

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF A MAN AT HMP ERLESTOKE IN AUGUST 2007**

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

February 2008

This is the report of an investigation into the death of a man. The man, who was in his early 70s, died from natural causes in August 2007 at the local hospital, whilst in the custody of HMP Erlestoke. I offer my condolences to his family and to all those touched by his passing.

The investigation was carried out on my behalf by one of my investigators. A review of the man's clinical care was carried out by a Medical Practitioner, who was commissioned by Wiltshire County Primary Care Trust (PCT). I am grateful to the clinical reviewer for his assistance. The clinical reviewer has found that the man received timely and appropriate care whilst at HMP Erlestoke. The man's medical and general care was comparable with, and at times exceeded, that which he would have received in the community.

The man suffered from shortness of breath and chest infections, and tests had diagnosed the possibility of lung cancer. However, the deterioration in his health and subsequent death happened before a full diagnosis and a treatment plan were possible. A post mortem was not requested by the Coroner because the hospital doctor confirmed that the direct cause of death was bronchopneumonia and lung cancer was a significant condition.

The man was admitted to hospital five days before he died. He was not subject to a prison officer escort, but prison staff who were at the hospital for other duties did spend time with him. I commend those staff for their compassion and decency. In particular, I wish to mention an officer, who stayed for an extra shift to keep the man company the night before he died, and another officer who went to his bed when told that the man was dying and stayed until he passed away. I have been pleased to learn that the Governor of Erlestoke has already formally recognised the actions of these two members of staff. I also commend the efforts made by staff at Erlestoke, in particular the Chaplain, for the way in which they ensured a decent and dignified funeral for the man when they thought he had no traceable family.

I make no formal recommendations in this report but bring five housekeeping points to the attention of the Governor and the Head of Healthcare. The Area Manager's attention is drawn to the words in the final paragraph of the report. I am pleased to note that my comments have been accepted.

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Prisons and Probation Ombudsman

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SUMMARY

The man was an elderly man, and already in poor health, when he received a custodial sentence. Due to his ill-health, he did not work when he was in prison, but officers kept his cell unlocked during the day so that he could come in and out of the association area when he felt able.

During his first three months at HMP Erlestoke, the man required little assistance from healthcare. However, at the beginning of March 2007, he started to experience shortness of breath and was diagnosed with a chest infection. This was the first of what became regular bouts of chest infection and breathing difficulties. The man was seen quickly and treated appropriately on each of these occasions. His difficulties continued to give the prison doctors cause for concern so he was referred for a chest x-ray at the end of April. The results showed some abnormalities and a repeat x-ray was recommended. The second x-ray determined that there was a possible malignancy so a computed tomography (CT) scan was requested. The CT scan took place on 16 July and showed the appearance of possible lung cancer. A doctor referred him, under the two week wait scheme, to see a chest physician for a full diagnosis and treatment plan.

Unfortunately, the man's health deteriorated quickly. On 14 August, he was seen by a prison doctor who decided that he needed 24 hour healthcare and he was admitted to hospital later that day.

Initially, the man did not want his relatives to be told that he had been transferred to hospital. However, after talking to a prison officer at the hospital, he decided to let his son, sister and a friend know. The addresses given for his next of kin were out of the local area so the prison asked the Bristol police to make contact. Unfortunately, his friend did not make contact and the police were unable to trace the man's relatives.

The man was in hospital for five days, during which time his condition deteriorated rapidly. He had been granted release on temporary licence (ROTL) and did not have any prison escorts. However, there was another prisoner at the hospital who was being escorted, and his escort staff also visited the man. There was a good relationship between the hospital staff and the officers. The officers were kept informed of the man's condition, and were able to support him accordingly and ensure that information was communicated back to the prison. This allowed prison staff to start planning for the man's transfer to a prison with an in-patients unit or hospice as appropriate, if he was discharged from hospital.

The man's condition did not improve, and at 10.30am on 19 August 2007 hospital staff told one of the prison officers at the hospital that the man was dying. The officer went to his bedside and sat with him and a nurse until he died.

