Investigation into the circumstances surrounding the death of a prisoner at Pinderfields Hospital, while in the custody of HMP Wakefield in April 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is the report of an investigation into the death of a 48 year old man, who died at Pinderfields Hospital on 1 April 2007. The man was serving a life sentence and was in the custody of HMP Wakefield. I would like to offer my sincere condolences to his family and friends for their sad loss.

One of my investigators, conducted the investigation. Wakefield Primary Care Trust (PCT), commissioned a review of the man's clinical care and treatment in custody.

I am grateful to the Governor of Wakefield, for his cooperation with the investigation. I am particularly indebted to the governor who was the appointed liaison officer, they have been very helpful to both my investigator and to the man's family.

On 30 March 2007, the man who died was taken to Clayton Hospital to have a follow up x-ray for an ongoing chest infection. When the x-rays were examined, he was immediately taken to Pinderfields Hospital where he was admitted for further observations. The man was told that he had fluid on his chest that needed to be drained, and that he was expected to be at Pinderfields for approximately four days. However, on 1 April, he died unexpectedly. A post mortem concluded that the cause of death was tuberculosis.

I apologise for the delay in issuing this report. The results of medical tests and the outcome of the post mortem were not notified until seven months after the death. Consequently, this delayed the clinical review which in turn meant I could not complete this report.

It seems clear that the man received a good standard of care at HMP Wakefield. I have made one recommendation regarding record keeping and highlighted one area of good practice in health promotion.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2008**

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SUMMARY

The man was sentenced to life imprisonment in February 1995. In May of that year he transferred to HMP Whitemoor - where he remained until 1999 when he transferred to HMP Full Sutton. His final transfer was to HMP Wakefield in December 2003. The only major medical concern during this period was a heart attack suffered at Whitemoor in August 1996.

In November 2006, after feeling unwell for some time, he was diagnosed as diabetic. He attended a first contact clinic in January 2007 for conditions mostly associated with his diabetes, but also complained of a cough and weight loss. As a result, he was referred for a chest x-ray at Pinderfields Hospital which took place on 16 February. The x-ray confirmed that he had a chest infection for which he was given a course of antibiotics. A follow-up x-ray was arranged. During the following weeks, the man continued to lose weight and the healthcare team at the prison prescribed Ensure as a nutritional supplement.

In March 2007, he was again seen by the prison doctor. Although he felt that he had improved, the doctor explained that he would still need to have another x-ray in April. Around two weeks later, the man was seen by nursing staff and his cough had returned. Samples of sputum were taken and sent for analysis. The results were negative indicating no serious infection.

The man attended Clayton Hospital on 31 March. After the x-ray, he was sent urgently to Pinderfields Hospital. A consultant at Pinderfields explained that his chest would have to be drained because of a build-up of fluid. He was admitted and treatment began. The escort staff said that the man was settled and spent most of the first night in hospital awake and talking with them.

On 1 April 2007 at around 2.30am, the man appeared to be having a panic attack. Nurses attended to calm him down and he appeared to relax. However, at 4.10am, escort staff again alerted the nurses as the man's breathing had become very shallow and he appeared to be in distress. The nursing staff administered oxygen therapy. At 5.12am, he removed his oxygen mask and appeared to go to sleep. The escort staff were concerned by this and, on checking him, discovered he was not breathing. They immediately called for medical assistance. Medical staff entered the room at 5.15am and attempted to resuscitate him, but at 5.30am a doctor pronounced that he had died.

The provisional findings of the post-mortem suggested the man had died from natural causes. After a considerable period, further tests on a sample taken from him prior to his death confirmed the presence of tuberculosis. In light of this information, the prison and local PCT put in place an action plan to minimise the potential risk to those who had been in contact with the man and to provide support.

This report reflects well upon the care offered to the man by HMP Wakefield. The report makes one recommendation relating to medical record keeping which has been accepted by the Prison Service. It also highlights one area of good practice

THE INVESTIGATION PROCESS

1. My investigator opened the investigation at HMP Wakefield on 2 April 2007. Notices were issued to staff and prisoners inviting anyone with any information to come forward. The investigator visited Wakefield on 12 April and collected background documents.

2. Having reviewed the documents, three members of staff were identified for interview and the investigator attended the prison on 12 June, with a colleague, to conduct these interviews. Whilst at the prison, he also interviewed a prisoner who had responded to the notices. The prisoner had known the man and had contacted the investigator with concerns about the medical care.

3. During the interview with the prisoner, my investigator was made aware of three other prisoners that had the same concerns about the man's medical care. He spoke to these prisoners and asked them to put in writing their concerns so that he may follow them up. On receipt of these letters, the investigator passed on the concerns to the clinical reviewer so that they could be looked into in more detail.

