Investigation into the circumstances surrounding the death of a man at HMP Wymott on 13 May 2006

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the death of a man, who was a prisoner at HM Prison Wymott. The man died in his cell on 13 May 2006. The cause of death was recorded as a massive pulmonary embolism. I offer my sincere sympathy and condolences to the man's family for their sad loss.

The investigation was carried out on my behalf by one of my investigators. An independent review of the man's medical care in prison was carried out by the Chorley and South Ribble Primary Care Trust. I am most grateful to the clinical reviewer for her assistance.

I would also like to thank the Governor and staff of HMP Wymott for their full and ready co-operation during the course of the investigation.

As with many of my investigations following a death from natural causes, my findings are strongly influenced by the clinical review. In the case of this man, the clinical reviewer judged that the level of care he received was not satisfactory, and concluded that his death was "potentially avoidable".

I have endorsed the three recommendations made by the clinical reviewer. In addition, I have separately identified one example of good practice.

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

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SUMMARY

The man who died was received at HMP Liverpool on 17 May 2005. At the request of his solicitor, he saw a consultant psychiatrist on 7 September, at which time he was diagnosed with a bi-polar disorder with a current state of hypomania. This diagnosis was confirmed by a psychiatrist from a local Mental Health Clinic on 2 December, and the man was prescribed Olanzapine 5mg.

Following a review on 16 December, the man's Olanzapine was increased to 10mg a day. He became more settled following this, but experienced some of the more common side effects of the drug, including weight gain and a dry mouth. He was also seen by a doctor on 2 January 2006, after complaining of a painful right calf. The doctor recorded that there was no sign of deep vein thrombosis, and considered it to be a muscular calf pain.

On 20 March, the man was transferred to HMP Wymott. He was reviewed by a registered mental nurse on 30 March, and referred to the visiting psychiatrist. There is no note of him having seen the psychiatrist or of having any further reviews at Wymott.

On 10 May, healthcare staff were called out to see the man when he complained of having been short of breath and anxious for a few days. The prison GP was consulted and diagnosed a panic attack and hyperventilation. The man was prescribed Propranolol 40mg, and given a brown envelope for re-breathing oxygen.

At around 7.45am on 13 May, healthcare staff were again called out to see the man. On this occasion he was breathing rapidly and talking quickly, and the nurse gave him a paper bag to breathe into and advised him to put in an application to see the doctor.

At around 3.50pm that afternoon, the man was found by an officer to be extremely short of breath and having difficulty breathing. An emergency call for assistance was put in, and two nurses attended. The nurses said that they found the man in an anxious state, and advised him to breathe into a paper bag. When his anxiety subsided, the nurses left the cell.

Around three to four minutes later, the officer was called back to the man's cell. On this occasion, she found him to be struggling for breath and in considerable distress. A Senior Officer went to recall the nurses, who were still on the wing. During this time, the man stopped breathing and was laid on the floor by the officer and a prisoner. The nurses commenced CPR and an ambulance was called, but the man could not be revived.

A subsequent post mortem recorded the cause of death as a massive pulmonary embolism.

The clinical review, conducted by the Chorley and South Ribble Primary Care Trust, is critical of the presumptive diagnosis of hyperventilation due to an anxiety attack made by the prison doctor on 10 May, and of the subsequent care that the man received. The review concludes that his death was "potentially avoidable".

I endorse the three recommendations made in the clinical review and highlight one example of my own of good practice.

THE INVESTIGATION PROCESS

The investigation was opened on 17 May 2006, when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. As a result, eight prisoners came forward. My investigator also interviewed four members of staff during the course of the investigation.

My investigator visited Wymott on 27-28 June 2006. He toured the prison and was able to familiarise himself with the healthcare centre and the wing on which the man had lived. My investigator was also given access to the man's prison files, including his medical record.

An independent clinical review of the man's health needs whilst he was in custody at Wymott was carried out by the Chorley and South Ribble Primary Care Trust.

