Circumstances surrounding the death in January 2007 of a man who was a prisoner at HMP Bristol

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is the report of an investigation into the death of a man who was a prisoner at HMP Bristol. The man died from apparent natural causes on 21 January 2007 in a local hospital. He was 78 years old.

I would like to offer my personal condolences to all those touched by the man's death.

This investigation was undertaken by one of my investigators. He and I would like to thank the Governor of HMP Bristol and her staff for their assistance. A doctor was asked by Bristol Primary Care Trust to undertake a review of the man's clinical care and I also much appreciate his help.

I have endorsed three of the recommendations made in the clinical review.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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

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SUMMARY

The man was born in Jamaica in 1928. He was 78 years old when he died on 21 January 2007 in a local hospital.

The man had been sentenced to life imprisonment in 1962. He was released on licence in 1975, but recalled into custody in 1991. In July 1991, the man was sentenced to a further 11 years imprisonment at the Central Criminal Court.

During his first health screen at HMP Shepton Mallet in 2003, it was noted that the man had previously undergone heart surgery for a triple heart bypass and had glaucoma.

The man had been recategorised as a category D prisoner and was due to transfer to an open prison. However, this did not happen as the man was a foreign national prisoner and had to remain under closed conditions until the Immigration Service reviewed his status. This was a direct result of the national review of foreign national prisoners designed to prevent prisoners being released incorrectly before their immigration status had been confirmed.

On 13 October 2006, the man was admitted to a local hospital. While he was in hospital he was diagnosed as having metastatic nasopharyngeal carcinoma (throat cancer). The man was discharged from hospital on 16 October, but re-admitted on 22 October. After this, the man did not return to Shepton Mallet and, other than a short stay from 1 to 3 November in the healthcare centre at Bristol, he remained in outside hospital until his death.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The security risk assessment was that handcuffs were not to be used and that only a single officer needed to be at his bedside. The man's friends were allowed to visit him whilst he was in hospital.

The man passed away during the evening of 21 January 2007.

The clinical review concludes that the man's clinical care was appropriate and equivalent to that available in the community. I have endorsed three of the four recommendations in the clinical review.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record and medical records.

2. The Bristol Primary Care Trust identified a doctor, a member of the PCT's Professional Executive Committee, to carry out a review of the man's clinical care. I am grateful to him for undertaking the review.

3. My investigator contacted Her Majesty's Coroner to inform her 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 her in her enquiries into the man's death.

4. One of my Family Liaison Officers contacted a friend of the man who was his nominated next-of-kin. This was to offer her the opportunity to meet with the investigator to discuss the purpose of the investigation and to raise any concerns or questions. She chose not to raise any matters at that time. I hope this report addresses any concerns she may have about the circumstances surrounding the man's death.

5. My investigator did not visit HMP Bristol. However, he did discuss aspects of the man's treatment with staff at both Shepton Mallet and Bristol and with the clinical reviewer.

HMP BRISTOL AND HMP SHEPTON MALLET

HMP Bristol

6. HMP Bristol is an inner city Victorian prison located in the Horfield area of the city. It first opened in 1883. Bristol is a category B prison with an operational capacity of 606. There are seven wings with accommodation being a mixture of Victorian galleried landings and two wings designed in the 1960s.

7. Provision of healthcare within the prison is the responsibility of Bristol Primary Care Trust. The healthcare unit has 20 in-patient beds. The healthcare centre was refurbished and reopened in June 2004. It is situated in a block shared with the segregation unit. Although the area is clean, well furnished and provides a therapeutic environment, there is limited disabled access.

8. HM Chief Inspector of Prisons carried out a full announced inspection of the prison in January 2005. At the time of this inspection, it was noted that healthcare at Bristol had improved considerably. However, the healthcare service was fragile and there continued to be management and staffing issues which adversely impacted upon the delivery of care.

HMP Shepton Mallet

9. HMP Shepton Mallet is the oldest prison in continuous use in England and Wales. In August 2001, it became the first dedicated category C prison for life sentence prisoners and has an operational capacity of 189.

10. A report by the Chief Inspector of Prisons in 2005 recorded that prisoners were very positive about all aspects of healthcare at Shepton Mallet. Healthcare staff were described as well qualified, professional and caring. They had responded well to the healthcare needs of the lifer population, many of whom were older with long-term chronic conditions.

11. The healthcare unit is very small and has no inpatient facilities. However, there is good access to primary care and an appropriate range of visiting specialists.

KEY EVENTS

12. The man arrived at Shepton Mallet on 23 October 2003, after being previously held at Albany, Brixton and Wormwood Scrubs. During the health screening procedure at Shepton Mallet, it was noted that the man had glaucoma and had previously undergone surgery for a triple heart bypass. A range of medications were prescribed to treat his various conditions and he was allowed to keep these in his possession for self administration.

