Investigation into the circumstances surrounding the death of a man at HMP Wakefield in 2009

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This is the report of the investigation of the death into the circumstances surrounding the death of the man who died at HMP Wakefield in November 2009. The man had been in custody since 1984 and was serving a life sentence. He had a history of mental and physical health problems, including asthma, bowel problems, acid reflux, cardio vascular and limited mobility. In November at 5.37am, a nurse was called to the man's cell and found him in bed not breathing, with no pulse or any signs of life. An emergency ambulance was called and the paramedic confirmed his death. The man was 63 years old.

The investigation was undertaken by one of my investigators. Her Majesty's Coroner for the County of Yorkshire held a post mortem into the man's death. It was noted that his death was of natural causes due to a gastro-intestinal haemorrhage and a bleeding lower oesophageal ulcer. I extend my sincere condolences to his sister, family and friends.

A review of his medical care was commissioned with Wakefield District Primary Care Trust (PCT). I am grateful to the clinical reviewer for her clinical review. I would like to thank the Governor of Wakefield and her staff for their assistance with this investigation. I am especially grateful to the prison liaison officer.

I make four recommendations for the attention of the Head of Healthcare. They include the presentation of medical notes and the documentation of allergies. Furthermore, I recommend a review of nursing staff skills and a multi disciplinary approach to long serving prisoners with complex medical problems. I note the good practice of healthcare and prison staff in managing the man's medical conditions.

In this final report, the prison service had accepted the four recommendations and their actions have been added to the recommendations. The man's family have seen the draft report and do not have any comments to add.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

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SUMMARY

From an early age the man was educated at a school for children with special needs. After leaving school he spent most of his adult life in prison for serious offences. Following his last conviction in 1984, he served his sentence in high security prisons and Rampton Secure Hospital where he was diagnosed with a psychopathic disorder. It was noted in his previous medical records that he had been diagnosed with chronic reflux oesophagitis linked to Barrett's Syndrome. (This condition is an abnormal change in the cells of the lower end of the oesophagus [throat] thought to be caused by damage from chronic acid exposure.)

In October 2007, the man transferred to HMP Wakefield from HMP Frankland. He was seen by a reception nurse who noted his previous medical history that included bowel problems, asthma, cardio vascular and obesity. (Throughout his time in Wakefield he was seen regularly by healthcare staff.) It was recorded by a doctor that the man had recently under gone full medical investigations for his bowel problems and no abnormalities were identified.

The man was escorted to hospital on three occasions between February 2008 and February 2009. The first time was to check his high blood pressure and raised body temperature. On the last two occasions, he had self harmed by cutting his arm and leg. Following each act of self harm an Assessment, Care in Custody and Teamwork (ACCT) plan was opened and he was admitted to the healthcare unit for observation. (An ACCT plan documents interventions, care and observations of prisoners at risk of suicide or self harm.) A psychiatrist examined the man on 31 March 2009 and prescribed Largactil, an anti-psychotic medication.

The man was seen in his cell on 26 November by a nurse after wing staff had reported that he was unwell. His observations (blood pressure and pulse rate) were in the normal range so he was advised to rest and take some fluids. Two days later a nurse examined him and again his observations were within the normal range. The nurse advised him to tell wing staff if his symptoms persisted and to rest.

At about 5.18am on 30 November, a wing officer was carrying out a routine check of prisoners and looked through the observation panel in the man's cell door. The officer saw blood on the man's' face, could not get a response from him and therefore radioed for urgent assistance.

A nurse and three officers responded to the emergency and found the man in bed with dried blood on his face and no signs of life. An emergency ambulance was requested and the nurse started cardio pulmonary resuscitation (CPR). Paramedics arrived at 5.57am and confirmed that the man had died at 6.02am.

The clinical reviewer has made recommendations in her clinical review. I endorse four of those recommendations and note one other. Furthermore, I endorse the good practice by healthcare and prison staff in managing the man's medical conditions.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 12 January 2010 when my investigator visited Wakefield. She was met by the prison family liaison officer and an officer and reviewed documents from the man's prison file and medical records. My investigator asked that copies from those documents be sent to her.

