Investigation into the circumstances surrounding the death of a man at HMP Wakefield in July 2006

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is the report of an investigation into the death of a man at HMP Wakefield in July 2006. The man died of natural causes after he collapsed in his cell. He was 60 years of age.

My colleagues and I offer sincere condolences to his family and friends for their sad loss.

This investigation has been undertaken by one of my colleagues. I would like to thank the Governor of HMP Wakefield and his staff for their participation in the investigation. Particular thanks go to the Deputy Head of Offender Management.

I much regret the delay in issuing this report. This was caused by a wait of almost ten months before I received the clinical review commissioned by the Wakefield District Primary Care Trust.

When he first arrived at Wakefield, the man had a number of long term medical conditions for which he needed to take medication and which needed to be monitored. He was admitted to the healthcare centre. He was diagnosed with prostate cancer in July 2004. While in Wakefield, the man spent prolonged periods of time located in the healthcare centre, mainly because he struggled to cope on normal location due to his poor physical and mental health. Indeed, he was located in the healthcare centre permanently for approximately 18 months before he died.

The comprehensive clinical review has raised a number of concerns. I am particularly concerned that there was apparently no coordination of the man's overall care and an over-emphasis on his terminal illness at the expense of his other chronic long term conditions. I fully endorse the recommendations made in the clinical review and include one of my own.

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

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Summary

The man had been located in HMP Wakefield since 5 February 2004. He transferred there from HMP Dovegate. Prior to that he had been located at HMP Exeter. On admission to Wakefield, it was clear that he had several long term chronic medical conditions which needed to be monitored and for which he needed medication. His medical problems included Type 2 Diabetes, cardiovascular disease and peripheral vascular disease (obstruction of peripheral arteries) which had resulted in a left lower limb amputation in 1990. He was also noted to be incontinent of urine and suffering from depression. He was diagnosed with prostate cancer in July 2004.

The man spent a substantial amount of time at Wakefield located in the healthcare centre, mainly because of his poor physical health and depression. He was there for the whole of the last 18 months of his life. He died there in July 2006 after collapsing in his cell. Staff attempted to resuscitate him without success.

I am satisfied that the man was appropriately located during his time at Wakefield. However, I am concerned that, as the clinical review team has identified, there was a general lack of co-ordination in the management of the man's health. The clinical review team note:

> 'With hindsight there appeared to be an over emphasis on the man's terminal health status, as evidenced in the interviews of several doctors and nurses. This over emphasis was to the detriment of the management of his chronic long term conditions. It is apparent that the man was not in the terminal stage of prostate cancer. It is highly likely that his increase in symptoms was due to his cardiovascular disease rather than his prostate cancer. His cardiovascular disease and diabetes were not optimally managed for the last 18 months of his life and his chest pain was not investigated in line with nationally agreed standards.'

The clinical review is very comprehensive and provides a detailed chronology of the man's clinical care while at Wakefield. It also discusses issues relating to the provision of that care.

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The investigation process

1. My investigator studied all relevant prison records relating to the man who died. These included his main prison record, medical record and statements made by prison staff.

2. The clinical review was undertaken by a team from Wakefield District Primary Care Trust consisting of the Practice Development Manager, the Medical Director, and the Senior Commissioning Manager (Prisons and Substance Misuse). I am grateful for their very comprehensive review.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation, and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. During the course of the investigation seven members of staff were interviewed jointly by my investigator and two members of the clinical review team.

HMP Wakefield

5. There has been a prison on the site of HMP Wakefield since 1595. In its current form, the prison dates back to 1845. All the cells are single occupancy and have integral sanitation and the prison has recently undergone refurbishment. The prison's healthcare centre is separate from the main residential areas.

6. Wakefield is a prison for men serving four years or over (including many life sentence prisoners) and forms part of the high security estate. It holds prisoners who potentially pose the greatest risk to the public, with the focus on serious sex offenders.

7. The prison provides workshops and an education department offering both full and part time education. The programmes department offers a range of offending behaviour courses including FOCUS (drug programme), Sex Offender Treatment Programme (SOTP) and the Enhanced Thinking Skills (ETS) programme.

8. The most recent report by HM Chief Inspector of Prisons in April 2005 came after an unannounced inspection and report 18 months previously. The report says: "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."

