A death in custody at

HMP Kirkham – June 2004

Report by the Prisons and Probation Ombudsman for England and Wales

October 2004

This is the report of an investigation into the circumstances of a death of a man at HMP Kirkham on 19 June 2004. The man's cause of death was intracerebral haemorrhage (bleeding inside the brain).

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO), as I can bring greater independence to the task.

The investigation has been carried out by one of my investigators and my Deputy carried out a review into the man's clinical care and treatment.

We would like to extend our condolences to the man's family for their loss. We would also like to thank the Governor in charge of Kirkham, and the other members of his staff who assisted with this investigation. We found staff helpful and all the documentation we might require already gathered together for us.

Stephen Shaw **October 2004**
Prisons and Probation Ombudsman

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Summary

The man was born on 17 January 1965 and was 39 years old when he died on 19 June 2004 from an intracerebral haemorrhage. At the time he was serving a four-year sentence at HMP Kirkham, an open prison near Preston.

The man's records were checked by PPO staff and a clinical review was carried out. We have found that the man's death was not connected to the fact that he was in prison, or to the level of care that he received there.

This report makes a recommendation in relation to general record keeping systems in Healthcare at HMP Kirkham.

Background

The man was arrested on 27 July 2003 and charged with two offences: wounding with intent to cause grievous bodily harm and theft. He was remanded into custody at HMP Forest Bank. The man appeared in court on 13 October 2003 and was committed to Crown Court and granted bail to appear at a later date. On 14 January 2004, he was convicted for the offence of wounding with intent to cause grievous bodily harm, but cleared of the second charge. He was sentenced to four years in prison and had an EDR (Earliest Date of Release) of 13 January 2006. The man had previously been in prison, but this had been many years ago.

The man lived in Manchester with his partner, (who since his death has taken on his surname) and their two children. The man had named her as his next-of-kin when received at Kirkham. He also had two other children from an earlier relationship who live with their mother.

Both of the man's parents are living, as are five brothers and four sisters. It is a large supportive family and relations between his partner and his blood relations are good.

The man's father was asked by PPO staff whether he had any specific concerns about the circumstances surrounding his son's death. He said that he was concerned that, when his son reported a migraine headache on 18 June 2004, his treatment consisted only of being given some medication with advice to rest in bed. He wondered whether his son's life could have been saved had he been taken to hospital and a scan conducted. He said that his own life had been saved a while ago when a scan had detected a haemorrhage, which had been successfully operated upon. PPO staff contacted the man's partner who was also asked whether she had any particular concerns. To date, she has not informed the PPO of any such concerns.

My investigator spoke to three prisoners who knew the deceased. My investigator was told that the man was a person who was always laughing and joking and who was very popular. The prisoners asked for their condolences to be sent to his family. Prisoners also made a collection for his partner, which raised a large amount of money.

One of the prisoners to whom my investigator spoke said that the man often seemed to be suffering from headaches and would walk around holding his head in his hands. He added that Healthcare staff often dismissed prisoners' complaints believing that prisoners were trying to avoid work.

Another prisoner said that even though prison management had spoken to prisoners as a group following the man's death, he felt that individual counselling should have been offered.

HMP Kirkham

HMP Kirkham is a category ‘D’ open training prison with accommodation for around 600 adult males. Kirkham is a working prison with workshops, a farm and gardens. It occupies the site of a former Royal Air Force Technical Training Establishment which was built during the 1939-45 war and used post-war as a major demobilisation centre. The facility was taken over by the Home Office in the early 1960s and has been in use as a prison since 1962. Starting in 1990, the original accommodation blocks have gradually been replaced with modern blocks each accommodating around 20 prisoners. All prisoners occupy single bedded rooms. The prisoner’s room was in block F7. Locking and unlocking of the main door to each block is controlled by prison staff, although prisoners hold individual keys to their own rooms for which prison staff hold master keys. Less than 100 metres from block F7 is a permanently staffed prison wing office.

Investigation process

My practice in cases of apparent deaths from natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator visited Kirkham on 23 June 2004 and he went to block F7 where the man was held. My investigator spoke informally with a number of staff to outline the facts relating to the man's death and was given access to all of his prison records, including the medical records.

The prison had taken statements from all staff who had had any significant involvement with the man immediately before, and then following, his death.

My investigator was given copies of all relevant records.

My investigator met the Chairman of the local Prison Officers Association (POA) and spoke by telephone to the Chair of the Independent Monitoring Board (IMB). Neither had any issues which they wished to draw to the PPO's attention.