4. Wakefield Primary Care Trust carried out an independent clinical review of the man's healthcare at Wakefield.

5. One of my family liaison officers contacted the man's family. Although they declined the offer of a home visit, they raised some issues for further investigation and clarification. They were mainly concerned about the medical care, in particular whether he had been diagnosed with pneumonia and why he had not been admitted to hospital sooner. I hope I have been able to answer their questions in this report.

6. I should record here, however, that the family were very pleased with the support and assistance they had received from the prison following the man's death. They singled out the prison's family liaison officer, for particular praise.

7. HM Coroner provided a copy of the post mortem for the investigator. It concluded that death was due to natural causes and that the man had succumbed to severe infection within the lungs comprising an empyema (the collection of pus within a body cavity), lobar pneumonia and pulmonary tuberculosis.

HMP WAKEFIELD

8. HMP Wakefield is a prison for male prisoners serving four years or over, including life sentence prisoners. It is part of the high security estate, housing prisoners who potentially pose the greatest risk to the public or state.

9. The prison's healthcare centre is separate from the main residential areas. All the cells have integral sanitation and the prison has recently undergone refurbishment.

10. The most recent report by HM Chief Inspector of Prisons, Ms Anne Owers, was published in 2005 and followed an unannounced follow-up inspection. The report concludes:

> "Overall, Wakefield was clearly a prison on the move. But there was a great deal of movement still required in order to make it a fully effective prison, able to engage properly with the serious and difficult offenders that it holds."

The report said of healthcare:

> "There had been little change in healthcare facilities since the last report. Wakefield provided 24 hour care for prisoners and had a 20 bed inpatient facility. Staff were enthusiastic and committed to improving services but there appeared to be a lack of strong clinical leadership particularly in primary care area."

11. A report by the prison's Independent Monitoring Board (IMB) in 2006 praised the healthcare department, which was said to do good work under difficult circumstances due to the lack of engagement by the PCT. The IMB also commented that staff morale was at an extreme low. However, the Board congratulated healthcare staff for the provision of palliative care to a number of terminally ill prisoners.

KEY FINDINGS

Events leading up to the man's death

12. The man who is the subject of this report was convicted on 18 January 1995 and sentenced on 22 February 1995 to life imprisonment. On 2 May 1995, the man transferred to HMP Whitemoor. He had no significant health concerns at Whitemoor until August 1996 when he complained of chest pains. A prison doctor admitted him to Peterborough District Hospital where he was diagnosed as having had a myocardial infarction (heart attack). Healthcare staff saw him on his return and began a programme to lower his weight and cholesterol. He was seen as an outpatient at Peterborough District Hospital and advised to continue with the programme of weight reduction. The man had no further serious chest problems while at Whitemoor.

13. The man transferred to HMP Full Sutton on 18 May 1999. During his time at Full Sutton, he was seen in the chronic disease clinic to assess his cholesterol and weight. His cholesterol levels were monitored regularly and the man was offered annual flu vaccinations. However, his medical notes indicate that he declined these (no reasons are recorded). Apart from the continuous monitoring of his cholesterol, he had no other contact with healthcare during this time.

14. He transferred to HMP Wakefield on 17 December 2003. For three years between his arrival and November 2006, the man only attended healthcare for minor ailments, including optician's appointments and dental referrals. On 21 November, he attended the treatment surgery and asked to speak to the Registered General Nurse (RGN). He told the RGN that he was experiencing symptoms of diabetes. He also said that he had been feeling unwell for approximately seven weeks but had not told anyone. (He gave no further explanation for his silence.) During the same afternoon, the RGN saw him for a full assessment at the diabetes clinic. She told him that if his blood sugar levels remained high he would be admitted to the healthcare centre and possibly begin insulin therapy.

15. His blood sugar levels did remain high. Consequently, the RGN admitted him to the healthcare centre the following day and he started insulin therapy. During his stay in the healthcare centre, he was given advice on managing his diabetes. Nursing staff observed him checking his own glucose levels and administering his insulin. It was recorded that staff found him to be very capable and confident in both procedures. The RGN attributed his motivation to the fact he disliked being located in healthcare and wished to return to the wing as soon as possible. He continued to be monitored at the morning surgeries and the diabetes clinic. His insulin levels were adjusted as necessary.