13. On 13 October 2006, after the man complained of intractable pain in his head, he was taken by ambulance to a local hospital. He was admitted to the ward and further tests were carried out. While he was in hospital he was diagnosed as having metastatic nasopharyngeal carcinoma (throat cancer). The man was discharged from hospital on 16 October and returned to Shepton Mallet.

14. The man's condition deteriorated and on 22 October he was again taken by ambulance to hospital. He did not return to Shepton Mallet, but was transferred to the healthcare centre at HMP Bristol on 1 November.

15. The reason the man did not return to Shepton Mallet was that he was receiving a controlled drug for pain relief and the prison does not have storage facilities for such medication. The Prison Healthcare Improvement Manager for Bristol Primary Care Trust discussed this with the Prison Medical Officer at Shepton Mallet and the Senior Specialist Pharmacist from Bristol Primary Care Trust. The Improvement Manager was advised that controlled drugs did not need to be stored at Shepton Mallet as they could be transported from Bristol in a sealed bag, signed for on receipt and applied directly to the patient. The Improvement Manager advised Shepton Mallet of this and was told that they would need approval from Somerset Primary Care Trust. However, Somerset Primary Care Trust did not give approval and the man had to be admitted to Bristol.

16. The In-Patient Manager at HMP Bristol re-iterated that the prison did not feel it was clinically safe for the man to move to Bristol. The In-Patient Manager was told by Shepton Mallet that they would contact the Area Prison Health Development Team. The Area Prison Health Development Team told Bristol that they had to admit the man. The Prison Healthcare Improvement Manager for Bristol Primary Care Trust told the Area Prison Health Development Team that she had concerns regarding clinical safety and the fact that the healthcare unit was on minimal staffing. The Area Prison Health Development Team recognised these concerns, but said there was no other choice in this matter. The man was admitted to the healthcare centre at Bristol at 8:00pm on 1 November.

17. The man returned to hospital on 3 November and remained there until his death. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The security risk assessment was that handcuffs were not to be used and that only a single officer needed to be in attendance. During his stay in hospital, the man was visited by friends and one of the chaplains at Shepton Mallet.

18. At around 9:50pm on 21 January 2007, the officer on bedwatch duty noticed that the man appeared to have stopped breathing. The officer informed the Staff Nurse who confirmed that the man had passed away. The officer immediately told the prison and also contacted the chaplain at Shepton Mallet.

19. The Head of Prisoner Management at Shepton Mallet contacted the man's nominated next-of-kin and several other friends to inform them of his death. HMP Bristol provided financial assistance towards the funeral costs and one of the chaplains from Shepton Mallet conducted the service at the man's funeral.

20. The post mortem identifies that the man's death was due to natural causes, as a consequence of congestive heart failure caused by coronary atherosclerosis (a degenerative change in the inner and middle coats of arteries in the heart). The clinical reviewer believes that the man's metastatic nasopharyngeal carcinoma (throat cancer) was a significant associated factor in the cause of his death.

21. I should also mention that the man had been recategorised as a category D prisoner and was due to transfer to an open prison. However, this did not happen as the man was a foreign national and had to remain under closed conditions until the Immigration Service reviewed his status. This was a direct result of the national review of foreign national prisoners designed to prevent prisoners being released incorrectly before their immigration status had been confirmed.

CLINICAL REVIEW

22. A review of the man's medical care was undertaken by a doctor on behalf of Bristol Primary Care Trust. The review found that the man had suffered from significant long-term chronic diseases.

23. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The clinical review concludes that there are no circumstances indicating that death could have been anticipated or prevented, but makes recommendations for improvements to clinical practice. The clinical reviewer draws attention to the good practice whereby the assessment of the man led to his admission to hospital being carried out in a timely manner.

24. The reviewer says that the man was well cared for in all clinical settings with timely diagnosis and treatment. However, he notes that Shepton Mallet and Bristol both had different medicine management policies. Prisoners in one prison were allowed to possess of opiates in the form of a patch whereas in another they were not. This made the management and transfer of prisoners difficult. The reviewer recommends that a single policy should be adopted across the local cluster of prisons.

25. The reviewer says that the man's condition led to his very rapid readmission as it could not be effectively managed in a prison healthcare setting. The reviewer notes that the man was admitted to the healthcare centre at Bristol with quite complex care needs and a plan for active support. He felt that this was beyond the realistic level of support that could be provided in this setting. The reviewer says that most patients who are looked after in prison healthcare centres have complex psychiatric conditions rather than physical needs. It is important to be clear in what circumstances complex care can be managed in the prison setting. The reviewer adds that there is a need to consider developing the capacity of prison healthcare to better support patients whose physical condition deteriorates and who are in need of more active rehabilitation or support. The reviewer notes that terminal care can and has been effectively managed at Bristol. He adds that care in transfer of patients and effective liaison with a clear clinical picture being present can lead to patients being safely supported. However, he says that closer liaison is needed in considering the needs of prisoners being transferred from acute hospitals to avoid discharges that are not in a patient's best interests, or whose needs cannot be managed effectively in a custodial setting.