2. Notice of the Ombudsman's terms of reference and notices of investigation had been sent in advance of my investigator's visit. No members of the Independent Monitoring Board (IMB) or Prison Officer's Association asked to see my colleague. (The IMB are volunteers who monitor the day to day routines of the prison.)

3. My investigator visited B wing where the man lived and spoke informally to two prisoners on the wing. Later, my investigator interviewed an officer, who knew the man well and had been one of his personal officers.

4. A letter from a friend of the man was received by my investigator and my investigator considered the contents of this letter. No other responses have been received.

5. A review of the man's healthcare was commissioned by Wakefield District PCT. The clinical reviewer carried out that review on behalf of the PCT.

6. One of my family liaison officers wrote to the man's sister explaining the investigation and asking whether she had any issues she would like to be explored. At the time of writing this report his sister has not raised any points for consideration. I hope the findings of the report help her to understand the events leading to her brother's death.

HMP WAKEFIELD

7. HMP Wakefield is one of eight high-security prisons within the prison estate. Wakefield was originally built as a house of correction in 1594. It is now a main lifer centre. The average number of prisoners is approximately 700, including 100 category A and 10 high risk category A prisoners.

8. Wakefield has a separate healthcare block. There is an out-patient section and an in-patient facility with capacity for 21 patients. Nursing care is available for 24 hours, seven days per week. A doctor is in the prison on Monday to Friday from 9.00am to 5.00pm. Outside these hours, care is provided via Local Care Direct (the local provider of out-of-hours primary health care). The in-patient facility contains a palliative care suite which allows staff to care for patients in advanced stages of serious illness.

9. Her Majesty's Chief Inspector of Prisons inspected Wakefield in 2008. An extract from report published in 2009 said:

> "Wakefield has improved considerably over the last five years and it is pleasing that in general the improvement has been sustained. There is still work to be done on aspects of safety, staff prisoner relationships and activities, but the principal issue to be tackled is how to motivate and engage serious sexual offenders, so that their risk is reduced and they can progress through the prison system."

10. The IMB published their Annual Report in 2009, an extract from the summary of that report said:

> "We again acknowledge that many improvements have taken place in the healthcare centre. We feel that treatment clinics that are now provided by appointment do seem to have improved the service provided. Our observations around the healthcare unit are positive and patients appear to be well cared for."

11. There have been 14 deaths due to natural causes at Wakefield since the Ombudsman's office took responsibility for investigating deaths in custody in 2004. Many of those deaths were from terminal or cardiac illnesses. Previous recommendations for the healthcare services have included the care of those prisoners with chronic illnesses. The Prison Service has accepted the recommendations and action plans have been formulated to address issues on care plans and special clinics.

KEY FINDINGS

12. The man was remanded into prison in 1983. He was sentenced to life imprisonment on 16 February 1984 and spent time in the high security prisons; Full Sutton, Durham, Whitemoor and Frankland. During his period in Whitemoor, he stayed in the Dangerous Severe Personality Disorder Unit. It was further recorded that the man spent sometime in Rampton Secure Hospital. Also, during this time, he received medical care for many illnesses including bowel, cardio vascular and chronic reflux oesophagitis linked to Barrett's Syndrome. (This condition is an abnormal change in the cells of the lower end of the esophagus [throat] thought to be caused by damage from chronic acid exposure). He also harmed himself on numerous occasions.

October 2007- January 2008

13. The man was transferred from Frankland to Wakefield on 25 October 2007. On his reception into Wakefield he was seen by a nurse who wrote in his medical notes that he had a history of various health problems including bowel, heart, asthma, eyesight, obesity and was a smoker. (A first reception health document was not contained in his medical notes.)