On 7 June 2006, one of my Family Liaison Officers, wrote to the man's ex-wife to ascertain whether she had any concerns for the investigation to address. A copy of the draft report was sent to the man's daughter. The comments that I received from her are discussed on page 15 of this report.

BACKGROUND

The man who is the subject of this report was born on in 1942. He was 64 years old at the time of his death.

As a teenager, the man spent three months in a detention centre after stealing a car. He spent no further time in custody until being remanded to HMP Liverpool on 17 May 2005. He was convicted on 13 October, and later sentenced to five years imprisonment.

The man transferred to HMP Wymott on 20 March 2006. He was described by fellow prisoners as someone who was well-liked, popular and humorous. He worked in the laundry at Wymott, and apparently enjoyed going to work and would always work hard.

HMP WYMOTT

Wymott is a category C training prison for adult male prisoners. Approximately half of the population are vulnerable prisoners, most of whom are sex offenders. The prison is located on the outskirts of Leyland in Lancashire. The maximum number of prisoners who can be held at Wymott is 1,046.

The commissioning of healthcare within the prison is the responsibility of the Chorley and South Ribble Primary Care Trust. The healthcare centre has a doctor available every weekday. Overnight and weekend cover is provided by local GPs who are on call. There is also a clinically qualified member of healthcare staff on duty at these times. There is no in patient care facility at Wymott and prisoners who require this care are referred to either HMP Preston or to local hospitals.

KEY EVENTS

At the man's first reception health screening at HMP Liverpool on 17 May 2005, he said that he had seen a doctor a week previously for stomach pains and indigestion for which he was taking antacids. He reported no other concerns about his physical or mental health. The man had a secondary health assessment on 30 June at which no problems were noted.

The man was seen by a consultant psychiatrist on 7 September, at the request of his solicitor. The consultant psychiatrist diagnosed a bi-polar disorder (a manic depressive illness) with relapses and remissions for many years. He determined the current state as being hypomania (a persistent elevated mood and hyperactivity) which had gone undetected.

Following this diagnosis, the man was referred to a psychiatrist at the a local Mental Health Clinic for assessment. This psychiatrist saw the man on 7 October 2005, and took a full history. At the time of this assessment, the psychiatrist did not consider that the man was presenting with hypomania, and queried the diagnosis. The psychiatrist held a further assessment on 2 December (mistakenly noted in the medical record as 2 January 2005), after having spoken to the man's daughter. At this assessment the psychiatrist did diagnose hypomania, and prescribed Olanzapine 5mg (an antimanic medication).

The man was further assessed on 8 December by a member of the Prison Community Mental Health Team (PCMHT). He said that he had a dry mouth, and was advised to take extra fluids. It was also reported that the man had been promoted in the workshop because he "never stops". He was then seen by the acting GP at Liverpool, on 16 December, when he was described as "loquacious" and "gesticulating a lot". The acting GP decided to increase the man's Olanzapine to 10mg.

Entries in the man's medical record on 29 December and 6 January 2006 indicate that he appeared to be more settled since his medication was increased. However, on 1 January, he saw a nurse after complaining of a painful right calf that was "cramp like in nature, worse at night time". He also complained of feeling dehydrated. The man was advised to drink plenty of water, and an appointment was arranged to see the prison doctor the next day.

At his appointment with the prison doctor on 2 January, the man said that he had developed pains in his right calf around one month previously, and again said that they were worse at night. He also said that the pains lasted for about 20 to 40 minutes before settling. The prison doctor noted that there was no sign of swelling and no sign of DVT (deep vein thrombosis). He recorded that the impression was of a muscular calf pain, and gave the man reassurance as such.

On 27 January at a review with the member of the PCMHT, it was noted that the man was far more settled. He complained of having experienced double vision on two occasions, and was advised to see the prison doctor. There is no record of the man seeing a doctor or optician, and no note in his medical record of any further problems with double vision.

The man was reviewed again on 3 February. On this occasion, he said that his tablets (Olanzapine) were "slowing him down". It was also noted that his weight had increased. At his next review, on 17 February, the man described his thoughts as "slowing down". He also complained of lower back pain, and was advised to see the prison doctor.