INVESTIGATION PROCESS

1. My investigator requested all the relevant prison records including the man's medical and core prison records. She visited HMP Erlestoke to see the areas where the man lived and met wing and chaplaincy staff who knew him.
2. After receiving the initial paperwork, my investigator found that there was a period between 29 December 2006 and 4 April 2007 for which there were no medical records. Records are held electronically at Erlestoke and it appears that the man had two files. The missing records were then sent to my investigator.
3. Notices to staff and prisoners were sent to the prison to be displayed. These invited anybody with information to talk to my investigator. In this instance, no-one raised any matters of concern.
4. Wiltshire Primary Care Trust (PCT) was asked to carry out a review of the man's clinical care. A Medical Practitioner carried this out on their behalf.
5. HM Coroner for Wiltshire was informed of my investigation. The Coroner did not direct that there be a post mortem because a hospital doctor was able to provide the cause of death. The Coroner will receive a copy of this report.
6. After some delay, the man's son and sister were formally informed of his death. One of my Family Liaison Officers spoke to his son to offer him and his family the opportunity of involvement in the investigation. The man's son only concern was that they had not been informed of his father's death directly.

HMP ERLESTOKE

7. Erlestoke is a category C training prison in Wiltshire. It holds adult males transferred from prisons across England and Wales who are progressing through their sentence. The operational capacity (maximum number of prisoners) is 426. Most of the cells are single occupancy.
8. Her Majesty's Chief Inspector of Prisons last inspected Erlestoke on an unannounced visit in May 2006. She found that the prison had continued to perform reasonably well in relation to safety, respect and resettlement. She also judged staff-prisoner relationships to be extremely good and supportive.
9. Healthcare was one of the services that had improved since the previous inspection and was reported as set for further improvements. These included a move to a larger better suited building. At the time the man was in Erlestoke, the healthcare centre was open between 8.00am and 5.30pm during the week. Six doctors each work one weekday morning and another acts as cover in case of absence. There is no in-patient facility or 24 hour in house cover, but there is access to out of hours doctors as in the community. The out of hours doctors are provided by Wiltshire Medical Services.
10. When my investigator visited the prison, she was told that there was a shortage of healthcare staff and, as a result, various clinics such as the smoking cessation clinic were not running as scheduled. This will be addressed within the programme of planned improvements to the healthcare centre. I am told that other improvements include a dedicated pharmacy area and two separate treatment rooms. The storage for medication and equipment will also be improved and there will be healthcare provision on Saturday and Sunday mornings.

Two week wait scheme

11. Under the National Health Service's two week wait scheme, patients with specific symptoms, signs or test results which may indicate the presence of cancer can be referred to hospital through a fast-track route that should guarantee a clinic appointment within two weeks.

Wing history sheets

12. Wing history sheets provide a record of any issues, concerns or interactions with an individual prisoner, and every prisoner should have one. The sheet should contain regular entries by the prisoner's personal officer, if allocated, as well as by any other member of staff who has involvement with the prisoner.

KEY FINDINGS

13. The man was sentenced to two and a half years' imprisonment on 12 September 2006. He was initially taken to HMP Bristol. When he arrived he was seen by healthcare staff for his First Night Health Screen. The screen records that the man suffered from angina and asthma, for which he was taking medication. The following day, prison healthcare staff confirmed this with his general practitioner (GP) and the man's medication was re-prescribed.
14. For the first two nights in custody, the man stayed in the healthcare centre, after which he was considered fit to move onto a residential unit. Special instructions were given to ensure that he had a ground floor cell and did not need to use any stairs. The instructions also said that, if the man was unable to go to the medical treatment hatch, his medication was to be taken to him. A record of these instructions was put on the man's wing file. Over the next three months, the only medical notes related to a skin complaint and allergy.
15. On 8 December, the man transferred to HMP Erlestoke. He was seen in the healthcare unit as a new prisoner on 11 December, and was noted to have had chronic obstructive pulmonary disease (COPD) and ischaemic heart disease. It was also recorded that the man continued to smoke despite advice.
16. The next entry in the medical record was on 29 December. The man had been complaining of shortness of breath. On examination by healthcare staff, he was found to be wheezy and was advised to stop smoking.
17. Each prisoner has a wing history sheet but there are no entries in the man's throughout his time at Erlestoke. With the exception of an entry in the medical record on 19 February 2007 relating to osteoarthritis of the hand, there are no records to show what or how the man was doing until 6 March.
18. On 6 March, the man was seen by the doctor. He was diagnosed with a chest infection, cough and shortness of breath for which he was prescribed antibiotics. The following month (on 4 April 2007), the staff nurse responded to a call from wing staff to see him as he was again having problems breathing. The nurse went to see him and telephoned the doctor who prescribed more antibiotics and advised that the man should see the duty doctor the following day. (The duty doctor did see him the next day and more antibiotics were prescribed.) The doctor recorded that the man was still smoking.
19. Approximately two and a half weeks later, on 24 April, the man again experienced shortness of breath. Wing staff telephoned for a member of healthcare staff to go and see him. The staff nurse and a healthcare assistant attended the wing and took the man's clinical observations. In the medical record they described him as being able to speak easily and being in good spirits. They advised him to improve his inhaler technique with a spacer. (The effectiveness of an inhaler is reduced if the patient does not use it