14. Between October 2007 and January 2008 the man was seen by healthcare staff on 14 occasions. During this time his blood pressure was noted to be variable and his bowel complaints were recorded as having been fully investigated when he was at Frankland. His medication was regularly reviewed and tests were carried out following a suspicion of a deep vein thrombosis (DVT), which proved to be unfounded. During this time, in consultations, he told healthcare staff that he was allergic to paracetamol and penicillin however, this had not been noted when he first arrived at Wakefield

15. After an episode of chest pain in November, the man had an electrocardiogram (ECG) to measure his heart rate, which was noted to be in normal range. Following an emergency visit to hospital, he was diagnosed with a chest infection, which was treated with antibiotics. It was recorded throughout his medical notes that he was not an easy prisoner to deal with. He was aggressive towards healthcare staff and demanding of their time, which included refusing treatments and medication, which he often return to healthcare staff.

January 2008 – January 2009

16. The man's negative behaviour continued throughout 2008 and he made frequent visits to healthcare. He was seen on many occasions by the doctors and his medication was reviewed regularly with the inclusion of appropriate medication for his ongoing health issues.

17. In February, he was taken to hospital with high blood pressure, a raised body temperature and a swollen leg. However, following some treatment in the accident and emergency department, he returned to Wakefield after becoming violent at the hospital.

18. On 17 July, following poor behaviour on the wing which resulted in the man being downgraded to the basic regime (basic regime is the lowest level of rewards for prisoners), he self harmed by cutting his right arm. He refused any support or treatment and became aggressive and swore at staff. An Assessment, Care in Custody and Teamwork (ACCT) was opened. He was admitted to the healthcare unit for observation. Full case reviews took place and the ACCT was closed in August when he returned to the wing. Healthcare staff, with the support of wing staff, continued to monitor his mental health through regular visits and assessments.

January 2009 – October 2009

19. The man harmed himself again on 6 February by cutting his leg. Following a visit to Pinderfields Hospital he retuned to Wakefield, was admitted to the healthcare unit and another ACCT was opened. Following a review of the ACCT document, the healthcare manager wrote that the man would be observed in the healthcare unit for a few days. Two days later, the Healthcare Officer (HCO) noted that the man had been talking of further self harm with intent to kill himself. The ACCT was revised to increase observations at irregular intervals.

20. After an appointment with a prison doctor, the man was moved to C wing a week later and the ACCT was closed. On 31 March, a psychiatrist, examined the man and prescribed Largactil, an anti psychotic medication.

21. Following another cut to his leg on 16 June, the was seen by healthcare staff. He did not express any further thoughts of self harm. However, wing staff prudently opened another ACCT document. During the initial ACCT review the man told the panel that his medication was not working and he wanted to see the psychiatrist. He further demanded his television set be returned and made threats to self harm if his requests were not met. (The man had been placed on basic regime for poor behaviour and the removal of his television set was part of that process.) It was noted that he was hostile and uncooperative throughout the ACCT review process.

22. Later, Registered Mental Nurse (RMN) discussed the man's behaviour and mental health with a second doctor. Both health professionals agreed that the man's attitude was personality driven as opposed to a mental health diagnosis. On 21 July, the psychiatrist saw the man for a psychiatric consultation.

23. Two days later, the man declined an out patient appointment at Pinderfields Hospital for a computerised tomography (CT) scan of his liver. (A CT scan is a procedure that takes internal images of the body.) This procedure had been requested by the doctor at Wakefield in response to the man's complaints of pain in his back.

August 2009 – November 2009

24. On 3 August, a second RMN saw the man who was feeling breathless and thought he was experiencing an asthma attack. The nurse noted that the cell was smoky and he told her he had just had a cigarette. He refused to take a peak flow test, to test his breathing. The nurse advised him about smoking and the effect it would have on his asthma.

25. On 25 August, a third prison doctor reviewed the man's medication and adjusted his prescription. A nurse prescribed pain relief of Tramadol on 20 October, after he complained of continuing back pain.

26. The third prison doctor examined fully the man on 4 November and took extensive medical history from him. The man told the doctor that he had a cough for nine days. The doctor noted that the man had high sugar levels from a blood test in August and was overweight. The doctor advised him to cut down his sugar intake. The man's observations were recorded as blood pressure 148/93, normal range is 130/80 and a pulse rate of 80 beats per minute (bpm), normal range is between 60-100 bpm.