My staff sent letters to the man's partner and father. Both were also contacted by telephone. The only specific concern that was raised by either was the father's question about whether his son should have been referred to hospital for a scan.

The Deputy Ombudsman, a qualified nurse, carried out a clinical review.

No formal interviews with staff were conducted. This report is based upon a thorough review of all relevant paperwork, including the written statements made by staff and the man's clinical records.

The Incident and Events Leading up to the Death

When the man first arrived at Kirkham on 14 January 2004 he underwent health screening as part of a standard induction process. The man reported having no concerns about his health. It was recorded that he did not have a GP. At a further health check completed several days later, a record was made that the man had a past history of suffering migraine headaches and that he wished to avoid working in bright light. The medical record showed that the man attributed his migraine headaches to a road traffic accident in which he had been involved in 2001.

Further evidence that bright light affected the man's condition is that on 23 May 2004 he was moved to a different room within his block as his original room was too light. On 6 June a note was made that the man had had no further problems following his room change.

From the time of his arrival at Kirkham, and up to 17 June 2004, the man consulted Healthcare on five occasions. Most of these consultations were for complaints other than migraine, although he did complain about migraine on 4 and 5 February 2004 for which he was appropriately prescribed brufen, paracetamol and propranolol. After 5 February, the man did not again consult Healthcare about migraine type symptoms until Friday 18 June.

On the morning of 18 June, the man saw a Healthcare Staff Nurse, who recorded that the man had symptoms of headache, nausea and a sensation of seeing flashing lights: all of these symptoms of migraine. The man was given brufen and paracetamol and an appointment was made for him to be reviewed by a doctor later in the day. At about 1pm that afternoon a doctor confirmed the man's symptoms, diagnosed migraine and prescribed cocodomol. The man then returned to his room to rest in bed and a notice was affixed to the room door stating that he was authorised to rest in his billet.

At the afternoon roll call, which took place at around 3.45pm, the man was not standing at his room door, as should have been the case. Instead, he was lying awake in bed. The Prison Officer who was conducting the roll call asked the man if he was all right, to which he answered that he was. At 8.45pm, the same Prison Officer carried out the final roll call of the day. Once again the man was lying awake in bed and he again informed the Prison Officer that he was all right.

The man's room door was still locked at the time of the 10.45am roll call on Saturday 19 June 2004. He would have locked the door

himself, presumably on Friday night. The Prison Officer who was conducting that roll call looked through the observation window and saw the man lying in bed. He appeared to be asleep. This did not arouse any suspicion in the Prison Officer's mind as prisoners were allowed to sleep late at weekends. Having completed the roll call, the Prison Officer returned to the wing office. A few minutes later a friend of the man knocked his door to wake him, as at weekends brunch was served at 11.15am and he would not have wanted to miss this meal. Unable to obtain a response, the other prisoner realised that something was wrong and he pressed the alarm button setting off an alarm bell in the wing office. The time was then 10.55am. A Prison Officer went immediately from the wing office to block F7. He unlocked the man's door and, on entering, found him to be unresponsive although his body was still warm to the touch. The Prison Officer radioed for assistance, including support from Healthcare. During this call he was asked whether the man was conscious, whether he had a detectable pulse or signs of breathing, whether an ambulance was needed. The Prison Officer was unable to detect a pulse or signs of breathing, but before he was able to do anything else, the Staff Nurse, together with a Student Nurse, attended the scene. The Staff Nurse commenced cardiopulmonary resuscitation (CPR). The time was now 11.00am. Ambulance service paramedics arrived on scene at about 11.20am and they joined in with the attempts to resuscitate him. Unfortunately all efforts proved unsuccessful and attempts to resuscitate were ceased at 11.40am.

Post Incident Response

The Governor was not on duty on 19 June 2004, but he went into the prison when notified of the man's death. Among other things, the Governor needed to consider how best to break the sad news to the man's partner. As it was the weekend, the prison was operating with reduced staffing levels, including a reduced number of senior staff. Moreover, it would have taken over an hour to travel to Manchester and the Governor did not want the partner to hear the news from a third party. On balance, the Governor considered that the best option was to ask for officers from Manchester Police to visit.