On 3 March, at his next review, the man made no further comment with regard to his medication or any apparent "slowing down" of his mental or physical capabilities. No problems were noted at this review. At a subsequent review on 6 March, the man complained only of a sore throat. At a further review on 15 March, the member of the PCMHT noted "no expression or observation of symptoms related to mania", and that the man was compliant with his medication. It was also noted that his weight had increased by eight pounds since imprisonment.

On 20 March, the man was transferred to Wymott. No concerns were raised at his reception health screening, other than his diagnosis of bi-polar disorder whilst at Liverpool. The man said that he was stable on his medication. He was referred to the local Mental Health In-Reach Team (MHIT).

The man was seen by a nurse from the MHIT on 30 March. The nurse noted that he "presented as calm and appropriate in behaviour and speech", and referred him to the visiting psychiatrist. There is no record of the man seeing a psychiatrist or of having any further reviews during his time at Wymott.

The man was not seen again by healthcare staff, other than when collecting his daily medication, until 10 May. A number of prisoners have, however, come forward to say that he was ill during this period. One of these men, who knew the man at Liverpool, said that he was a different person when he arrived at Wymott. The prisoner said that the man's "natural liveliness had gone and he had slowed down". He also said that, following his arrival at Wymott, the man "seemed to deteriorate every day".

Another prisoner, who had also known the man at Liverpool, said that he "deteriorated once he came to Wymott". This prisoner said that the man was "short of breath, struggling to work". Other prisoners also came forward to say that the man had been ill for around one or two weeks prior to seeing healthcare staff on 10 May. Each of them described similar symptoms, including difficulty in breathing, shortness of breath and difficulty walking.

On 10 May at around 8.30am, the Primary Care Manager at Wymott was called out on an emergency response to see the man. The Primary Care Manager attended and found the man between A-wing and B-wing, as he had been on his way to work. She said that the man was standing up and able to speak in full sentences. She took him to healthcare, as this was closer than his wing. The man was able to walk over slowly, and said that he had been short of breath and a bit anxious for a few days.

On arrival at healthcare, the Primary Care Manager checked the man's legs for pain and swelling but found none. When asked, the man said that he had no chest or leg

pain. He again said that he was short of breath, and the Primary Care Manager recalled in interview that he appeared agitated and anxious at the time. The man's blood pressure (130/100) and pulse (112) were then taken by a nurse. Both of these readings are higher than the normally expected boundaries. The Primary Care Manager and the nurse attempted to take an ECG, but could not get the pads to stick due to the man's agitation and sweating. The prison GP was consulted, and the Primary Care Manager said that he told them that they could not get an ECG because the man was hyperventilating.

At interview, the prison GP said that when the man was brought to healthcare he appeared to be suffering from a panic attack. He said that the man had no chest or leg pain, and that his pulse, blood pressure and respiratory rate all fitted in with a panic attack. The prison GP therefore prescribed Propranolol 40mg (a beta blocker, for reducing the heart rate and controlling symptoms of anxiety). He also gave the man a brown envelope for re-breathing oxygen. The man then returned to the wing, and was told not to attend work that day.

At around 7.45am on 13 May, a nurse received a telephone call to attend the man on B-wing. One of her colleagues gave the nurse a paper bag to take with her as she knew that the man had been diagnosed as hyperventilating and having panic attacks.

The nurse said that, on her arrival on B-wing, the man was not having difficulty breathing, but rather was breathing rapidly and talking quickly. He said that he was experiencing no pain, and complained of a cough. The nurse advised the man to put in an application to see the prison GP, and gave him the paper bag for future use. At 10am, the nurse saw the man again when he came to collect his medication from the treatment hatch on the wing. She said that at this time he was not hyperventilating or carrying the paper bag, and that he said that he was "ok" when she asked how he was.

At around 3.50pm on the afternoon of 13 May, an officer attended a call bell on B5 landing. She went to the man's cell and found him to be "extremely short of breath and having difficulty breathing". The officer therefore put in a code blue call for assistance. (The code signifies that a prisoner is having difficulty breathing and healthcare assistance is required quickly.)

