Circumstances surrounding the death of a man, a prisoner at HMP Shrewsbury, at North Stafford Royal Infirmary in November 2008

Report by the Prisons and Probation Ombudsman for England and Wales

November 2009

This is the report of an investigation into the death of a man who died in November 2008 at North Stafford Royal Infirmary, Stoke-on-Trent. He was in the custody of HMP Shrewsbury when he passed away. He was aged 29.

The loss of any family member is acutely painful, but especially so whilst they are in custody. I offer my sincere condolences to his family and friends.

The man had arrived at HMP Shrewsbury in November, just two days before his death. The following morning he collapsed and hit his head while collecting his medication. Later that day, he was found unconscious in his cell and was taken to the Royal Shrewsbury Hospital. He was transferred to North Stafford the next day, but sadly did not regain consciousness. The post mortem confirmed that the primary cause of death was from damage resulting from epilepsy, and not from the blow to the head.

The investigation was conducted by one of my investigating officers. In addition, I commissioned a clinical review of the man's healthcare and would like to thank the clinical reviewer, a Risk Adviser at the local Primary Care Trust, who was appointed by the PCT to undertake the review. I would also like to thank the Governor of Shrewsbury and his liaison officer for their assistance.

I make five recommendations in this report, and note the man's cell allocation and the removal of restraints during his final hospital stay as examples of good practice.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2009**

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SUMMARY

The man collapsed onto the floor during an epileptic fit in November 2008 when he went to collect his morning medications in HMP Shrewsbury. That evening, he was found unconscious in his cell at 8.30pm and admitted to the Royal Shrewsbury Hospital. It was discovered that he had a head injury and he was transferred to North Stafford Royal Infirmary, Stoke-on-Trent, to be operated upon. He died in hospital without regaining consciousness.

The man had come into custody on 11 November. This was the third time he had been in prison. He suffered from diabetes and epileptic fits (the last being a week before he arrived at Shrewsbury) and he was an alcoholic. During his initial healthscreen, the doctor prescribed medication for his illnesses and for his detoxification from alcohol. He had said that he drank six litres of cider per day, and was suffering severe alcohol withdrawal symptoms.

In view of his health problems and for his safety, the man was allocated the bottom bunk bed in a shared cell on the lowest floor of the prison. This meant that he did not have to use the stairs when collecting his medication.

Following his fit the following morning, he was immediately attended by five nurses. He was checked for any injuries and his clinical observations were taken including his pulse, blood pressure and breathing. There were no visible physical injuries and, when questioned, he did not complain of any pain or injury. He did not think he had suffered a head injury and returned to his cell.

The man was checked by a nurse a couple of times before lunchtime. He answered the questions on a three page questionnaire concerning his alcohol problems. Although he vomited once, his observations had also improved slightly and he appeared to have recovered from his fit.

When he did not attend to collect his medication at 4.00pm that afternoon, a nurse went to his cell to give it to him. She went with an officer and they found him snoring loudly. They tried to wake him but then decided to leave him as they thought he was asleep. At 8.30pm that evening, when nurses tried again to wake him for his medication, they found that he was unconscious and unresponsive, and immediately called for an ambulance.

Although an operation at North Stafford Royal Infirmary to remove a subdural haematoma was successful, epilepsy had caused extensive damage and the man died without regaining consciousness. He was aged 29. His parents were at his bedside.

THE INVESTIGATION PROCESS

1. My office was notified of the man's death in November 2008. Notices announcing the investigation were supplied by my investigator, and displayed by the prison to staff and prisoners who were invited to contribute any relevant information. No prisoners or staff made contact.

2. All relevant prison records relating to him were studied by my investigator. They included his main prison record, medical records and statements made by staff. One of my family liaison officers made contact with his girlfriend and parents.

3. A clinical review of the man's healthcare was undertaken by the clinical reviewer, a Risk Adviser at the local Primary Care Trust. The clinical reviewer also made himself readily available to answer any queries during the investigation, and his assistance was much appreciated. The scope of the clinical review was to:

   - Examine the provision of care and treatment, including risk assessment and risk management.
   - Examine, to the extent necessary, the secondary care provided.
   - Provide a chronology of the health and social care events leading up to the incident.
   - Identify any care of service delivery failures along with the factors that contributed to the problems.
   - Examine policy and practice.
   - Identify any root cause(s) that inform the identification of learning opportunities to be included in the action plan.
   - Make clear sustainable recommendations for the health community and the Prison Service.
   - Provide explanations and insight for the relatives of the deceased.