9. The report also 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 the primary care area. Many of the nursing staff were frustrated they could not put their wide range of clinical skills to use as much of their time was spent on providing basic care. Despite this, 66% of prisoners, compared to 38% in 2003, rated the overall quality of healthcare provided by nurses as good or very good. The use of locums to cover the shortfall of GP's did not provide continuity of care for prisoners, which was a cause of concern to them."

Key events

10. The man was convicted of serious sexual offences on 29 May 2002 and was sentenced to14 years imprisonment. He was located in HMP Exeter. He was admitted to the healthcare centre on reception and immediately placed on a F2052SH form. (This was the system used by HM Prison Service to monitor and support a person at risk of suicide or self harm which has been replaced by ACCT (Assessment Care in Custody Teamwork). The man indicated that he was depressed and had attempted suicide before he was sentenced. On 18 June, there was a discussion regarding transferring him to either Wakefield or HMP Kingston (in Portsmouth). On 20 June, there was a multi-disciplinary review and the man's transfer to another prison was again discussed. Kingston was considered the most appropriate prison in terms of his overall care. However, it was felt Kingston was too far from his home.

11. On 24 June, there was a request from Exeter to HMP Wakefield to transfer him there as there is no full time healthcare provision at Exeter. On 19 July, it was noted in his core record that he appeared quite happy and had had a visit from a close friend.

12. On 5 August, the man was told that he was going to be transferred to HMP Frankland (in County Durham). He was said to be quite distressed and was concerned that he would not be able to see his one visitor and his elderly mother. He said he would hang himself as he had nothing to live for. He was still being monitored by the F2052SH which was subsequently closed on 6 September.

13. On 30 September 2002, it was agreed that the man would be transferred to HMP Dovegate (in Staffordshire). The man was still unsettled and F2052SH was reopened on 16 September. It was closed again on 9 October but on 3 November he took an overdose.

14. The man was transferred to Dovegate on 6 December and was admitted to the healthcare centre on reception. He was generally unsettled at Dovegate and was monitored by F2052SH from 25 July 2003. He had a feeling of helplessness and told a Community Psychiatric Nurse (CPN) that he had no reason to live. He was referred for psychodynamic counselling and saw a Senior Residential Occupational Therapist (SROT) on 30 July. He told the counsellor that he had been trying to save his medication with the intention of killing himself. He also said that he had put a polythene bag over his head on 22 July. The man had follow-up appointments with another occupational therapist over the next two months. He was moved to normal location at the beginning of September. He was very concerned about being bullied by other prisoners and had difficulty moving around in his wheelchair. He was back in the healthcare centre on 11 September.

15. The man arrived at HMP Wakefield on 5 February 2004 and remained on the F2052SH. (The clinical review provides a comprehensive chronology of his time at Wakefield. I shall not repeat this information here but instead simply mention some significant events.) The first reception healthcare screen noted his medical problems and the plan was to refer him for an assessment by the diabetic nurse. It was also recommended that he see a nurse regarding his incontinence. There is no evidence this ever happened. It was also the intention to increase his mobilisation in his right leg, but there was no plan of how this was to be achieved. The man's blood pressure was also to be checked fortnightly as he was taking anti-depressants. Finally, a full blood count was arranged and showed abnormal results. There is no evidence of any follow-up action after that.

16. The man saw a diabetic nurse specialist on 5 February and she fully assessed him. She referred him urgently to the chiropodist and optician. There is no evidence, however, that he was ever seen by a chiropodist. (He saw an optician on 28 July.) The diabetic nurse specialist discussed the man's blood glucose control with a doctor and metformin was prescribed. She also recommended an urgent referral to a general surgeon due to the poor condition of his left leg. There is no evidence the man was referred to a general surgeon, although he was seen by a doctor about his circulation who considered he had osteo-arthritis.

17. On 7 February 2004, the man was admitted to hospital complaining of chest pain and shortness of breath. He described the pain as similar to what he had experienced eight years previously when he suffered a heart attack. He was discharged on 8 February and was told he had angina. His beta blocker medication was increased.

18. On 11 March, the man was reviewed by the diabetic nurse and she noted an improvement in his blood sugar levels. His diabetic medication remained the same. No date was noted for the next review. There is no evidence of a further formal review, although the diabetic nurse said in interview that she reviewed him informally when she worked in the healthcare centre. The F2052SH was closed.