properly. The spacer allows the inhaler to be discharged into a plastic chamber before being inhaled.) The man was given extra Ventolin (the medication in the inhaler) in case he ran out during the night. An appointment was made for him to see the doctor the next day.

20. The man did not attend the arranged appointment, but there is no reason recorded for this nor evidence to suggest it was followed up. However, he was seen two days later, again after complaining of shortness of breath and a cough. More medication was prescribed and a referral was made for a chest x-ray. My investigator asked the clinical reviewer if the x-ray should have been arranged sooner. The clinical reviewer replied that an x-ray is usually only requested if there is a concern that the condition does not respond to treatment. He believes that the man's condition was treated appropriately, and, when there were concerns that treatment was ineffective, an x-ray was requested in a timely manner.
21. The x-ray took place on 30 April. The results showed Chronic Obstructive Airways Disease (COAD) – also known as COPD – and possible hilar¹ enlargement. A repeat x-ray was recommended for four to six weeks time.
22. Two weeks later, on 15 May, the healthcare manager noted that the man was wheezing and had shortness of breath. She requested that the doctor should see him. The doctor noted acute exacerbation of COAD and prescribed antibiotics and steroids.
23. On 4 June, wing staff asked healthcare to see the man again because he was experiencing the same symptoms. He was again advised to increase the use of his inhaler and was given an appointment to see the doctor the next morning. The staff nurse told the wing officers that, if his condition became worse or if he became unable to talk, they should call an ambulance. The man was still smoking. When the doctor saw him on 5 June, the man was diagnosed with another chest infection and more antibiotics were prescribed.
24. The repeat x-ray took place on 7 June, which was within the recommended timeframe. Unfortunately, the radiographer did not flag the x-ray as abnormal or ask for the report to be typed urgently. The report was therefore not issued until 18 days after the examination, and a further four days passed before the prison received it.
25. The duty doctor saw the results of the x-ray on 29 June. The results showed possible malignancy and an urgent CT scan was recommended. The doctor wanted to see the man to discuss the findings and an appointment was made for 5 July, but the man did not attend. Again, no reason was recorded.
26. The man did see a prison doctor the next day (6 July 2007). The doctor logged that the chest x-ray showed abnormalities and concluded that a CT scan was needed. The man agreed to have the scan and a referral was

¹ Hilar: of or relating to or located near a hilum. The hilum is the central area of the lung where the air passages (bronchi) and blood vessels from each side join up. Swelling of the lymph glands in this area is often the first sign of lung cancer to show on an x-ray.

made. The medical records do not show it, but the clinical reviewer has found that the CT scan took place ten days later.