4. Her Majesty's Coroner was contacted by my investigator to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist his enquiries into the man's death.

5. My investigator visited HMP Shrewsbury on 17 December to familiarise himself with the general environment where the man was located when he suffered the seizure. He also visited the cell where he was found unconscious and spoke with members of staff including the Governor and the liaison officer.

6. On 4 February 2009, my investigator and family liaison officer visited the man's parents at their home. This gave them the opportunity to discuss the

purpose of the investigation and to raise any concerns or questions that they would like explored and addressed.

7. The man's father was concerned about the care his son received when he fell and hit his head. He also wanted to know why his son was not admitted to hospital until 9.00pm that night. He believed that if his son had been treated promptly he would still be alive.

8. The man's father explained that his son had been living at home but had not mentioned his court case, and had not contacted them when he went into prison. He did not know his son suffered from seizures or received medication for them. He knew that his son was a diabetic and had been diagnosed a year earlier. Both parents were aware that their son drank alcohol but did not know to what extent.

9. On 25 February 2009, my investigator returned to Shrewsbury where he interviewed a prison officer and three nurses. The clinical reviewer was present with my investigator in the appropriate interviews. The interviews were recorded and a transcript was made of each.

HMP SHREWSBURY

10. Shrewsbury is one of the oldest prisons in England and there has been a jail on the site since 1793. The present prison was built in 1877. It holds both sentenced and un-convicted men from the courts in Shrewsbury, Mid Wales and Stoke-on-Trent. It currently has an operational capacity of 340 adult male prisoners who occupy mainly double cells within two wings, 'C' wing and 'A' wing. 'A' wing cells are located on four galleried landings, known as A1 (ground floor), A2, A3 and A4 landings.

11. The local Primary Care Trust is responsible for healthcare provision within the prison. The Primary Care Centre is staffed by a multi-disciplinary team under the management of a doctor and a healthcare manager. It is currently open from 7.30am to 9.00pm daily and provides primary healthcare; substance misuse services / dental / psychiatric / optical / chiropody / counselling services; and STI (sexually transmitted infection) / BBV (blood borne virus) / Well man, asthmatic and diabetic clinics.

12. There is a system of emergency radio calls in place to ensure that staff are aware of the type of emergency. 'Code blue' is a local procedure used to alert the communications room staff that someone is experiencing breathing difficulty. The radio operator in turn alerts healthcare staff, who can then attend with the correct emergency equipment.

Previous deaths at Shrewsbury

13. There have been seven deaths at Shrewsbury since April 2004. None of the circumstances of the previous investigations is similar to those in this case.

Her Majesty's Inspectorate of Prisons

14. HM Chief Inspector of Prisons made a full announced inspection of Shrewsbury in June 2006. In the report of the inspection, the Chief Inspector said, "Communication and joint working between healthcare and the prison regime were good, and healthcare was well supported by Shropshire Primary Care Trust."

Independent Monitoring Board (IMB) report

15. Each prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community. They have full access to prisoners and every part of the establishment. In its latest annual report, for the year ending 30 April 2008, Shrewsbury's IMB did not highlight any issues which are particularly relevant to this investigation. The report said that, "Healthcare within the prison is continually striving to improve."

KEY FINDINGS

16. In November 2008, the man was sentenced by Welshpool Magistrates Court to 20 weeks imprisonment for a common assault. He arrived at HMP Shrewsbury at 4.30pm later that day. During his reception, he was described by staff as being polite and co-operative.

17. A nurse conducted the man's reception healthscreen. He told her that he had been in custody before and was not at all concerned. He said that he was a smoker and an alcoholic and, having consumed alcohol earlier that day, was suffering from severe withdrawal. He agreed that he would benefit from an alcohol detoxification programme. It was noted that he also expected to receive medical treatment for epilepsy and diabetes.

18. During the healthscreen, the man provided his doctor's details. He said that he had recently seen his doctor regarding his liver function, blood tests, diabetes, and a pressure ulcer on his left foot. He also said he suffered from epileptic fits, the last being a week ago. The fits had been investigated at Royal Shrewsbury Hospital, where he had had an electrocardiogram and a brain scan.