27. Two weeks later, the third prison doctor saw the man in the healthcare unit and a diagnosis of cellulitis, an infection, was noted on his left leg. An antibiotic was prescribed and again, the man was advised to lower his sugar intake.

28. A second nurse was asked by wing staff to see the man in his cell on 26 November. He was complaining of feeling unwell and passing blood in his urine. His blood pressure reading was 144/77, with a pulse rate of 85bpm and temperature of 37 degrees. He further told the nurse he had diarrhoea and pain in his groin. A sample of urine was tested and no abnormalities were detected. The nurse spoke to the third prison doctor about the man's symptoms and the doctor said there was no need for antibiotics but he would see him if he got any worse. The nurse advised the man to rest and take plenty of fluids. She returned to see him later that evening and his temperature was normal at 36.5 degrees. The nurse again advised the man to take plenty of fluid.

29. Two days later, a third RMN saw the man at the request of wing staff. Staff told the nurse he had been shaking and did not feel well. The RMN took a blood pressure reading of 140/70 and a pulse rate of 62bpm. The man complained of pain in his left arm but not in his chest. The nurse told him to tell wing staff if his symptoms persisted and notified healthcare staff on night duty of the man's present ill health.

30. At 11.02pm, a fourth RMN was contacted by wing staff. The man wanted the nurse to be aware of his symptoms and that he felt unwell. The nurse wrote in his medical notes that she had been fully briefed, and if he felt very unwell, she would visit him during the night. The following day on 29 November at 2.05pm, the third RMN wrote that the man had been seen that morning in his

cell. He said he felt better and had been chatting and smoking with his friends, although he still had loose stools.

31. About 5.18am on 30 November, the first officer on the scene was carrying out a routine check of prisoners. The officer looked through the observation panel of the man's cell door, saw blood on his face and could not get a response from him. The officer radioed for urgent assistance and for a member of the healthcare staff to go to the man's cell. Three officers immediately went to the cell and opened the door. The officers could not find a pulse and they thought that the man appeared to be dead.

32. The first nurse on the scene arrived at the cell at 5.38am and saw him lying in bed with dark dried blood around his mouth, on his sheets and pillow. There was no pulse or signs of breathing and he was cold to the touch. Despite the signs that the man had died, the nurse commenced cardio pulmonary resuscitation (CPR) and asked for an emergency ambulance to be called. At 5.57am a paramedic arrived at the man's cell and, after an examination, confirmed death at 6.02am.

33. Following the man's death, a prison family liaison officer, and a member of the chaplaincy team visited the man's sister to inform her of her brother's death. The family liaison officer continued to support the man's sister in the days following his death. A memorial service was held in Wakefield's chapel which was attended by the man's family. The prison offered funeral expenses to his family.

ISSUES

Clinical care

34. A review of the man's medical care was commissioned with Wakefield PCT. The clinical reviewer appraised the man's medical notes and met my investigator to determine the extent of her report. They agreed to concentrate the review on the man's most recent time in custody.

35. The clinical reviewer reviewed the man's medical notes and recorded that it was poorly presented, confusing and incomplete. This significantly impacted on the time taken to undertake the chronology for her report. My investigator supported her findings and was unable, as a non clinician, to fully examine the notes and get a clear timeline of the man's medical history and interventions throughout his sentence.

36. Whilst it is difficult to keep medical notes in a semblance of order, particularly for the case of long serving prisoners, they should be time ordered so they can be comprehensively read. I agree with the clinical reviewer's recommendation about the maintenance of medical records.

The Head of Healthcare should review the methods available to produce printed information from System 1 so that an accurate account of healthcare can be provided. Systems should be put in place for maintaining individual medical records in a structured way.

37. I also note that the further advises that a yearly healthcare summary of prisoners remaining in custody for over five years.