When police officers visited the address they had been given they found the house boarded up and they informed the Governor about this. Shortly afterwards, the Governor was told that a letter from the man's partner had been found in the post room in which she gave her new address. The Governor contacted Manchester Police again to ask for a visit to be made to the new address. Before the visit could be made, however, the man's partner's daughter telephoned the prison as she had heard from other sources that her father had died. Very shortly after this call Manchester Police confirmed that they had visited the man's partner at her new address and had informed her of the death. Shortly afterwards, the man's partner telephoned Kirkham and spoke to the Governor. Later that same day the Governor also spoke to the man's father when he too telephoned the prison.

The man's family were offered the opportunity to visit the prison and to see the man's room, however the family did not take up this offer.

The Governor at Kirkham, accompanied by the prison's Head of Operations and Principal Officer, spoke to the prisoners as a group about the man's death. Prisoners were reminded about the support that was available to help them cope with the incident: Listeners; the duty officer; the chaplaincy; their own friends in the prison. The Governor spoke individually to two prisoners whom he considered potentially the most vulnerable – one was the man who had tried to rouse the man and had then raised the alarm when unable to do so; the second was a prisoner who was understood to be related to the man. During the remainder of 19 June 2004 and through the following day prison staff made a point of being around and available for prisoners to speak to them if they wished to do so.

A notice about the man's death was posted in all residential areas in Kirkham inviting prisoners to contact staff or a listener if they felt they needed counselling.

To ensure preservation of evidence, the man's room was sealed as soon as it was practicably possible to do so. Statements were taken from relevant staff on the day of the incident. All the necessary information was gathered together for the purposes of an investigation.

The man's death was confirmed at post mortem to have been caused by an intracerebral haemorrhage.

Level of Compliance

Standards of health care in prison are intended to mirror those available in the outside community. The man's records indicate that while at Kirkham his health care needs were dealt with adequately. This aspect of his care is described in the independent clinical review, which concludes that he was well looked after and there were no major areas where his care could have been improved. Record keeping, however, was less than adequate.

Findings

When the man arrived at Kirkham he reported a past medical history of migraine headaches and one of the other prisoners told my investigator that the man seemed to suffer from frequent headaches. Despite this, the man's records show that he only very rarely consulted Healthcare about this condition, although his records do show a number of consultations with Healthcare for a condition that might have been piles.

Regardless of why the man only rarely consulted Healthcare about migraine headaches, the clinical review has indicated clearly that the healthcare he received at Kirkham had been appropriate. This included the man's treatment on 18 June 2004 when he did report symptoms indicating the onset of a migraine headache. The man's father wondered whether his son's symptoms should have triggered referral to hospital where a scan could have been carried out. I am satisfied, however, that the man's presenting symptoms did not indicate that such a response would have been appropriate at that time, particularly given his past medical history of migraine.

Although the clinical review found that the man's care and treatment at Kirkham had been appropriate, a number of deficiencies in record keeping have been identified.

I note that Kirkham asked Manchester Police to deliver the sad news of the man's death to his partner. This was in line with practice in many jails and I entirely understand why the Governor reached the decision he did. However, I also note that the man was a relatively young man, and his death was entirely unanticipated. Preston and Manchester are not very far apart, and I believe that, had the Governor or a member of his senior staff delivered the sad news in person, this would have constituted very best practice.

Conclusions

The man was well cared for in Kirkham and the healthcare he received there was probably at least as good as it would have been outside in the community. There were no indications to staff that the man had a developing condition that ultimately proved to be fatal.

Recommendations

I recommend that a full review of record keeping systems in the Healthcare department take place as soon as possible. Good record keeping promotes best practice in patient care, but also provides safeguards in the case of legal or disciplinary action. Both the General Medical Council and the Nursing and Midwifery Council are resolute on this matter.

Response to recommendation from HMP Kirkham

In response to the recommendation on record keeping made in the PPO's draft report, the Governor at Kirkham wrote that the following would take place:

- During September/October 2004 an internal audit of Inmate Medical Records (IMRs) and pharmacy will take place which will be consistent with Nursing and Midwifery Council (NMC) guidelines.
- All Staff Performance and Development Records will include specific reference to standards and responsibilities in relation to record keeping, with immediate effect.
- A sampling exercise will occur twice yearly to ensure compliance with NMC guidelines. There will also be a feedback report to the Senior Management Team meetings, twice yearly, to monitor progress in this area.

Good Practice

A full investigation might have revealed aspects of the man's treatment that amounted to good practice, but in this case, where the death was clearly due to natural causes, the more limited type of investigation that has been conducted has not brought these to light.