19. The man told the nurse that he had been diagnosed with type 2 diabetes four years ago and been receiving prescribed medication (metformin: a first line drug for type 2 diabetes treatments). However, when this was later checked with his doctor, it was discovered that he had not collected his medication since July 2008.

20. As a result of his physical health problems and alcohol abuse, the nurse referred the man to the doctor. A prison doctor prescribed librium (a treatment given for the management of acute alcohol withdrawal syndrome) and vitamin B. The doctor instructed that the man should be 'located flat' which meant that he would be located on the lower floor landing and would not have to go upstairs to the healthcare centre for his medication.

21. The man was also prescribed carbamazepine (a drug used in the treatment of epilepsy). The doctor referred him to the diabetes clinic and to the dressing clinic for his ulcer. When the man told the doctor that he thought he had an appointment at the Royal Shrewsbury Hospital, the doctor wrote that this should be re-arranged. The man was given 30mg of librium (at both 5.45pm and 8.00pm) and 500mg of metformin and 100mg of carbamazepine. He was located in cell A1-20 where he had the bottom bunk bed. (It was a shared cell.)

22. At 7.30am the next day (12 November), the ma went to the medication hatch (known as the A1 hatch on A wing), where he suffered a fit which lasted between one and two minutes. A Staff Nurse was on duty in the office of A1 Wing when he heard a commotion. He went outside and saw that the man was experiencing a seizure. He put a 'code blue' call over the radio network.

23. A second Staff Nurse arrived from the second floor landing. She knew the man as she had treated him during a previous sentence and was aware of his history of epilepsy. She put him into the recovery position and placed a blanket under his head. A third Staff Nurse also went down to A1 landing where she saw the man laying in the recovery position. She noticed that he was breathing spontaneously, and moving and starting to open his eyes and look around.

24. Two Sisters attended together from an office in the primary care department. They saw the man on the floor being attended to by the other nurses. The first Sister noticed that he was moving but was not fully conscious. The second Sister noticed that he started to respond to voice commands as his level of consciousness returned. Together, the nurses discussed further action. The third Nurse and second Sister then left the scene.

25. A Principal Officer (PO) was also on duty carrying out the Orderly Officer's duties. (The Orderly Officer is in charge of the day to day running of the prison.) He too responded to the 'code blue' and saw that the man was being attended to by healthcare staff. He asked what had happened and what the prognosis was. Staff told him that the man had collapsed and had suffered a fit. He asked if anyone had witnessed the fall, but no one could categorically say that they had.

26. The first Sister was informed that the man was undergoing a librium detoxification for alcohol misuse and other medication as well. She then went to the addiction room on A2 landing to bring down the librium prescription chart. The man's normal prescription chart was already in the A1 landing office.

27. Upon her return, the first Sister saw that the man was now conscious but confused. The Sister was told by an Officer that, at the onset of the fit, the man might have hit his head when he had fallen. The Sister passed this information to the second Staff Nurse and told her that observations should be taken.

28. The man's blood pressure, pulse and a number of other routine physical and responsive tests were checked. He was asked a series of questions to check his response. He answered the questions satisfactorily and had no visible injuries. The nurses thought that he seemed to have recovered quite quickly.

29. A wheelchair was brought to the scene and the man was helped into it and taken back to his cell. He walked unassisted to his bed and lay down on the bottom bunk. At that point, the first Staff Nurse left fellow nursing staff in attendance and returned to his duties.

30. The second Staff Nurse went to collect the man's medication and, on her return, saw that he was being helped into bed. The first Sister told the second Staff Nurse to contact her if she needed assistance, and then left. The man sat up on his bed and the second Staff Nurse gave him his medication. She recorded his current observations and thought that he seemed fine.

31. The orderly officer was also concerned that the man might have banged his head. He assumed, after seeing him on the floor and the state that he was in, that he would probably go out to hospital. He went to check what staff were available to escort him to the hospital if required.

32. Whilst the orderly officer was in the centre office, the second Sister arrived and told him that the man would not need to go out to hospital. The nurse told him the man had had his responses checked, and they were sure that he had had an epileptic fit. The orderly officer saw that by this stage the man was starting to come round. That was the end of his involvement, although he did request that an F213 (a form used by staff to report injuries to prisoners) be completed.