    A single policy across the local cluster of prisons around opiates would make it easier to manage necessary transfers of prisoners.

    As the prison population becomes older there is a need to consider the development of medical rehabilitation and support in a local

prison to cater for more complex medical needs. This would need to be resourced and provided by a single centre on behalf of a group of prisons.

Closer liaison is needed in considering the needs of prisoners being transferred from Acute Hospitals to avoid discharges that are not in a patient's best interests.

26. The reviewer suggests that there appears to be a culture where prisoners who become debilitated, ill or likely to need long periods in hospital are transferred out of existing prisons to transfer the costs of bed watches, supervision and funeral costs to a different prison. He says that his discussions with a number of individuals suggest this is a significant problem. In this case, it appears that one element leading to reluctance to allow the man to return to his previous prison related to this issue. The reviewer argues that transfers are often not in the best interests of patients as they mean moving away from friends and from clinical staff with whom they have built relationships. In his review, the clinical reviewer recommends that, in order to avoid the financial incentive to transfer patients who have high needs, the cost of providing bed watches, supervision and funeral costs should remain the responsibility of a prison establishment for a three month period after transfer from the establishment.

27. In response to this recommendation, Somerset Primary Care Trust has said that the Healthcare Team at Shepton Mallet made a significant effort to determine which clinical setting would be best placed to provide the care needed by the man. They completed a detailed risk assessment which was reviewed by the Clinical Governance Manager, the Director for Provider Services responsible for the prison, and the Interim Director responsible for Nursing and Clinical Governance at Somerset Primary Care Trust.

28. Somerset Primary Care Trust added that there was also ongoing discussion between the healthcare departments at Shepton Mallet and Bristol. These discussions were between the Governor and the Senior Management Team at Shepton Mallet and the Deputy Governor at Bristol. The Deputy Governor at Bristol was well aware of the situation and said that the key factor in all their discussions was what was best for the man. A strategic decision was made by the Somerset Primary Care Trust that the healthcare team could not provide adequate care for the man in Shepton Mallet, as they operate a primary healthcare service that is not staffed during the out of hours period and has no in-patient facilities.

29. Somerset Primary Care Trust stressed that funding issues were not a priority and were never raised. The type of concerns that were highlighted by the Primary Care Trust were of clinical expertise, the issue of supplying controlled drugs within the prison and the fact that the man would need 24 hour nursing care. It was for these reasons, they

argued, that when the man was discharged from hospital he was transferred to Bristol as that prison has 24 hour healthcare which was more appropriate for his needs.

30. Whatever the particular circumstances in respect of the man, I am not personally persuaded that a prison should retain responsibility for healthcare and associated costs for a period of three months following a transfer.

CONCLUSION

31. The man had moved to Shepton Mallet in 2003. After he was transferred to a local hospital in November 2006, Bristol took responsibility for the security arrangements at the hospital. The man died of natural causes in the hospital in January 2007.

32. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital seem to have been suitable, and to have struck a good balance between public protection and respect for the man.

33. In light of the findings of the clinical review, and my own investigation, I conclude that the man's medical care was satisfactory.

RECOMMENDATIONS

Medical

1. **A single policy across the local cluster of prisons around opiates would make it easier to manage necessary transfers of prisoners.**

   Accepted - There are regional transfer protocols regarding transfer of prisoners on opiate medication in final draft form. This will be established across the south west. Best practice nationally in relation to opiates and opiate addiction was circulated when the Integrated Drug Treatment System was announced. The resources to fund this are currently not available; attempts have been made to provide an equivalent service at a local level

2. **As the prison population becomes older there is a need to consider the development of medical rehabilitation and support in a local prison to cater for more complex medical needs. This would need to be resourced and provided by a single centre on behalf of a group of prisons.**

   Partially accepted – Prison Service Instruction (PSI) 21/2001 National Service Framework (NSF) for Older People highlights the need for older people and their carers to experience well co-ordinated care and support. Proper assessment of the range and complexity of older people's needs and prompt provision of care improves ability to function independently. The NSF reinforces the message that NHS organisations are responsible for addressing the older people's health care needs, as local councils with social services responsibility are for addressing their social care needs. It stresses that these organisations must continue to develop their work in partnership with each other and with other agencies such as housing and prisons to deliver joined up services which address the full range of needs that older people have. It is up to the Primary Care Trust to accept how they would like to commission this.

3. **Closer liaison is needed in considering the needs of prisoners being transferred from Acute Hospitals to avoid discharges that are not in a patient's best interests.**

   Accepted - This would have to be done on a case by case basis and would involve a multi disciplinary conference before discharge back to prison.