Overview of the man's medical history

38. The man's medical notes indicated that he had experienced various health problems throughout his time in custody. Entries in those notes showed that medical investigations had been carried out at varying intervals with a negative result, except for Barrett's Syndrome.

39. He was treated for chronic reflux oesophagitis, (when stomach acid flows back into the throat area), a condition associated to Barrett's Syndrome. The man underwent medical investigations including bowel procedures and biopsies in 2002, which were found to be normal. He was prescribed medication with a holistic term of Proton Pump Inhibitors (PPIs). (This group of drugs work on the cells that line the stomach, reducing the production of acid.)

40. The most significant medical investigations took place in the hospital in 2007. The man had cardiac, bowel and further biopsy procedures but nothing untoward was noted.

41. Most notable were the number of occasions that he refused healthcare treatment and his periods of self harm. He would not take advice from

hospital staff and would discharge himself from their care or stop investigative procedures. However, he often later had second thoughts, apologised and asked for help on several occasions.

42. The man was seen by a psychiatrist and diagnosed with an untreatable psychopathic disorder. His behaviour was unpredictable, and at times aggressive and abusive. The last set of notes are illegible from the psychiatrist, due to poor electronic copying, however an assessment at Rampton Secure Hospital in 1999, recorded that no further psychiatric hospital treatment would be of benefit to him.

43. The clinical reviewer noted that the man's pattern of self harm remained the same during his period in Wakefield. On the occasions he self harmed, an ACCT document was opened and he was monitored in the healthcare unit, followed by continued care on the wing.

44. Throughout his time in custody, the man consistently complained about healthcare services. Nevertheless, it was noted by the man that all complaints had been fully investigated and been unfounded.

First reception health screening document

45. The man had been in several prisons before his transfer to Wakefield however, on reception a first reception health screening document was not evident in his medical notes. Whilst a medical history was taken from the man and well documented on the electronic system, a reception screening should have been found in his medical record. I am unable to say whether one was completed or not. I note the clinical reviewer's recommendation held in the clinical review referring to first reception health screen documents.

The man's allergy to some medications

46. It is apparent from previous medical history that the man was allergic to penicillin which was first documented in 1985, but removed in November 2009. He had been given this medication on three occasions whilst at Wakefield with no adverse reaction. Likewise, the man had told healthcare staff that he was allergic to paracetamol but it was prescribed on one occasion with no reaction. However, he had signed a request for medication in 2005, saying he was not allergic to paracetamol.

47. These supposed allergies were not noted on his reception into Wakefield but the man seemingly told healthcare staff during consultations.

48. The clinical reviewer commented:

> "There appears to have been a lack of awareness by some nurses regarding the man's documented allergy to both paracetamol and penicillin."

49. I endorse the following two recommendations.

The Head of Healthcare should review the systems in place to document allergies in medical records, on prescriptions charts and pharmacy records.

An audit of existing skills and competencies within the nursing team should be carried out in order to identify training needs in relation to prescribing and administering medication with particular reference to allergic reactions.

The man's refusal of medical treatment

50. Investigations were undertaken and the diagnosis of chronic reflux oesophagitis linked to Barrett's Syndrome and a hiatus hernia (where the stomach protrudes into the diaphragm) was noted as a possibility in 1992. However, the medical investigations in 2007 did not refer to a hiatus hernia, but did accept a diagnosis of Barrett's Syndrome.

51. The man was prescribed the appropriate medication for all his conditions, but frequently returned it to healthcare staff or refused to take it. His non compliance in taking his medication may well have impacted on his symptoms. He was referred for an endoscope procedure in 2009, but it is unclear from the medical notes whether he received this appointment or not.

52. It was noted that the man appeared to have a history of anaemia but no cause was found for the condition. He was prescribed the appropriate medication but again repeatedly returned it to healthcare which again may have impacted on his health. In July 2009, he refused to attend hospital for a scan appointment on his liver.

53. Lastly, the man was diagnosed with asthma in 2001, and whilst he often refused to co-operate with its monitoring he was prescribed an inhaler and seen by healthcare staff when experiencing an asthma attack.