19. On 15 March, the man was discharged from the healthcare centre to ordinary location on B wing and was said to be slightly anxious. On 2 May, another F2052SH was opened. It was closed on 10 May. On 11 June, he was seen by the mental health in-reach team who did not diagnose any identifiable mental health illness. He was referred to a registered mental health nurse for a follow up assessment. There is no evidence that happened, although in interviews nurses said the man's mental state was assessed informally while he was in the healthcare centre.

20. On 26 July, the man had a scan and a biopsy for suspected prostate cancer. On 18 August 2004, he attended an outpatients appointment

at the specialist hospital and was told that he had prostate cancer. He was made aware of the prognosis and planned treatment which was hormone injections. He was referred to a hospital in Leeds for a bone scan.

21. On 20 September, the man was admitted to the healthcare centre for observation and assessment as he was not co-operating with his treatment. He was discharged back to the wing on the same day as he said he felt worse in the healthcare centre. On 11 November, he was enquiring about the result of his bone scan in August. There is a note to him from the clinical director: 'Results of scan have not been communicated to us. The hospital doctor did say he would discuss results with you.' There is no evidence this was followed up by the clinical director. On 7 October, a letter sent to the medical officer noted that the man's bone scan showed some signs of secondary spread of the cancer. There is no evidence the man was told this or any evidence of future plans for treatment. On 12 November, he refused to be admitted to the healthcare centre as he said it made him depressed.

22. On 22 November, the man formally complained that he was located in a high security prison. He complained that this was unreasonable due to his disability. He was advised by the sentence manager that the Sentence Planning Board considered his category and allocation appropriate. It was explained that the decision was based on a number of factors including nature of offences, length of sentence and time left to serve. (A prisoner's allocation and categorisation is reviewed annually by the Sentence Planning Board.) The man was placed on a F2052SH on 25 November. This was closed the next day.

23. On 1 December the man was admitted to the healthcare centre for a comprehensive assessment of his condition. He was noted to be confused and tearful. On 7 December, there was general improvement in his condition and he returned to normal location. On 13 December, he was seen on the wing by a nurse and, as he was not coping, it was suggested he be admitted to the healthcare centre. He again refused. On 5 January 2005, the man was admitted to the healthcare centre suffering from nausea, vomiting and pain. His hormone injection was due on 20 January but there is no evidence it was given. It is noted on 1 February that incontinence was still a problem, but there is no evidence of any plan to deal with this. On 11 February, his hormone injection had still not been given, and there is a note in his medical record to discuss with the urology nurse specialist. On 1 March, there is a note that he was still waiting for the injection and that, if nurses were unable to give the injection, they should contact the urology nurse specialist. There is no evidence that the injection was given or that the urology nurse specialist was contacted. On 4 March, the man was moved to a cell on the top floor of the healthcare centre to enable better observation of him and interaction with other prisoners. On 10

March he was much brighter and more settled. The urology nurse specialist gave him his injection on 31 March.

24. On 14 April, tests showed that he was responding to the hormone treatment. It was noted in his medical record on 19 April and 28 April that he was waiting for a urology review. This was followed up by a letter to the urology consultant from the clinical nurse specialist on 11 May requesting a review.

25. On 6 May, it was noted during a Palliative Care Team review that the man's right foot was swollen. The team asked a doctor to review it. There is no evidence this happened.

26. On 13 May, the man was assessed by a wheelchair therapist to examine his posture and consider how to relieve pressure. He was provided with a wheelchair and cushion. On 9 June, the Palliative Care Team asked for him to have regular blood sugar checks. There is no evidence that happened. The man's next hormone injection was due on 30 June. It was not given. On 8 September, the doctor was called to see him as he complained of stomach pain, was grey and was constipated. His observations were within normal limits. His blood sugar was not checked.

27. The man was moved to the palliative care suite on 30 October. On 21 December, it is clear there was confusion over responsibility for the hormone injections. The consultant urologist assumed the urology nurse specialist was giving the hormone injections while the urology nurse specialist assumed the prison nurses were doing it. The urology nurse specialist wrote a letter on 22 December: 'I am not responsible for the man's injection therefore I did not have one on order. Staff on hospital wing have been shown how to give injection - needs ordering and giving as soon as possible.' There is no evidence of any consultation with prison healthcare staff as to why the injection was not being given and no evidence of forward planning for future injections.