33. At about 9.30am, the second Staff Nurse returned to the man's cell and completed a routine severity of alcohol dependence questionnaire. This is a three page questionnaire used to assess whether or not is the patient has a problem with alcohol dependence. A score of 31 points or higher indicates severe alcohol dependence. The man answered all of her questions.

34. The man told the second Staff Nurse he had been drinking heavily for ten years, and been drinking seven litres of white cider daily for the last 12 months. (He had told the reception nurse during his reception healthscreen that he drank six litres daily.) He also answered 'yes' to having had a history of fits, and said that he had undergone an alcohol detoxification programme in February 2008. The man had a final score of 39 points.

35. During the assessment, the man went over to the sink and vomited once. The second Staff Nurse then recorded his observations again to check him after his fit and in case he had suffered a head injury. The observations were slightly better than the previous recordings. When questioned further, he said he had no head pain and no recollection of hitting his head. He said that he had fits approximately once a week. The Nurse advised him she would telephone the doctor anyway.

36. At approximately 9.50am, the second Staff Nurse telephoned a second prison doctor to advise him of her opinion of the man. She told my investigator that she told the doctor that the man was unwell and was withdrawing from alcohol, and that he had agreed to having anti-nausea medication. The doctor prescribed 10mg of metoclopramide, an anti-emetic (to help stop nausea and vomiting).

37. The second Staff Nurse returned to the man's cell to administer the anti-emetic injection. She noted that he presented as well in the circumstances as she would expect a prisoner under a detoxification programme. He asked her for the time and when he would next have his librium.

38. At about 10.30am, the third Staff Nurse rang the Addictions Department in the prison to ask about the man's dressing on his foot. It needed soaking off and replacing. She was told that, as he had vomited, he had been given an anti-

emetic and would therefore not be well enough to go to healthcare for his dressing. Because of the risk of infection, it was not practical to dress his wound in his cell so the Nurse put his name in the clinic book to attend the next day.

39. The second Staff Nurse returned to monitor the effect of the medication and give the man his lunchtime medication at 11.30am. He had had no further vomiting. The Nurse saw that he seemed brighter, was talking and had sat up to take his medication. He was given 500mg of metformin and 100mg of carbamazepine. The nurse had no further concerns about him at that time.

40. The second Staff Nurse left the cell and telephoned the man's outside doctor to check his medication. It was confirmed that he was prescribed metformin 500mg but had not collected a prescription since July 2008.

41. At approximately 2.30pm, the second Staff Nurse again discussed the man with the first prison doctor who prescribed further metoclopramide if required. The nurse then telephoned the hospital and booked an outpatient appointment for the man for 11.00am on 18 November.

42. A fourth Staff Nurse commenced her shift at about 1.00pm and recalled in interview that someone had told her that a prisoner had had an epileptic fit earlier that day and had hit his head. Besides other duties, she was also allocated the 'locate flat' medication to dispense at tea time.

43. A fifth Staff Nurse accompanied the fourth Nurse to the A1 landing arriving about 3.50 to 3.55pm. It had been decided that the fifth Nurse would dispense the medication so that she could get more practice on the wing, as she had only started working at the prison Healthcare Department on 3 November. She had qualified as a nurse two years earlier.

44. The fourth Nurse explained to the fifth Nurse that the treatment folder always had three duplicated lists of the medication to be given to prisoners and that this was clipped to the front. Appointment slips for triage or to see the doctor were put into the various landing trays and then given out to prisoners by the officers.

45. The officer on duty was given one of the lists with the names of the prisoners instructed to come to the hatch for their medication. The fifth Nurse then went through each prisoner treatment chart giving the correct amount of medication, and signing each one as she went along. At the same time, the fourth Nurse double checked by ticking off who had attended. Everyone came for their medication except for the man.

46. Both Nurses planned to take the man's medication to his cell together, but the fifth Nurse suggested that one of them could look after the rest of the medication in the office. The fourth Nurse agreed with this as the fifth Nurse was a qualified registered mental health nurse and had already dispensed medication to the rest of the prisoners.

47. The fifth Nurse left the office with an officer at 4.20pm to take the man's medication to his cell. They found him asleep and snoring loudly. The fifth Nurse attempted to wake him and shook his arm but was unable to rouse him. The officer also attempted to wake him but was not successful. The fifth Nurse had no concerns about his physical health. She reported back to the fourth Nurse that she had been unable to wake him and that they would try him again later.