16. The man attended a first contact clinic on 26 January 2007 with multiple complaints. These included painful feet, legs and ribs, and insomnia. He also complained of feeling lethargic (a common symptom of diabetes). Further symptoms were a sore throat and hacking cough, which he had had for approximately four weeks. His weight was recorded as having dropped by 7kg in one month. He was prescribed a course of antibiotics and given simple cough

17. On 30 January, a doctor referred him for a chest x-ray at Pinderfields Hospital which was carried out on 16 February. The report of the x-ray recorded, “Ill defined air space opacification noted in the right mid zone with air bronchograms. Also linear opacity possibly suggestive of mild fibrosis noted in the left para cardiac region.” It was suggested that the man attend for a follow up x-ray in eight weeks after a course of antibiotics had been administered.

18. The man was seen by the prison doctor in healthcare on 23 February. He said he felt the antibiotics prescribed were not working and that he still had a productive cough. The doctor extended the course of antibiotics for a further seven days and advised him to rest in his cell and not to go to work for one week.

19. During this period, he continued to lose weight and, as a result, he was prescribed Ensure, a nutritional supplement. However, there appears to have been some confusion as to the reasons for his weight loss. The man spoke at length to his wing officer, who mentioned that his weight loss was noticeable. he told the officer that, since being diagnosed as a diabetic, he had been careful about what he ate and had been trying to lose weight. The officer also recorded that since January there had been a change in him. He was associating less on the wing and spending more time in his cell. When the officer spoke with him about his health, he “appeared to accept he was recovering from pneumonia” although there was some confusion as to whether this diagnosis had ever been given. His fellow prisoners had also noticed his weight loss and had asked him about his health. He told them that he was being treated for an illness but did not say what this was. When interviewed, prisoners also mentioned that the man had expressed concerns about his medication. He had told them he was only receiving paracetomol from the healthcare staff (at the time, it is likely he was also actually receiving a course of antibiotic treatment).

20. The prison doctor saw the man again on 8 March. He said that he felt generally better but was still having night sweats. His weight was stable at this time. The doctor explained that despite this improvement he should have a follow-up chest x-ray later in April.

21. During his next consultation with the doctor on 20 March, the man was coughing excessively. He told the doctor that he was coughing up “gunge” and was keen to provide a sample of sputum. The doctor explained that the samples needed to be taken at various times of the day. She arranged the test and sent the samples away. The doctor also had concerns that the dust in the textile shop where the man was working might have been the cause of his problems, and advised him to cease work there until he was well again. He followed this advice.

22. His next contact with the doctor was on 26 March when he attended the clinic to enquire about his sputum results. The doctor explained that it could take up to three weeks for results to be returned. However, the man told her that his

23. The following day, he attended the treatment centre where he was seen by the RGN who had dealt with him originally. He said that he had a sore mouth which had developed overnight. In interview for this investigation, the RGN recalled thinking that the man looked 'shocking' due to his weight loss. During the appointment, she noticed that the man was due to go to the Clayton Hospital later that morning for his follow-up chest x-ray. She saw him again that day when he was taken to the treatment room to be assessed as fit to travel. He was in a wheelchair as he was experiencing breathlessness. He told the RGN that the two officers who had escorted him had advised that it would be better to postpone the appointment given his shortness of breath. The RGN reassured the man that the decision rested with her and, in her opinion, it was important for him to attend. Before he left, he spoke with the RGN again and asked to be located in healthcare on his return from the appointment. This came as a surprise to her given his aversion to being located there in the past.

24. The RGN spoke to both the inpatient manager and the doctor to inform them of her concerns about the man. They agreed that on his return from the appointment he would be placed in the healthcare department for observations.

25. At 10.50am on 30 March, escorted by three officers, he went to Clayton Hospital, a short drive from the prison. After the x-rays were taken, the medical team told the escorting staff that the man needed to be taken immediately to Pinderfields Hospital. They arrived within 15 minutes and he was seen by a consultant who admitted him as an in-patient. The consultant told the man that he had fluid on his chest which had to be drained, and then further x rays would be taken. Staff informed the prison of his condition and that he had been admitted to Pinderfields.

26. At this time, the man was handcuffed to an officer as is normal practice with most prisoners when outside of prison. It is understood that, once he was in bed, staff applied the escort chain which enables more movement. It also allowed medical staff better access to him in order to administer treatment.

27. At 8.00pm, a doctor checked on his progress. He was sitting up in bed and in good spirits. The doctor informed the escort staff that the man was expected to remain in hospital until Monday 2 April. There was nothing to suggest that his family needed to be contacted at this time. The man was awake for most of the night talking to the escort staff, and told them he needed very little sleep. The escort staff said that he had given no cause for concern.