27. The results of the scan appear to have been received by the prison on 8 August, but the clinical reviewer has found that it was not date stamped as is usual practice. Nevertheless, an urgent doctor's appointment was made for the next day, 9 August.
28. The scan showed appearances compatible with lung cancer. The doctor made an urgent referral for the man to see a chest physician at the local hospital for full diagnosis and a treatment plan. The request was for an out-patients appointment under the 'two week wait' scheme.
29. Four days later, on 13 August, a phone call was received by healthcare staff. It is not known for certain who made the call but it would appear that it was from wing staff. A prison officer told my investigator that another officer had seen the man in his cell. He had been vomiting and was struggling to sit up. The officer tried to lift him, but was unable and called the prison officer for assistance. They managed to get him to sit upright and then contacted healthcare. (Although the officer did not know the exact date, it would appear that it was on 13 August and that it was these staff who contacted healthcare.)
30. Healthcare staff were told that the man's overall condition had deteriorated. The out of hours doctor was contacted and arrived to see the man. The doctor diagnosed a chest infection and prescribed antibiotics and pain relief. As previously, it was recommended that the man should see the prison duty doctor the next day. No record of the consultation was sent to the prison, but it has been confirmed by the clinical reviewer.
31. The consultation was followed up and the doctor saw the man in his cell on 14 August. The entry in the medical record shows that he looked very unwell and was in pain. He had an irregular pulse, was feverish and was coughing. The doctor thought that the man needed to be in a 24 hour care unit and suggested a transfer to a prison with this facility or admission to hospital.
32. A decision was made for him to go to hospital, although there is no record of who made it. A member of healthcare staff ordered an ambulance, which arrived later that day to take the man to hospital. Initially, he went under prison escort which meant he was handcuffed and accompanied by two officers.
33. During contact with the hospital on 16 August, healthcare staff were told that the man's health was not good. He was using a humidifier and receiving oxygen. That day he had had a scan (the type of scan is not identified) and a pleural tap, which is a procedure to remove fluid from between the lining of the lungs and wall of the chest.
34. That afternoon, a governor at the prison asked healthcare to assess the man's fitness in relation to his ability and likelihood to escape. The prison was considering releasing the man on temporary licence (ROTL). The hospital

confirmed that the man was unable to get out of bed and was breathless even in bed. They also said that the chest x-ray taken that morning looked worse than they had expected.

35. The risk assessment for the ROTL is not in his files, but he was in fact granted ROTL on 16 August which meant that he was not escorted by officers or handcuffed. Hospital and prison staff recognised, however, that he was frightened and might receive some comfort from visits by prison staff. The prison arranged for officers on another hospital escort to spend time with him.
36. Due to the state of the man's health, the hospital consultant was concerned and asked who his next of kin were so that nurses at the hospital could contact them. The prison records show that the man was also asked this by the prison staff, but at that point he did not want anybody contacted about his health.
37. Although the x-ray had shown his condition to be worse than initially thought, consideration was given to discharge plans if his health improved. To this end, prison healthcare staff recognised that he would need to go to a prison with a 24 hour care unit until a decision could be made about his security risk for a future transfer to an appropriate place of care (for example, a hospice).
38. On 17 August, bedwatch officer one was one of the prison officers on the other hospital escort. She went to sit with the man for a while. She told my investigator that she would check on him and they would share some jokes and laugh. The officer spoke to the man about his friends and family and his reluctance to let them know about his health. The officer told my investigator that, after discussing it, the man agreed that he should think about what was fair to them and gave her the details of his son and sister. He did not have the telephone numbers, only addresses in Bristol. The officer contacted the prison with these details. The man also gave her the name and address of a friend in Bristol which the officer also passed on.
39. The addresses in Bristol were some distance from Erlestoke and so the Duty Governor contacted Bristol police for assistance. This is common practice when family live some way from the prison itself. The duty governor asked the police to make contact with the man's next of kin to let them know he was in poor health in hospital.
40. The chronology of the police actions is unknown but they contacted the prison later that morning to say that neither the man's sister nor son lived at the addresses given. The prison also passed on the name and address of the man's friend. It appears from the records that he was informed of the situation at 1.20pm and given the prison contact details but did not get in touch.
41. The staff nurse at the hospital arranged for the hospital's Roman Catholic priest to see the man. In a statement by one of the hospital doctors in the medical records, it was noted that hospital nursing staff were also trying to notify the man's next of kin. The prison's Roman Catholic priest also visited

the man and liaised with his friend and colleague – the hospital Roman Catholic priest. The hospital priest would see the man when the prison priest could not.