48. The fourth Nurse did not go and try to wake the man. Her previous experience was that some prisoners missed their medication due to being tired, whilst on other occasions they refused to take it. He was not seen between 4.20 and 8.00pm.

49. The fourth Nurse and a sixth Staff Nurse accompanied each other on the 8.00pm medication rounds; one signed the treatment charts whilst the other dispensed the medication. About half way through the round, an officer and the man's cell mate approached them to report that they were still unable to wake him. The fourth Nurse went into the cell and called him by name a few times as well as telling him it was time for his medication. The cell mate assisted by sprinkling water onto him face. The fourth Nurse took the man's hand and patted it, calling his name to help to alert him, but was unable to obtain a response.

50. A seventh Staff Nurse was in the primary care department when the sixth Nurse returned and told her that they were unable to wake the man. She explained that he was a diabetic who was on a librium detox for alcohol withdrawal, and was not responding to the nurse and officer. They immediately went to the man's cell. He was lying in bed on his back with his eyes closed. He was breathing spontaneously and a stridor (a high pitched sound resulting from turbulent air flow in the upper airway) could be heard.

51. When the nurses examined him, they found that his pulse was within normal limits but that he did not respond to any sort of external stimulation. Paramedics were called to attend. The sixth Nurse told the fourth Nurse to carry on dispensing medication for the prisoners. The sixth and seventh Nurses assisted the man until the paramedics arrived.

52. The man was removed from his bottom bunk with the help of two officers. He was rolled onto his right side into a semi-prone position. The seventh Nurse maintained his airway. He was administered 100 per cent oxygen at 15 litres per minute. The seventh Nurse saw that his pulse was regular with good volume and that he had a good colour and was breathing spontaneously. However, his pupils were fixed and dilated and he had been incontinent of urine.

53. The seventh Nurse also observed some movement in the man's right arm. Apart from this, he remained unresponsive throughout the time that the two nurses were with him. The ambulance crew arrived at the prison at about 8.40pm. The nurses continued to administer oxygen and maintain his airway whilst he was transferred to the ambulance.

54. According to the communications observation book the ambulance left at 9.10pm and went to the Accident and Emergency Department at the Royal Shrewsbury Hospital. The man was escorted by two prison officers and was restrained by a closeting chain. A bedwatch book (a log of events while a prisoner is in hospital) was started at 9.00pm.

55. The man was still unconscious when he was taken straight into the resuscitation unit at the hospital. He had x-rays and other tests also took place. At 11.00pm, his escort chain was removed and he was taken for a CT scan (a computerised tomography, which uses x-rays to make detailed pictures of structures inside the body). It was noted that there was a possibility of a head injury and that he might have to be transferred to another hospital.

56. Prison healthcare were informed by the hospital at 00.10am that the man‘s condition was serious and that he was going to be transferred to another hospital. Authority was given by the duty governor to permanently remove the restraints. At 00.50am that morning, the man was transferred by ambulance to North Stafford Royal Infirmary.

57. At 01.40am, the man went into theatre to undergo surgery for a subdural haematoma. At 01.45am, the prison tried to contact his girlfriend who he had named as his next of kin. At 3.00am, she was contacted, advised of the situation and, following authority from a governor at the prison, was offered a taxi to the hospital and back home.

58. The man came out of theatre at 5.00am and was moved to the multiple injuries unit. His condition was deemed to be critical. Surgeons were recalled when his condition deteriorated further. He remained critical and non-responsive to treatment. The prison was kept informed of the situation at regular intervals, and at 6.20am his girlfriend arrived.

59. Prison staff also obtained the telephone number for the man’s mother. They called it, but found that the phone did not take incoming calls. Healthcare staff contacted the hospital at 8.30am to ask for an update. The information from the duty staff nurse was that the man had suffered a subdural haematoma and his condition was deemed to be critical. At 8.50am, the prison were contacted and asked to try again to contact his mother.

60. The doctors next assessed the man at 9.30am. Healthcare were informed at 10.10am that within the next couple of hours the hospital would withdraw treatment if he remained unresponsive, and they were asked again to contact his parents. At 12.44pm, the Governor and Reverend visited the hospital and spoke to the consultant who said that he would continue with mechanical assistance until the man’s family were notified. Contact details were then passed to the Reverend by the police liaison officer, and the family were finally contacted.