The call was responded to by two nurses. They described the man as in an "anxious state" on their arrival at his cell. At interview, one of the nurses also said that the man was hyperventilating. She did not think that his blood pressure was taken at this stage and could not remember taking his pulse. The nurses advised the man to blow into a paper bag to regulate his breathing and calm his anxiety. The man's anxiety subsided, and the nurses then left his cell. They advised him to carry on breathing in the bag, and said that they would speak to the doctor about his breathing and anxiety.

At around 4.15pm, the officer responded to another call bell on the B5 landing, this time accompanied by a senior officer. On their arrival, they found the man struggling to get his breath and thought him to be in considerable distress. The senior officer went to summon the two nurses who had seen the man earlier, as they had not yet

left the wing. The nurses retrieved the emergency equipment from the treatment room on the wing and returned to the man's cell.

During this time, the officer remained in the cell with the man. He appeared to the officer to be shivering so she went to put a blanket around his shoulders. As she was doing so, the man slumped forward and stopped breathing. With the help of a prisoner, the officer laid the man on the cell floor. The senior officer then returned to the cell and asked the prisoner to leave. He was followed by the two nurses.

The nurse who was interviewed said that, on her return to the cell, the man was "on the floor unconscious and not breathing". The nurses immediately began CPR, and asked the senior officer to arrange for an ambulance to attend. CPR was continued until the arrival of the paramedics at around 4.30pm, during which time no response was received from the man. The paramedics took over CPR on arrival, and also gained no response. At around 4.40pm, the paramedics decided that CPR should be discontinued and pronounced death. A post mortem, conducted on 17 May 2006, identified the cause of death as a massive pulmonary embolism.

The Governor of Wymott, with the duty governor, visited the man's daughter on the evening of 13 May to break the news of his death. The prison provided funding to meet all of the funeral costs.

ISSUES

The clinical review, conducted by the Chorley and South Ribble Primary Care Trust, is critical of the care received by the man at Wymott. In particular, the clinical reviewer expresses concern over the examination carried out on 10 May 2006 and the subsequent diagnosis. She considers the diagnosis of hyperventilation due to a panic attack to be "presumptive in a man with no previous recorded history of anxiety symptoms". The clinical reviewer goes on to say that the examination and investigations carried out on 10 May were "insufficient to rule out a chest pathology". She also notes that no mention was made in the clinical record of any examination of the man's legs for signs of a possible DVT.

The clinical reviewer also expresses concern at the treatment that the man received on the morning of 13 May. She notes that there is "no record of any examination, no pulse or blood pressure recordings, merely the repeated recommendation that he breathe into a paper bag". The reviewer was also concerned that there was no entry in the medical record to suggest that the nurse who attended that morning had considered the possibility that the diagnosis of an anxiety attack might have been incorrect.

The man experienced some of the more usual side effects of the drug Olanzapine, including weight gain, hyperglycaemia (a level of glucose in the blood that is too high), somnolence (unnatural drowsiness) and a dry mouth. The clinical reviewer expresses concern, however, that he may have experienced an adverse drug reaction linked to Olanzapine, and that the Olanzapine "may have been the predisposing cause of the man's deep vein thrombosis and pulmonary embolism".

At Liverpool, the man was reviewed by a member of the PCMHT on a weekly basis following his diagnosis of bi-polar disorder. He was assessed by a member of the Mental Health In-Reach Team on 30 March 2006 at Wymott, ten days after his transfer to the prison. He was referred to a visiting psychiatrist, but it does not appear that the man saw a psychiatrist during the remainder of his time at Wymott, nor does it seem he had any further reviews. The Mental Health In-Reach Manager at Wymott told my investigator that it would not be unusual for a prisoner to wait for more than six weeks to be seen by a psychiatrist, if he was considered to be settled at his initial assessment. Nevertheless, this is of concern given the concerns that the clinical reviewer raised with regard to the man's possible reaction to Olanzapine.