28. The man was given his hormone injection on 11 January 2006 by prison healthcare staff. The last injection before that appears to have been given on 31 March 2005. There is no record of injections being given in June or September 2005, and there was no plan for the next injection to be given in April 2006.

29. On 28 February 2006, the man complained of chest pain and a tingling sensation in his left hand. A nurse got advice from a doctor over the telephone and Glyceryl Trinitrate (GTN) spray was administered effectively. This is an indication the pain could have been related to cardiac problems as GTN is used in treating angina. The clinical reviews says: 'There is no evidence that the correct medication was administered as recommended in the National Service Framework - Coronary Heart Disease- Standard 6.' The man was placed on an ACCT on 31 March. The ACCT document was closed on 2 May. On 7

May, 23 May and 1 June, the man was still complaining of breathlessness. There is no evidence he saw a doctor about this.

30. On 6 June, there is evidence that the man was not in the terminal phase of cancer. On 28 June, a prison nurse contacted the urology nurse specialist then wrote: ‘Appointment to see urology consultant brought forward to end of July early August by urology nurse specialist. Advised for him to have a catheter fitted in the meantime.’

31. On 5 July 2006, the man complained of tightness in his chest and he started a course of antibiotics for a suspected chest infection.

Issues

32. The clinical review team identified a number of issues in relation to the man's clinical care which are comprehensively detailed in their report. The review identified a lack of overall 'case management' for his clinical care, with no clinician taking the lead to coordinate and review it. The man did not actively have input into his own care either. He did not have a shared care plan which he had agreed. It is clear he felt he was not kept updated about his prostate cancer. He asked to see the Clinical Director on 4 October 2004, and it does not appear that he was told about his prostate cancer until he asked the palliative care nurse on 11 November 2004.

    The Healthcare Manager must ensure that there is a formalised case management approach to the care of prisoners with serious long term medical conditions with a clearly identified person taking the lead in reviewing and coordinating their care. Prisoners should also have an input in agreeing a shared care plan.

33. The clinical review also identifies that there was a complete lack of clarity and coordination concerning the role of the urology nurse specialist and the prison nurses in managing the man's prostate cancer. On a positive note, it was considered that the Mid Yorkshire Hospitals NHS Trust (MYHT) Palliative Care Team provided a comprehensive and high quality service to the man. It is evident there were frequent assessments by the urology nurse specialist and the palliative care team. However, prison doctors and nurses over-relied on the urology nurse specialist and wrongly saw her as the leading clinician regarding overall case management. For example, hormone injections for the prostate cancer were haphazardly managed, with some administered by the nurse and some by prison healthcare staff. Injections should have been administered every three months but the man did not receive any injections between March 2005 and January 2006. Despite this, his cancer did not appear to be showing any signs of progression, and this was confirmed in the consultant urologist's letter of December 2005. Prison nurses considered it a specialist role and were not confident in administering the injections despite being shown what to do by the urology nurse specialist. The urology nurse specialist was not aware therefore that the injections were not being given to him which meant some injections were missed.

    The Healthcare Manager must ensure that healthcare staff communicate appropriately with all those involved in treating a prisoner to ensure an appropriate standard of continuous care.

    The Healthcare Manager must ensure that a clear policy is developed to clarify responsibility for the administration of hormone injections to patients with prostate cancer.

34. The clinical review comments as follows on the standard of medical entries and record keeping:

> 'Quality of written nursing assessments, care plans, reviews, evaluations and daily intervention notes were on the whole adequate. The nursing entries in the medical record are mostly written clearly and can be understood. The clinical records are factual, accurate and appear to be contemporaneous but many of the medical entries are not legible and not structured which made it difficult to assess appropriateness of treatment and treatment reviews. Not all entries are timed and signed and few have the name of the author printed. A record keeping audit by the healthcare manager in 2006 confirmed that clinical record keeping still needed to be improved.'

In the man's case, the prescription charts are of poor quality, for example with incomplete or illegibly completed personal details. The allergy section was never completed for him which resulted in him being re-prescribed medicine on 18 May 2006 to which he had previously had an allergic reaction on 7 May.

The Healthcare Manager must remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.