61. When the hospital was contacted by prison healthcare for an update at 2.20pm, they were informed that both parents were travelling to the hospital. The hospital had said that treatment would be withdrawn when the parents arrived. The man's parents arrived at the hospital at 3.30pm.

62. The first Sister contacted the hospital at 4.20pm and was told that the man's parents had arrived and that treatment was being continued. At 4.30pm, both parents and his girlfriend were spoken to by the Governor and Reverend to share with them the circumstances leading to his admittance to hospital.

63. At 6.00pm, treatment for the man was stopped and, shortly afterwards, he passed away. The hospital doctor recorded the time of death as 6.27pm.

64. Shortly after the man's death, the prison activated its death in custody contingency plan. West Mercia Police, the Governor, the Coroner, the Independent Monitoring Board, and my office were informed. A prison family liaison officer was appointed, and a Sikh Minister from the prison liaised with the man's parents.

65. The police visited the hospital and the prison and took several statements, copies of which were supplied to my investigator. The police found that there were no suspicious circumstances.

66. A post mortem examination was carried out at Royal Shrewsbury Hospital on 14 November by a consultant histopathologist. The primary cause of death was found to be "anoxic laminar cortical infarct of brain" (damage to the brain due to an inadequate continuous flow of oxygen), "due to (or as a consequence of) epilepsy." Secondary causes were listed as alcoholism and a treated left subdural haematoma. A morbid condition, type 2 diabetes mellitus, was present, but in the pathologist's opinion this did not contribute to the man's death.

67. The pathologist commented:

> "[the man] suffered anoxic damage to the brain following an attack of epilepsy. This anoxic damage was severe and was the primary cause of his death. The subdural haematoma was successfully evacuated surgically and was survivable. Hence, in my opinion, death was due to natural causes."

68. Support and counselling was offered to the nursing staff who had treated the man. Prison staff were also offered support but, as the man had only recently arrived at the prison, none felt this was needed. My investigator was told that staff felt well supported after his death. Prisoners were also told of his passing, but none came forward with any concerns.

ISSUES CONSIDERED DURING THE INVESTIGATION

Allocation of the man's cell

69. When the man arrived at Shrewsbury, a full medical history was taken. He said that he was diabetic and withdrawing from alcohol. He also had a pressure ulcer on his left foot. After prescribing him medication, the first prison doctor advised that he should be located on the lower landing so that he would not need to walk up stairs to collect his medication. He was allocated an appropriate cell, and also given a lower bunk. I believe that this was appropriate to his needs, and regard it as good practice.

Clinical Care

Initial Treatment

70. When the man had the epileptic fit he was attended to by five nurses and recovered quickly. No signs of injury were found and the observations taken did not indicate any injury.

71. When interviewed by my investigator, the second Nurse said that when the man fitted (both this time and previously) it could have been the result of the large amounts of alcohol he drank before coming into prison. She said that he quickly stopped fitting but, had he continued for any length of time, or if any of the nurses had been concerned in any way, an ambulance would have been called immediately.

72. The second Nurse said that, when she checked the man, she found no visible or physical injuries and there was no bleeding. When he came round, the nurses took his clinical observations. When they were taken, the results were as she would expect them to be for someone who had just had a fit, was withdrawing from alcohol, and had a previous history of fits. She gave him his medication and a drink, and checked his head for bruising. He told her that he had no head pain or injuries.

73. When interviewed by my investigator, the orderly officer said he had dealt with epileptic fits in the past and there did not seem anything out of the ordinary in this case. He had asked if the man had hit his head and was assured that it did not appear so. He went on to say that it is not uncommon for prisoners to bang their heads (for example, on lockers). When an accident occurs, he takes advice from medically trained staff.

74. At the end of the interview, the orderly officer was asked if there was anything he wanted to add. He said:

> "I think that anything that was done for the prisoner at the time, anything that could be done I think was done. I think that everybody was satisfied at that particular time that he had suffered a fit and that was as far as it went. I don't think anybody in fairness could anticipate the events of the next 24 hours."

75. The clinical reviewer has looked at the care given to the man during this period. He finds that:

> "Both during, and after, the man's seizure in the morning, staff acted appropriately and in accordance with the observations and information available to them."