28. The following afternoon, a member of the prison's chaplaincy team, visited the man and spent a short while talking with him. Later that day, he had further x-rays to monitor his progress. He ate his evening meal and was given his medication at 10.25pm. At that time he was relaxed and lying on his bed. Over the next few hours, he appeared settled.

29. However, at 2.30am on 1 April 2007, the man began to have what appeared to be a panic attack. The prison officers alerted nursing staff who attended and calmed him down. Following this episode, he remained settled until 4.10am when the officers noticed that his breathing appeared very shallow and rapid. They immediately notified the nursing staff who attended. The man's breathing became worse and he began sweating. Nursing staff asked for the restraints to be removed to enable treatment to be administered to him, and this was done. He was then given oxygen and appeared to settle. A doctor examined him at 4.58am, taking his pulse and temperature, before informing the escort staff that he was happy for the restraints to be reapplied.

30. The man appeared comfortable breathing with the aid of oxygen, but at 5.12am he removed the mask and appeared to go to sleep. The escort staff felt that something was wrong, and when they checked it was clear that he was not breathing. They immediately alerted nursing staff. The resuscitation team entered the room at 5.15am and attempted to revive him. At 5.25am, the hospital suggested the man's next of kin be notified of his condition and this was passed to the control room at the prison. Efforts to revive him continued but sadly, at 5.30am, his death was confirmed.

Events following the man's death

31. Following the man's death, the duty governor, was contacted. He ensured that the prison's contingency plans were followed with all relevant departments being notified. The Governor published notices informing both staff and other prisoners of the death and of the services available to those who felt particularly affected by it.

32. A Principal Officer was appointed as the prison's Family Liaison Officer after the man's death, but this role was later taken over by a Governor. The Principal Officer telephoned the one of the man's brothers. He told her that their other brother would deal with all the necessary arrangements, but he was currently out of the country and expected back on 2 April.

33. A post mortem was carried out at midday on 1 April given initial concerns that he might have been suffering from tuberculosis. An infectious disease of this kind would have required precautionary measures to be taken at HMP Wakefield. However, the post mortem initially ruled out tuberculosis and this was relayed to the prison.

34. The prison family liaison, along with staff from the prison chaplaincy team, attended the man's funeral. The prison offered to meet the funeral costs.

35. On 26 April, a sputum sample taken from the man on his admission to Pinderfields Hospital that had originally shown as negative was reported to be positive for mycobacterium (TB) after being cultured.

36. It was mentioned in documentation that there was national press coverage of the case. However, my investigator was unable to find evidence of this during his investigation. To prevent anxiety within the prison population and wider

ISSUES

Staff Conduct

37. My investigation found that Wakefield cared for the man extremely well. His personal officer, and the nursing staff, particularly the RGN, showed compassion in all their dealings with him. This care continued when he was admitted to hospital, a fact which is evident from the bed watch log. The Governor may wish to consider if he should formally recognise the professional way in which members of his staff conducted their duties.

Clinical Care

38. The doctor, who conducted the clinical review concludes that the medical interventions that the man received while in custody were timely and appropriate given his symptoms. The fact of his imprisonment was not a barrier to him receiving a good quality of healthcare.

39. The prison referred him appropriately and all appointments were attended as scheduled. The prison also initiated tests and acted correctly on receiving the results. However, the routine investigations failed to identify the TB. In summary, the clinical reviewer notes the following:

> "In my opinion, the single most significant contributory factor would appear to be that our routine investigations (chest x-ray, sputum culture, routine haematology tests) are still not sufficiently sensitive enough to pick up and confirm the diagnosis of TB. All of these investigations were however carried out."

40. The clinical review makes no recommendations. In light of the overall finding of the clinical review that I have quoted above, I judge that the prison health team cannot in any way be held responsible for the fact that the initial tests did not highlight the man's tuberculosis.

Recording of medical information

41. During my investigation, it was often difficult to find specific details relating to the man's care in his medical record, such as results from x-rays and other tests that had been carried out. It was also difficult to decipher some of the written entries and the identity of their authors.

The Governor and Head of Healthcare should remind all clinical staff of their obligations to comply with the rules regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.

The Prison Service accepted this recommendation and in response said,

> *All healthcare staff to be issued with current Guidance on Records and record keeping in line with NMC (National Medical Council) Guidelines.*

Actions taken following confirmation of tuberculosis

42. Following the results from toxicology tests the action plan developed by Wakefield PCT and the prison's healthcare team sought to prevent anxiety within the prison population and wider community in relation to tuberculosis. It also gave prisoners access to information and the opportunity to be tested.