The clinical reviewer concludes there are a number of factors, including his drug treatment, that may have contributed to the man's reduced mobility and predisposition to deep vein thrombosis. However, she notes that "this is a treatable condition if detected early and treated promptly". She goes on to say that, in her opinion, the man's death was "potentially avoidable and this therefore raises issues regarding the appropriateness of the care he received at Wymott".

This is a disturbing conclusion. In the light of her consideration, the clinical reviewer makes the following recommendations, each of which I endorse.

Chorley and South Ribble PCT, as overall commissioners of the prison health services, should raise concerns/performance issues regarding the medical

care of this patient with the Southport and Formby PCT, on whose performers list the prison medical officer is registered.

The prison healthcare manager or the prison doctor should make an on-line report to the Commission on Human Medicines regarding the side effects experienced by this patient while on the drug Olanzapine.

The prison mental health team should ensure that they review all patients on psychotropic medications on a regular basis, and that they ask about, document and take appropriate action regarding any significant side effects.

Family response to the draft

I received a number of comments from the man's daughter, through her solicitor, on my draft report, which I have discussed below.

- Interaction between Olanzapine and Propranolol

The man's daughter was concerned that no consideration had been given to the interaction between Olanzapine and Propranolol. The man was prescribed Olanzapine 5mg daily on 2 December 2005, with the dosage increased to 10mg daily on 16 December. Olanzapine is an antimanic, and was prescribed following the man's diagnosis of hypomania. Propranalol 40mg (a beta blocker, for reducing the heart rate and controlling symptoms of anxiety) was prescribed by the prison GP at Wymott on 10 May 2006, following his diagnosis of a panic attack.

My investigator asked the clinical reviewer to address the interaction between Olanzapine and Propranolol. The clinical reviewer says that she is not aware of any documented adverse reaction between Olanzapine and Propranolol, and notes that there is none listed in the British National Formulary (the standard formulary used by the majority of medical practitioners in the UK).

- Timing of the ambulance call on 13 May 2006

The man's daughter questioned whether an ambulance should have been called when her father was seen by nursing staff at 3.50pm on 13 May 2006. My investigator put this question to the clinical reviewer. She notes that the nursing staff did not call an ambulance at this time "because they did not recognise how ill (the man) was". The clinical reviewer goes on to say that, even if an ambulance had been called, "it is unlikely that this would have made a difference to the outcome as the man was already exhibiting symptoms of a massive pulmonary embolus". It does not appear that the nursing staff who attended at 3.50pm took any observations. I believe that they should have done so. Depending on the outcome of these observations, it may then have been appropriate to call an ambulance.

- Wing staff's knowledge of the man's condition

The man's daughter was concerned that wing staff would have been unaware that her father was seen in healthcare on 10 May 2006, as he collapsed whilst not on the wing and there was no entry made in the wing history sheet. She was concerned that wing staff would not therefore have been aware of the seriousness of the incident when her father called for help at 3.50pm on 13 May.

An officer attended the man's cell at 3.50pm on 13 May when he pressed his call bell for assistance. She found him to be "extremely short of breath and having difficulty breathing". The officer therefore made a 'code blue' call for immediate healthcare assistance. I am satisfied that there was no delay on her part in calling for medical assistance when the man was first taken ill on the afternoon of 13 May.

RECOMMENDATIONS

Chorley and South Ribble PCT, as overall commissioners of the prison health services, should raise concerns/performance issues regarding the medical care of this patient with the Southport and Formby PCT, on whose performers list the prison medical officer is registered.

Accepted – full response to follow

The prison healthcare manager or the prison doctor should make an on-line report to the Commission on Human Medicines regarding the side effects experienced by this patient while on the drug Olanzapine.

Accepted – full response to follow

The prison mental health team should ensure that they review all patients on psychotropic medications on a regular basis, and that they ask about, document and take appropriate action regarding any significant side effects.

Accepted – full response to follow

GOOD PRACTICE

The Governor and duty governor personally went to break the news to the man's next of kin on the evening of his death.