42. Through most of the night of the 17 August, the man settled and slept well. He woke at 3.30am with difficulty breathing, but soon fell asleep again.
43. When the bedwatch officer took over her shift again on 18 August, she wrote in the escort log of the other prisoner that the man seemed happy to see her, and that he was joking about not being able to talk very well with his oxygen mask on. The officer told him that breathing was more important and they laughed about it.
44. At 2.20pm, the officer told the prison that she had been told unofficially that the man only had limited time left to live. There was no further treatment being given apart from pain relief. The man told the officer that he did not have a will and did not mind what happened to his possessions. He also told her that he would like to be buried in the large cemetery in Dublin but did not know the name of it. At 5.00pm, the prison's Roman Catholic priest came to see him and gave him the last rites. The priest told my investigator that he felt the man received these with great devotion.
45. Prison management checks took place for the hospital escorts at 5.50pm. This is in line with prison procedure. The second prison officer told the duty governor that she was concerned about the length of time the man had left to live and did not want to leave him on his own overnight. The duty governor agreed to speak to the night staff, but the officer took it upon herself to request permission to remain on duty and stay overnight. Permission was granted and the officer remained until 7.20am on 19 August.
46. Another prison officer took over the escort shift for the other prisoner and spent some time with the man. At 8.20am, the officer logged that the man was sleeping but his breathing was rapid. An hour and a half later, the officer noted that he had been to see the man again. Although the man looked at the officer, he made no verbal response. The officer felt that the man's condition had deteriorated and spoke to the hospital nurses to ask that prison staff be kept informed.
47. Two hours later, at 10.36am, the officer was called by nursing staff and told that the man was passing away. The officer went to his bedside and stayed with him and a nurse until he died at 10.45am.

Events following the man's death

48. The man's next of kin could still not be traced. The evidence shows that the prison attempted to find them with the help of the police, and that the hospital had also contacted the local police. There were no next of kin details listed in the prison records or on the man's Pinphone numbers and no records of any visits.

49. My investigator spoke with the Coroner's officer to ask if any next of kin details were known. As with the prison and the hospital, the Coroner's officer only knew that the police were trying to trace the man's son and sister.
50. Due to the services not being able to notify any next of kin, Erlestoke took responsibility for burying the man and the prison's Roman Catholic priest arranged a full funeral. A requiem mass was held at the prison on 23 August 2007 for prisoners and staff who would be unable to attend the funeral.
51. The man was buried on 4 September. The service was taken by the prison's priest in his parish church. The Roman Catholic priest had told his parishioners about the funeral and asked for their support to give the man a dignified Christian funeral. The priest told my investigator that the church was full, with approximately 150 people at the service including members of the prison chaplaincy and management team. The local parishioners had also arranged for flowers, and prisoners who knew the man contributed towards a wreath.
52. On 3 November, the prison Roman Catholic priest and members of his parish held a service and blessed the graves in the cemetery. The priest would like the family to know that this included the man's grave, and that one of the parishioners looks after it and keeps it tidy. It was one of the man's son's concerns that the family did not know of his death and so were not at his funeral. I hope that they can take some comfort from the knowledge that their father was given good care and treatment, and a proper burial arranged with the best intentions.

ISSUES

Healthcare provision

53. The man was in poor health when he went to prison. My investigations look at whether the medical treatment a prisoner receives in prison is comparable to what he or she could expect in the community. The evidence shows that the man received appropriate and timely medical intervention.
54. My investigator did note that there was a short delay in referring the man for his CT scan and asked the clinical reviewer's view on this. The clinical reviewer had questioned the doctor. The doctor said that this would have been the first time the likelihood of cancer had been raised with the man and therefore he felt he should speak to him himself. This resulted in a week's delay which the reviewer said would not have affected the outcome. The reviewer believes that the doctor's intention to involve the patient was exemplary.