    I am pleased to see that Wakefield PCT and the prison healthcare team had the foresight to introduce a joint protocol to increase awareness of tuberculosis. This information was circulated beyond the prison gates and should be recognised as good health promotion practice.

Family

43. The man's family were concerned that he might not have been promptly diagnosed and treated for TB. However, during the investigation it was apparent that medical staff at the prison had treated him for the symptoms presented at the time. The doctor and nursing staff who had been treating him regularly were clearly shocked and saddened by his death, given that they had performed all the necessary tests and believed his illness to be under control. As indicated by the clinical reviewer, there does appear to be a national problem regarding the effectiveness of the screening process for TB. The final results of tests support the family's initial concerns. However, I hope this report reassures them that the care he received while in custody was of a high standard and the ineffectiveness of the screening process was beyond their control.

44. The appointed governor acted as both liaison with my office and as the prison's family liaison officer. She performed her duties to a very high standard, ensuring that the man's next of kin were dealt with appropriately and compassionately. Despite her core work commitments, she provided regular assistance throughout, and the family greatly appreciated this.

Family's response to draft report

45. Following the issuing of my draft report, the man's family responded with a number of concerns that I have attempted to address.

    The lack of statements from other prisoners who knew the man better than the prisoner interviewed. Why no other prisoners were asked about their opinion of events.

    When the original notice went out only one response was received. It was not until my investigator arrived at the prison to conduct the interviews that he was informed that there were in fact about four other prisoners that would like to speak with him. The interviewed prisoner informed the investigator of this. Due to time constraints, he was only able to speak briefly with these individuals and arranged for them to put in writing their concerns. This they did and all had concerns regarding the healthcare afforded to the man. In view of this, the

investigator passed on their concerns to the clinical reviewer. These letters did not contain anything that had not been previously mentioned by the prisoner interviewed. They were not annexed to the report because permission was not granted by the letter writers.

Concern that the man was portrayed as being a loner, which is not how the family remembers him.

My investigator was informed that the man was clearly a popular individual on his wing and I make mention of his involvement in the band. But I also make equal reference to his choice to spend more time in cell as his health issues continued.

Prison Officer not addressing the man's weight loss.

The wing history documents clearly showed the amount of interaction that the officer had with the man. When my investigator interviewed her she was very genuine in her regret that he had died. It was clear that she had conversed with him regularly and given his explanation for his weight loss she had no reason to question it further. She was also fully aware that he was, as he had stated, recovering from pneumonia. The transcript of the officer's interview makes this clear and, given that she had no medical training, it is in my opinion fair that she would have no reason to question the man's account for losing weight.

Concerns regarding nursing care.

The man's family said that he had complained to them that he did not have a good relationship with the RGN, feeling that she had not been helpful when he reported symptoms to her and that she obstructed his attempts to see a doctor. The medical record clearly shows the input that the RGN had with the man. It was very often her that he would be seen by when attending the treatment area. There is no evidence of him being dissatisfied with the care that he received from her and he made no mention of any concerns to any other officer or prisoner. He did however mention to others on the wing that he was not happy with the treatment he was receiving but would tell officers that he was.

Poor Medical records.

Unfortunately this is an ongoing concern in many cases. In relation to the man's medical record the entries made from 26/01/07 onwards are very legible except for those by the doctor but these were clarified with her during her interview with my investigator. I have however made a recommendation in relation to record keeping that should address this concern.

Disappointment at no one being held to account for the failure to diagnose TB and concern over the Clinical review.

The purpose of my investigation is to ensure that individuals who become unwell while in prison custody are afforded the same standard of treatment as those in the wider community. During my investigation, it was apparent from the

documentary evidence provided that the Healthcare team at the prison had cared for the man very well. The relevant tests were conducted as his illness continued but the results to these proved negative. As a result, the medical team continued to treat him for a chest infection. Tuberculosis was only confirmed after his death following a very lengthy and in-depth toxicology examination. The clinical review blames the failure of the screening procedures nationally and supports the findings that the prison did every thing they could to identify the cause of the ongoing illness. I fully appreciate the familys concerns in this area but feel that my investigation has taken account of all the available information in reaching its conclusion. However, I have passed on the family's concerns to HM Coroner who may wish to investigate the medical findings in more depth prior to the inquest.

RECOMMENDATION AND GOOD PRACTICE

The Governor and Head of Healthcare should remind all clinical staff of their obligations to comply with the rules regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.

I am pleased to see that Wakefield PCT and the prison healthcare team had the foresight to introduce a joint protocol to increase awareness of tuberculosis. This information was circulated beyond the prison gates and should be recognised as good health promotion practice.