

**Circumstances surrounding the death in November 2006
of a man who was a prisoner at HMP Wellingborough**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

September 2007

This is the report of an investigation into the death of a man. The man was a prisoner at HMP Wellingborough who died from apparent natural causes on 12 November 2006 at outside hospital. He was 44 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. He and I would like to thank the Governor of HMP Wellingborough and his staff for their assistance. A doctor was asked by Northamptonshire Primary Care Trust to undertake a review of the man's clinical care and we also much appreciate his help.

As is the case in many of my investigations following a death from natural causes, I am much influenced by the findings of the clinical review. The review draws attention to the quality of medical record-keeping. I endorse the one recommendation made by the clinical reviewer.

I note that in the last days of his illness, the man was released on temporary licence. This was despite the nature of his offences and the length of sentence he was serving. I believe this to have been entirely proper and an example of good practice. In other investigations I have undertaken, these factors have sometimes proved to be a barrier to allowing prisoners to die with dignity.

The man had long-standing health problems and there is no reason to suppose that his death was in any way related to the fact that he was in custody. The clinical review assesses that his treatment was equivalent to that he would have received had he been at liberty.

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 the investigation.

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Prisons and Probation Ombudsman

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SUMMARY

The man was born in 1962. He was 44 years old when he died on 12 November 2006 in outside hospital.

The man was received into custody on 6 December 2005. In March 2006, he was sentenced to 42 months imprisonment at Kingston Crown Court.

He was initially held at HMP Wandsworth before being transferred to HMP Wellingborough on 18 April. During health screens at both prisons, it was noted that the man had an alcohol and drug addiction problem, and that he had previously undergone heart surgery for an aortic valve replacement to improve the blood flow to his heart.

On 4 August, the man was admitted to outside hospital where he was found to have anaemia, melaena and acute renal failure. He was later transferred to another outside hospital. Before he was discharged from hospital on 17 August, the man was informed that he would require kidney dialysis three times a week.

During the afternoon of 4 November, staff at Wellingborough were informed that the man was not feeling very well. Assistance was requested from the healthcare centre. Medical staff responded immediately and an ambulance was requested to take the man to outside hospital.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used. However, after the man was again transferred to another hospital on 6 November, the restraints were removed. On 7 November, the man was granted release on temporary licence (ROTL) and the staff on bedwatch duty were withdrawn.

The man passed away during the early hours of 12 November 2006. His cause of death was infective endocarditis (an inflammation of the lining, valves and muscle of the heart).

The clinical review concludes that the man's clinical care was appropriate and equivalent to that available in the community. However, the clinical reviewer comments unfavourably on the quality of report keeping. I endorse the one recommendation in his review.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff.
2. The Northamptonshire Primary Care Trust commissioned a General Practitioner to carry out a review of the man's clinical care. I am most grateful to him for undertaking the review and completing it so expeditiously.
3. My investigator contacted Her Majesty's Coroner to inform her 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 in her enquiries into the man's death.
4. One of my Family Liaison Officers contacted the man's family to offer them the opportunity to meet with the investigator to discuss the purpose of the investigation, and to raise any concerns or questions they would like explored and addressed. The family expressed concern about lack of communication immediately after the man's death. My staff have done their best to address this question in dialogue with the man's family, and I hope they have been able to provide some explanation for the family.
5. Having studied all the available documentation, my investigator did not consider it necessary to visit HMP Wellingborough. However, he did contact staff there and discussed aspects of the man's treatment. He also discussed issues relating to the man's medical care with the clinical reviewer.

HMP WELLINGBOROUGH

6. HMP Wellingborough currently holds 648 adult male offenders. It first opened in 1963 as a Borstal and held young offenders until 1990. Following a temporary closure whilst essential repairs were carried out, Wellingborough re-opened as a category C training prison for adult men.
7. The commissioning of healthcare within the prison is the responsibility of Northamptonshire Primary Care Trust. The healthcare centre employs a part-time doctor and operates an out of hours GP Service. There are no in-patient facilities; these are provided by HMP Leicester as and when necessary. However, there are a number of out-patient clinics on site, including dentist, optician and psychiatrist.

KEY EVENTS

8. The man arrived at Wellingborough on 18 April 2006 after being previously held at Wandsworth. During the health screening procedure at both prisons it was noted that he had an alcohol and drug addiction problem. It was also recorded that the man had previously undergone open heart surgery for an aortic valve replacement. A range of medications were prescribed to treat his various conditions and he was allowed to keep these in his possession for self administration. Whilst the man was at Wandsworth, he received a heroin detoxification programme.
9. On 30 June, the man was seen by a prison doctor at Wellingborough who noted his medical history and prescribed aspirin which was started on 5 July. The man's next appointment was on 28 July with another prison doctor and a nurse. The man told them that he had intermittent chest pains and tightness, and some numbness in both his hands. A referral to the cardiology team was made.
10. Around 8:00pm on 31 July, the man complained of abdominal pain with diarrhoea, chest pain, shortness of breath, not sleeping, and having a puffy face. Arrangements were made the next day for him to have an electrocardiogram (ECG) and blood pressure review.
11. On 3 August, the man was assessed by another nurse as he was again complaining of shortness of breath, along with reduced appetite, sleeplessness, pain in his side and inability to get up to go to the toilet. A nurse discussed the man's condition with a doctor by phone that afternoon. The doctor felt that the man could wait for assessment until the following morning.
12. On 4 August, the man was seen in his cell by the prison doctor. The doctor decided that the man needed to be immediately transferred to the Accident and Emergency Department at the local hospital. After the man was admitted to hospital, he was found to have anaemia, melaena and acute renal failure.
13. On 6 August, the man was transferred to the Intensive Care Unit at another hospital. As a consequence of his condition, the man was informed that he would require kidney dialysis three times a week. While the man was in hospital, further tests were carried out with regard to his renal failure. The man was also diagnosed with septic cerebral emboli (a possible blood clot on his brain) and Goodpastures syndrome (severe inflammation of the lungs).
14. After his discharge from hospital on 17 August, the man was initially escorted by one officer to hospital to undergo his dialysis treatment. The escort was withdrawn from 28 August and the man then travelled for his treatment unescorted. From 18 September, the man attended a renal unit for his dialysis.