Record keeping

Medical records

55. When my investigator received the medical records for the man, there were no records for the period between 29 December 2006 and 4 April 2007. She requested these from the prison and discovered that on one occasion when the man went out for a hospital appointment he was given a new record on return. The prison sent the extra records but there are only two entries on them. The first in February related to his osteoarthritis, and the second (on 6 March) was regarding his shortness of breath and a cough. I am pleased to note that the prison have said they will look into this duplication to stop it recurring.
56. Both the clinical reviewer and my investigator found that handwritten entries were at times illegible, unsigned and/or undated. There was correspondence from other medical providers that was not date stamped. Although I make no formal recommendation, the Head of Healthcare should remind staff of the need to stick to the recommended guidelines for completing medical notes.
57. The radiographer at the hospital where the man had his x-ray flagged the report as urgent for the first x-ray. This is good practice. However, this did not happen for the second x-ray and the results took nearly three weeks to reach the prison, thus contributing to the delay in reaching a definitive diagnosis. The systems for producing these reports are not within my remit, and the clinical reviewer believes that new systems are set to come into place that may speed the process. However, the Head of Healthcare at Erlestoke and the PCT may wish to share my concern with their hospital colleagues.
58. The out of hours doctor did not send a record of the consultation on 13 August to the prison doctor. The clinical reviewer found that this was because the prison was not recorded as the 'surgery' to which the man was attached.

There are lessons to be learnt for both services. The Head of Healthcare may wish to share my report with Wiltshire Medical Service (WMS) so that WMS can ensure that Erlestoke are recorded as the contact and records are sent to the prison.

Prison records

59. I commented at the beginning of this report that all prisoners should have wing history sheets. However, there were no entries made in his wing history sheet after he arrived at Erlestoke. This is poor practice, and has made it difficult to find out about the man's time on the residential units. My investigator spoke to an officer on the man's unit who was able to tell her about his health and his situation. The medical records show that officers regularly contacted them when the man was unwell and this information should have also been recorded in his wing history sheet.
60. I am satisfied that officers were aware of the man's health and monitored him accordingly. I am also satisfied that on this occasion I do not need to make a formal recommendation. However, I draw this matter to the Governor's attention so that action can be taken to ensure wing history sheets serve their intended purpose.

Escort logs (Bedwatch logs)

61. The interactions with the man were recorded in another prisoner's bedwatch log because the man did not have one. The man should have had a bedwatch log for the period between 14 and 16 August before he was granted ROTL, but they are not in his file. Ordinarily there would not be a log for a prisoner who was granted ROTL. But in this case staff were still visiting him, and therefore the interactions should have continued in his original log if there was one. It is not appropriate for this type of confidential information to be kept in another prisoner's file.
62. Once more, I draw this matter to the attention of the Governor so that he can share it with staff in the event that a similar situation arises again.

CONCLUSIONS AND HOUSEKEEPING POINTS

63. I have been pleased to learn of the thoughtfulness and compassion of many of the staff at Erlestoke. In particular, wing staff ensured that the man was referred to healthcare colleagues whenever his health deteriorated and made sure that he was allocated a ground floor cell. When he went into hospital for the second time, two officers escorting another prisoner made sure that he was not alone as his life drew to an end. In addition, the prison and the chaplain took great care to arrange a full and dignified funeral.
64. I make no recommendations in my report, although there are five housekeeping points that the Governor and Primary Care Trust will wish to consider. The first concerns the quality of the healthcare records and the importance of conforming to the guidelines for completing medical notes. I have also commented on the delay between the man's repeat x-ray and the results reaching the prison. Third, I found that the records of out of hours medical consultations were not sent to the prison.
65. The remaining two housekeeping points relate to prison matters. First, the Governor will have recognised that the man's wing history sheet did not provide a record of the care and attention given to him by wing staff. He will wish to satisfy himself that history sheets are being completed appropriately.
66. Finally the care and comfort given by officers who were at the hospital for other duties should not have been recorded in the records for another prisoner.
67. However, I would not wish to conclude this report by writing about things staff could have done better. For I have been hugely impressed by the actions of the second prison officer, who stayed for an extra shift to keep the man company the night before he died, and the third prison officer who went to his bed when told that the man was dying and stayed until he passed away. I understand that the Governor of Erlestoke has already formally recognised the actions of these two members of staff. It may be that the Area Manager will wish to add his own commendation.