35. It is also apparent that there is an incomplete written account of the events around the man's death. The prison doctor who attended made a complete entry in his medical record describing her actions. However, the nurse who found him collapsed in his cell did not have time to record her account of events in the man's medical record before it was taken away to be put in a secure location. That was following the prison's contingency plan for dealing with a death in custody but led to an incomplete record of events in the man's medical record. However, the nurse did complete an incident report following the man's death which detailed her actions.

36. I agree with the conclusion of the clinical review that there was an apparent over-emphasis on dealing with the man's prostate cancer at the expense of the management of his other conditions. For instance, in November 2004, his medication to lower his cholesterol levels was stopped as he refused to take it as he said it made him feel nauseous. There is no evidence this decision was ever reviewed. A person with cardiovascular disease and diabetes would normally be prescribed medication to lower cholesterol as it significantly reduces their risk of cardiovascular complications.

37. The man's diabetes was not formally monitored except for an initial assessment when he first arrived at Wakefield and a follow-up assessment. The nurse who completed these assessments said in

interview that she did informally review the man whenever she was working in the healthcare centre. However, his blood glucose levels and blood pressure were not monitored regularly which, as the clinical review points out, is essential to reduce the chance of developing complications of diabetes.

38. It also appears there was no formal assessment of the progression of his peripheral vascular disease. There should have been management of his pressure areas, particularly as he was wheelchair-bound and incontinent. There was no plan either to ensure his mobilisation was encouraged, even though according to entries in his medical record this was requested both on 5 February 2004 and 19 May 2004.

39. Despite documentary evidence that a continence advisor should be consulted for him, a care plan was never put in place and advice was never sought. This resulted in inconsistent management of that problem by several different nurses.

40. The clinical review is very critical of the management of the man's chest pain:

> 'Despite the man's history of cardiovascular disease and having previously suffered a heart attack in 1990, it does not appear that any action was taken to investigate the incidents of pain in the left side of his chest particularly after events on 28 February 2006. The man responded to the use of GTN spray which suggested that his pain might have been related to cardiac complications and needed further investigation. He was not referred for further assessment or treatment to relieve his pain and to reduce the risk of a coronary episode. After 28 February there was a general deterioration in his physical and mental state. He became more anxious and his chest pain increased which caused him some concern. On 26 April, a nurse noted in the medical record that the man was feeling despondent due to the increasing pain in his chest and deterioration in the quality of his life. It seems that healthcare staff assumed the increase in chest pain was due to possible secondary spread of cancer to his ribs. However, a chest x-ray taken in March 2006 did not confirm this.'

41. The review concludes that the man was not in the terminal stage of cancer and that: 'it is highly likely that his increase in symptoms was due to his cardiovascular disease rather than his prostate cancer. His cardiovascular disease and diabetes were not optimally managed for the last 18 months of his life and his increase in chest pain was not investigated in line with nationally agreed standards.'

The Healthcare Manager must ensure that any action regarding a patient's care is taken forward appropriately and in a timely

fashion to provide a more holistic approach to care to ensure all the patient's needs are met.

The Healthcare Manager must formalise the role of prison nurses with specialist interests such as diabetes and palliative care providing appropriate job descriptions.

Recommendations

The Healthcare Manager must ensure that there is a formalised case management approach to the care of prisoners with long term conditions with a clearly identified person taking the lead in reviewing and coordinating that care. Prisoners should also have an input in agreeing a shared care plan.

The Healthcare Manager must ensure that healthcare staff communicate appropriately with all those involved in treating a prisoner to ensure an appropriate standard of continuous care.

The Healthcare Manager must ensure that a clear policy is developed to clarify responsibility for the administration for hormone injections to patients with prostate cancer.

The Healthcare Manager must remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.

The Healthcare Manager must ensure that any action regarding a patient's care is taken forward appropriately and in a timely fashion to provide a more holistic approach to care to ensure all the patient's needs are met.

The Healthcare Manager must formalise the role of prison nurses with specialist interests such as diabetes and palliative care providing appropriate job descriptions.

The Prison Service has accepted the above recommendations apart from the second one which has been partially accepted. They point out that, 'Daily briefings are held as part of the medical practice, in which all staff attend. Care Plans are completed on a daily basis. Contact is made with other NHS Providers for patient care where appropriate. Through working in partnership with Wakefield PCT, a new Electronic Patient Record has been set up. This will further improve the communication/care process for patients within Wakefield Prison. A review of the Medical Practice communications Policy will be carried out incorporating recent developments.'