54. It is noted that he often refused to attend medical appointments and did not always comply with his medication. The doctors and healthcare staff were aware and recorded this in his medical notes.

Conclusion of the clinical review

55. The clinical reviewer noted that the man had been known to healthcare staff at all the prisons he had been in during the last 25 years. Whilst his behaviour had been challenging, she judges that his healthcare was managed appropriately. Medical investigations took place for his physical health problems despite the man's view and lack of belief in the results. The man seldom complained of dyspepsia (indigestion) or any related symptoms.

56. The clinical reviewer noted:

> "There is nothing to suggest that in the days prior to his death that any signs or symptoms relating to his oesophagitis were ignored."

57. Nevertheless, the clinical reviewer has noted that whilst the man had complex health problems, a multi disciplinary approach to its management and care was not apparent. No management plans were evident for his ongoing health problems and no member of the healthcare staff was identified to oversee and co-ordinate his care.

58. I endorse the following recommendation made by the clinical reviewer.

The Head of Healthcare should review the clinical leadership within the primary healthcare setting, and audit roles, responsibilities and working practices to develop a structured case management approach to prisoners with complex long term conditions.

59. The clinical reviewer concluded her review by reiterating that the poor presentation of the man's medical records made the compilation of the clinical review extremely difficult and time consuming.

Good Practice

60. The clinical reviewer noted that it was evident from the documentation that there were times when the man was exceptionally difficult, and was inconsistent when describing his health problems. Nevertheless, healthcare staff treated him in a professional manner. He refused some medical procedures, medication and treatments but was offered the opportunity to change his mind and take advice and care from staff.

61. It was also evident from the man's personal officer that wing staff cared well for the man despite occasional abuse and disruptive behaviour. The man was diagnosed with a mental health illness and this was monitored by all staff at Wakefield.

62. I note the following comment by clinical reviewer and recorded it as good practice:

> "The healthcare professionals and officers involved in managing the man's healthcare should be commended."

CONCLUSION

63. The man underwent numerous medical investigations which included a diagnosis of chronic reflux oesophagitis linked to Barrett's Syndrome. Whilst being treated for this health problem it is known that he often refused medication and medical interventions. His attempts to self harm were managed appropriately through ACCT documents and he was seen by a psychiatrist in March 2009.

64. The clinical reviewer makes several recommendations around managing long serving prisoners with complex medical conditions, the presentation of medical records, documentation of medical allergies and the auditing of nursing staff skills.

65. I judge that the man received appropriate care from both healthcare and prison staff taking into consideration his mental health problems which may have impacted on his challenging and inappropriate behaviour.

RECOMMENDATIONS

For the Head of Healthcare

1. The Head of Healthcare should review the methods available to produce printed information from System 1 so that an accurate account of healthcare can be provided. Systems should be put in place for maintaining individual medical records in a structured way.

   Accepted - "Monthly meetings with Systm One facilitator for additional staff training. Electronically produced prescriptions are in the process of being implemented to maintain accurate records."

2. The Head of Healthcare should review the systems in place to document allergies in medical records, on prescriptions charts and pharmacy records.

   Accepted – "Medication audit completed March 2010 and report due during Summer."

3. An audit of existing skills and competencies within the nursing team should be carried out in order to identify training needs in relation to prescribing and administering medication with particular reference to allergic reactions.

   Accepted – "Practice Development Facilitator is monitoring training & has developed a spreadsheet for mandatory & personal development training."

4. The Head of Healthcare should review the clinical leadership within the primary healthcare setting, and audit roles, responsibilities and working practices to develop a structured case management approach to prisoners with complex long term conditions.

   Accepted – "Matron and Practice Development Facilitator in place with effect from October 09. Audit delayed due to suspension of several members of staff. Structured case management process is being developed during April/May 2010. Group clinical supervision is scheduled fortnightly & individual clinical supervision has now been commenced."

Good Practice

1. I note the professionalism of both healthcare and prison staff in managing the man's medical conditions.