Further clinical interventions

76. At 9.30pm, the second Nurse returned to the man's cell to complete the severity of alcohol dependence questionnaire and was able to observe him further. During this period he vomited, which she considered as likely to be a withdrawal symptom from his alcohol dependency. She consulted the doctor who agreed with her assessment and prescribed an anti-emetic. No further observations were planned.

77. Nevertheless, the second Nurse returned an hour later and found that the man had not vomited again. This confirmed her earlier opinion that it had been a withdrawal symptom. When interviewed, she was asked why she thought he had vomited. She said that it could have been due to the alcohol detoxification, a reaction to the fit or a head injury. She also said:

> "If he had vomited more than once I would have thought it was to do with his head injury but as he only vomited once I thought it was to do with his alcohol detox. People do very often vomit after they've stopped drinking and they go on to prison. He'd said he had no head pain and no recognition of hitting his head. It would have been in the back of my mind. I took his observations and they were a little bit better than they had been previously. His blood pressure and pulse were lower."

78. The second Nurse also went on to say that the man had been drinking heavily outside prison, and had not been taking the medication for his diabetes. She thought it likely that he would have a fit if he stopped drinking so quickly.

79. The clinical reviewer notes that the second Nurse correctly referred the man to the doctor to confirm her assessment. She then returned an hour later and established that he had not vomited again. This reinforced her belief that her initial opinion was correct.

80. Although the second Nurse acted reasonably, the clinical reviewer believes that:

> "… signs of subdural haemorrhage can be delayed and difficult to diagnose. The regime of observations could have extended longer, and may have resulted in earlier treatment."

While, in the man's case, it was possible that the vomiting was caused by alcohol detoxification, it could also have been a sign of a brain injury. The clinical reviewer does not, in this case, think that the outcome would have

been different had he been treated earlier, given the findings of the post mortem. However, he had potentially suffered a serious brain injury and there was no plan in place to monitor for any signs of this. The clinical reviewer makes the following recommendation, which I endorse:

The Head of Healthcare should ensure that there are clear, defined care plans for any condition which can be difficult to diagnose, and where an adverse outcome can be serious.

Afternoon medication

81. When the man did not collect his medication in the afternoon, the fifth Nurse and an officer went to see him. They found him snoring loudly and tried to wake him, but decided to leave him as they thought he was in a deep sleep. They did not find this unusual as sometimes prisoners do not turn up for their medication because they are tired, asleep, or refusing to attend. The Nurse had no concerns about his physical health. She reported to the fourth Nurse that she had been unable to wake him and that they should try again later. The fourth Nurse did not consider the circumstances to be of concern.

82. The fifth Nurse had been working since the morning. She was aware there had been an emergency and by the afternoon was aware (in interview, she could not remember how) that the man had had a seizure. She was not aware, however, that he had suffered a potential head injury as well and this would have made a difference to how she responded to him.

83. The fourth Nurse commenced her shift at 1.30pm. In interview, she recalled hearing that a prisoner had hit his head, but was unaware who the prisoner was. When interviewed by my investigator, she said, “Looking back on the incident we could have had a better history of the man, yes, observations as well, regular obs. It should have been carried on … from when he had them earlier.”

84. It is clear that the staff who saw the man later in the day were not fully aware of what had occurred in the morning. Had they been, they might well have acted earlier and sought further treatment for him. It is important that staff are given such relevant information as soon as possible if patients are to be given the best and most suitable treatment. The clinical reviewer makes the following recommendation, which again I endorse.

The Head of Healthcare should ensure all staff are aware of significant healthcare issues with patients, and that there is an effective method of communicating information between shifts.

Recording information in medical records

85. My investigator asked the fifth Nurse whether she recorded that the man had missed his medication. She said:

"Because I verbally handed over to try him again, I didn't make any entry on his meds chart or in his IMR [medical record] because I wasn't expecting it to be eight o'clock that they next went. I was expecting them to try him again a little bit later because I knew that the carbamazepine was something that he would have needed."

86. Sadly, it is unlikely that it would have altered the outcome had staff returned earlier to the man's cell to give him his medication. However, it is important that medical records are noted when medication is missed, and so I make the following recommendation.

The Head of Healthcare should ensure that staff are aware that the quality of medical records is a key aspect in patient care, and that missed medications should be included within the patient's notes.