15. Around 3.25pm on 4 November, a Prison Officer and Senior Officer were informed by a prisoner that the man was not feeling very well. The officers entered the man's cell and found him collapsed on his bed. An immediate call for assistance was made by one of their colleagues to the prison healthcare centre. When a nurse arrived at the man's cell she found that he was drowsy, and trying to respond verbally but unable to do so. The nurse then asked for an ambulance to be called and administered oxygen. A paramedic arrived within ten minutes and the man was taken to outside hospital.
16. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used. However, after he transferred to another hospital on 6 November, permission was given for the restraints to be removed and they were not reapplied. The man was visited by his family and his condition was discussed with them by staff at the hospital.
17. After the man was granted release on temporary licence (ROTL) on 7 November, the staff on bedwatch duty were withdrawn, although contact was maintained between the prison and the hospital. The man passed away at 8:15am on 12 November 2006.
18. The hospital contacted the man's family to tell them of his death. The family was also contacted by the prison chaplain and the residential governor to offer condolences and support. The prison appointed a family liaison officer. She maintained contact with the family and assisted with the arrangements for the funeral. The prison provided financial assistance towards the funeral costs. A memorial service was later held by the prison chaplain at the prison. The man's popularity was further demonstrated by a collection by prisoners on his wing which raised £74. This was used to buy a wreath, with the remainder being given to charity.
19. A post mortem was not carried out as the man died from a diagnosed condition, infective endocarditis (inflammation of the lining, valves and muscle of the heart), after being in hospital for a number of days. There was no reason to believe untoward circumstances were associated with his death.

CLINICAL REVIEW

20. A review of the man's medical care was undertaken by a doctor on behalf of Northamptonshire Primary Care Trust. The review found that the man had suffered from significant long-term chronic diseases. The reviewer noted that the man had a medical history of acute bacterial endocarditis and that he had undergone surgery for an aortic valve replacement in 2005.
21. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The clinical review concludes that there are no circumstances indicating that death could have been anticipated or prevented, but makes recommendations for improvements to clinical practice.
22. The clinical reviewer judged that there were a number of minor areas of record-keeping that could be improved. He noted that hospital correspondence took time to reach the prison and some conditions did not seem to appear in the prison notes as a consequence. He did not believe that this affected the man's care, but any lack of communication and documentation potentially puts patient care at risk.
23. The clinical reviewer judged that the prison medical notes were at times minimal and did not evidence the taking of a clear history and examination followed by management plans. The reviewer gave an example of this when the man had line sepsis treated by staff at the outside renal unit. A superficial infection was treated, but there was no record in the notes that the prison knew that the man had septicaemia at that time other than that he had been given antibiotics. It was also documented that the man had occasionally had problems with his dialysis, but not what they were or how they might affect him. The clinical reviewer advised:

"Notes related to more serious illnesses should contain more detail than was recorded and a summary of serious conditions [included] in the relevant section. There were a number of statements in [the man's] prison medical records that were facts but made little attempt to explain them or record an ongoing management plan with regard to them."

24. The clinical reviewer concluded that quality record keeping in the clinical notes should be the priority of all clinicians and administrative staff within the health environment. He added that chronic conditions should have clear ongoing management plans that any clinician being called to see the patient can follow. The clinical reviewer suggested that proper use of EMIS clinical software could facilitate this.

The standard of record keeping must be improved including the information being recorded. All decisions regarding the care of prisoners must be recorded in the medical records, including who made them and why they were made.

CONCLUSION

25. The man arrived in prison with a history of chronic health problems. He moved to Wellingborough in April 2006 and died of apparently natural causes in November 2006 in an outside hospital.
26. Given the generous collection following his death, and the comments made by staff and prisoners at Wellingborough, it appears the man was a respected and well liked prisoner.
27. After the man's health deteriorated and it became clear that his condition was terminal, the prison made timely and appropriate arrangements for his release on compassionate grounds. I commend the action of managers at Wellingborough in having made these arrangements.
28. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with sensitivity. The security arrangements at the hospital seem to have been suitable, and to have struck a good balance between public protection and respect for the man.
29. In light of the findings of the clinical review, and my own investigation, I conclude that the man's medical care was satisfactory. I have endorsed the one recommendation from the clinical review.

RECOMMENDATION

- 1. The standard of record keeping must be improved including the information being recorded. All decisions regarding the care of prisoners must be recorded in the medical records, including who made them and why they were made.**

Response from the Prison Service: The recommendation will be passed on to the health care provider, Care UK, and copied to the Primary Care Trust (PCT). Implementation will be monitored through the partnership meeting between the PCT, HMP Wellingborough and Care UK.