31 March 2006, this man attended the hospital for dialysis. His weight was recorded as 60.9kgs pre-dialysis. Apart from complaining about toothache, there was nothing abnormal noted about him on his return from hospital..

During a night time check at 11.15pm, the man complained of left sided numbness and appeared distressed. When asked if he was in pain he said "no" but his reactions indicated something different. His observations (pulse and blood pressure) were taken. The prison's on call doctor, was contacted, and the advice given was that he should be taken to the Accident and Emergency Department at a nearby hospital.

An entry to reflect the above was recorded in the healthcare centre's observation book: "Whilst doing intermittent watch on prisoner he was seen to be unwell. He was unlocked so staff could check on him. Obs were done and duty doctor and manager were called. Blue light ambulance called and prisoner has been taken to A&E." This entry was written by an officer.

The incident log sheet shows that at 11.51pm the ambulance was called. It arrived at midnight and left for the hospital at 00.29am. At approximately 1am, a nurse assessed the prisoner and stated that he would be admitted.

In attendance were two Officers. They commenced a bedwatch log. The man Was in restraints at this time but they were removed at the request of a doctor at 2.45am. A call was made to inform the prison that this was the case. At 4.20am, he went for a CT scan. He was then moved to the ITU (intensive care unit). The prognosis was not good and he was expected to die. The restraints were never reapplied. Another officer took over the bedwatch at 9am after being briefed by the night staff.

On the morning ward round made by the consultant, the decision was made to turn off his life support. The man passed away at 9.30am.

Issues

Was the man appropriately screened on reception to Belmarsh?

The clinical reviewer has concluded that there are inappropriate entries made within the initial medical screening form. Under the section “record any health related observations about the prisoner’s physical appearance” the words “appears a physical wreck!” have been written. The reviewer finds that this entry, along with others, is unhelpful, inappropriate and insulting and suggests that the prison takes a trivial approach to health screening. It is recorded that the man was receiving weekly dialysis and medication at a London hospital. He was appropriately placed within the healthcare centre. There was regular dialogue between the prison and the hospital where he had been receiving dialysis to ensure that his medical needs were met.

Did the man receive quality physical care?

The clinical review concludes that histories were taken from the man to establish the nature of his many health problems. The medical records contain evidence of a caring approach by prison staff and the visiting GP service. Regular appointments with secondary care were kept up during the man’s confinement at Belmarsh so that appropriate care could be provided.

Did the man receive equitable healthcare?

The clinical reviewer finds that the care provided to the man was equitable with the care that might have been provided had he not been a prisoner.

Conclusions

Bedwatch Entries

This bedwatch ran for approximately 9 hours in total. The entries in the log are to relay information about the prisoner from staff to staff. They should be decent and respectful of the patient. All of the entries complied with the instructions given to officers.

Use of Restraints

The man had been attending hospital for over two years. He had not been in restraints for some time due to his ill health. I therefore question the use and necessity of the restraints used to convey him to the Accident and Emergency Department on 31 March (they were removed after two hours or so at the request of the hospital doctors) However, it must be appreciated that the Orderly Officer (person in charge of the prison at night with limited staff on duty) made a decision in difficult circumstances and without prior knowledge of this man. I accept that his decision was appropriate in the light of the limited information he had at the time.

Record Keeping.

There was regular communication between the hospital where the man received dialysis and Belmarsh relating to the man and the care he required. His medical records were kept up to date, although names are not printed alongside the signatures of medical staff as they should be. The clinical review concludes that the standard of record keeping was not acceptable. I would also suggest that the Governor, in conjunction with the PCT, considers the prospects for computerising medical records as this is becoming more and more the norm.

Recommendations

- The Governor should remind all healthcare staff that entries in a prisoner's medical record must be signed and accompanied by the author's name in print.
- I and the clinical reviewer would urge the Governor to think about the implementation of computerised medical records. They would be especially useful for a man like this who had such complex medical issues over a long period of time. They also allay any problems with identifying staff and reading entries that are not clear.
- The Governor should remind healthcare staff that use of inappropriate language is unacceptable. Entries in medical records should not be of a degrading or flippant nature.
- It is regrettable that this man was restrained on his final journey to hospital when more humane arrangements had already been in operation for several months. I recommend a review of relevant procedures in the healthcare centre with a view to ensuring that decisions about the use (and non-use) of restraints are consistent.
- I endorse the clinical reviewer's recommendation regarding dialysis. The Governor and PCT should consider the benefits of "Home dialysis" on an individual basis for all prisoners requiring dialysis treatments.

Good Practice

- Healthcare staff at Belmarsh managed this man's complex medical issues with patience and sensitivity.
- Communications between the hospital and prison health services seem to have been appropriate and are well documented. There is evidence of regular and ongoing correspondence between the services involved to ensure effective and safe treatment.
- There is evidence that this man's death was anticipated and that he had joined in discussions about dying with his GP at the prison and the chaplain.