Evening medication

87. At the evening medication round, the man was found to be unresponsive and was clearly very unwell. Staff acted promptly and appropriately to summon emergency assistance and gave appropriate emergency care.

Prison records

88. During the investigation, it was discovered that no entries were made in the wing observation book about the man. Staff also failed to complete a form F213 (a form recording injuries to prisoners) either when he had the fit or when he was discovered unconscious in his cell.

89. When interviewed, the orderly officer agreed that if a prisoner falls over, bangs their head, or cuts themselves, an F213 form should be completed. He requested that the form be completed but, as nobody had seen the fall, no one took responsibility to fill the form in.

90. The orderly officer was also asked about the staff observation book (SOB) and he said that it is used to record significant events. He said he would have expected the man's fit to have been recorded in the SOB, but also said, "in the absence of anybody saying 'Will you please do it?' I imagine everybody else probably thought somebody else was doing it." The orderly officer expected that an entry would be made in the SOB when a 'code blue' was called, when the man went to hospital, and after he had died. When told that none of these events was recorded in the SOB he said, "We all take it for granted somebody has put it in there. On this occasion nobody has."

91. It is important that staff make appropriate and timely entries into logs, and file reports as required. In this case, it would appear that they did not do so, and therefore I make the following recommendation.

The Governor should remind all staff of their responsibilities in relation to the requirements of keeping comprehensive records when injuries and other significant events occur to prisoners.

Use of restraints

92. It is a common theme in many of my reports that a risk adverse approach is often taken to the use of restraints when prisoners are taken to hospital. On this occasion, I believe that the decision by the Governor not to reapply the escort chain after the man had had his CT scan was a proportionate, decent and correct decision.

Debriefs

93. Following the man's death, it is unclear whether any formal debriefs were held involving staff from both healthcare and the prison. Prison Service Order (PSO) 2710, which deals with issues following deaths in custody, states "There must always be a hot debrief immediately after the incident [death in custody] and provision for this should be made in local contingency plans."

94. A second PSO, PSO 8150, deals with post incident care for staff. In this PSO, it is recommended that a critical incident debrief is held in the weeks following a traumatic incident. The definition of a traumatic incident does not include deaths from natural causes, and so in this instance a critical incident debrief was not required.

95. Although the relevant PSO can be read as saying that Shrewsbury was not required to hold a hot debrief (as the death occurred in hospital), I believe that on this occasion it would have been wise to do so. I make the following recommendation:

The Governor should consider extending the use of debriefs to all deaths in custody

CONCLUSIONS

96. The man collapsed and hit his head while collecting his medication in November 2008. Both during and after his seizure, staff acted appropriately and in accordance with the information available to them. Nevertheless, had observations been extended for longer, this might have resulted in earlier treatment.

97. Signs of subdural haemorrhage can be delayed and difficult to diagnose. Staff carrying out the afternoon medication round were not aware of the full circumstances or history. Had they been, they told my investigator they would have reacted differently.

98. Later the man was found unconscious in his cell and taken to the Royal Shrewsbury Hospital. He was transferred to North Stafford the next day, but sadly did not regain consciousness. The post mortem confirmed that the primary cause of death was from damage resulting from epilepsy, and not from the blow to the head.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there are clear, defined care plans for any condition which can be difficult to diagnose, and where an adverse outcome can be serious.

The Prison Service has accepted this recommendation and has commented that care plans are in the process of being developed

2. The Head of Healthcare should ensure all staff are aware of significant healthcare issues with patients, and that there is an effective method of communicating information between shifts.

The Prison Service has accepted this recommendation

3. The Head of Healthcare should ensure that staff are aware that the quality of medical records is a key aspect in patient care, and that missed medications should be included within the patient's notes.

The Prison Service has accepted this recommendation and that training is ongoing

4. The Governor should remind all staff of their responsibilities in relation to the requirements of keeping comprehensive records when injuries and other significant events occur to prisoners.

The Prison Service has accepted this recommendation and a Governor's Order has been issued accordingly

5. The Governor should consider extending the use of debriefs to all deaths in custody

The Prison Service has partially accepted this recommendation and has commented that the governor will view every Death in Custody separately and arrange necessary debrief accordingly

GOOD PRACTICE

1. I note the man's cell allocation and the removal of restraints during his final hospital stay as examples of good practice.