INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

A MAN AT HMP LINDHOLME IN NOVEMBER 2004

Report by the Prisons and Probation Ombudsman for England and Wales

August 2005

This is the report of an investigation into the death of a man who died at the Doncaster Royal Infirmary on 22 November 2004. He had become ill the previous day and had been released on licence on compassionate grounds from HMP Lindholme.

I wish to offer my sincere condolences to his family for their loss.

This investigation was conducted by one of my Senior Investigators.

I would like to extend my thanks to the Governor and his staff at Lindholme for their help and co-operation during this investigation.

A clinical review was undertaken by the Doncaster Central Primary Care Trust into the medical care that the man received. I am grateful to the Head of Clinical Governance for the PCT, for his report.

I wish to commend the Governor's decision to release this man on compassionate grounds after he was admitted to the Intensive Care Unit, thereby allowing his family some time alone with him, through the withdrawal of the prison staff from his bedside.

This case is unusual in that the Coroner did not treat him as a serving prisoner due to his release on compassionate grounds the day before. There was no request for a toxicology report and no inquest into his death was held.

Deputy Prisons and Probation Ombudsman
for England & Wales

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Summary

1. The man was sentenced to three years and one month imprisonment on 24 August 2004 for attempted theft, breach of a probation order and failing to answer his bail. He transferred to Lindholme on 14 September to continue serving his sentence.

2. In the early hours of the morning on 21 November the man rang his cell bell for assistance. When the Operational Support Grade (OSG) looked into his cell he saw that he appeared to be having some kind of fit. The OSG contacted the night staff who attended and entered the cell.

3. Whilst two of the officers placed a mattress on the cell floor and watched the man, the Senior Officer (SO) arranged for the on-call doctor to be paged.

4. The doctor rang and spoke with the night duty SO and advised that the man should be taken to hospital. However, whilst they were talking, an officer told the SO that he had calmed down and was sleeping.

5. The doctor then advised that the man should be kept under observation until the doctor came to the prison later that morning, but that he should be taken to hospital immediately if there were any change. The doctor now accepts that he should have transferred him to hospital, however as stated in the Clinical Review the delay would not have made any difference to the final outcome.

6. The SO gave instructions that the man should be watched by an officer remaining in the cell with him. There are conflicting accounts of whether that happened.

7. When the early shift Healthcare staff arrived at the prison they were told of the situation and went straight to the man's cell. Although he was breathing, he was unresponsive. An ambulance was called and he was taken to the Doncaster Royal Infirmary. He was subsequently transferred to the Intensive Care Unit (ICU) where at 12:45 pm on 22 November he died.

8. It was later established at a Post Mortem examination that he died of a spontaneous intracerebral haemorrhage due to or as a consequence of a disease of his kidneys. The pathologist concludes that there was no evidence to indicate a traumatic death or death from drug abuse.

9. The Coroner has decided that he will not hold an inquest into this man's death.

Investigation methodology

10. The investigation was opened at HMP Lindholme on 6 December 2004. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices had been previously sent to the prison and were issued to staff and prisoners informing them of the investigation. Other notices were displayed around the prison.

11. My investigator spoke with a member of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB) to elicit their views on the prison in general and the man's death in particular.

12. A meeting was arranged with the investigating officers from South Yorkshire Police who were able to discuss their investigation and, by consent of the Coroner, allowed my investigator to read the witness statements.

13. Several members of staff were formally interviewed regarding the man's death. The transcripts of those interviews are attached at the end of this report.

14. One of my Family Liaison Officers (FLO) contacted the man's mother and offered the opportunity to meet with her and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. A meeting took place on 12 April 2005 with his mother and her solicitor. My investigator also met with his brother at a separate time.

15. 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 for his information. The Coroner has taken the view that because the man was released on a temporary licence on compassionate grounds, he was not a serving prisoner and that an inquest was not required.

The man

16. The man was born in Pontefract, West Yorkshire in 1980. He had a sister, who died a few years ago and a brother. He has a young daughter whom he saw every fortnight, but he was not living with her mother.

17. The man began committing offences when he was 14. He continued to commit offences, mainly of dishonesty and those involving motor vehicles, throughout his life. His mother told my investigator that he began using cannabis when he was 15 and then progressed onto 'harder' drugs.

18. In January 2004 he had decided that he wanted to stop using drugs and had got himself onto a programme at the local Turning Point centre. His mother said that he was having weekly drug tests to prove to her that he was drug free. She said that he continued to be tested weekly right through to August. He was due to start work at a local warehouse the day after his last arrest.

19. He was 24 years old when he died.

The family

20. His mother was concerned that he had been complaining about bad headaches for several weeks before his death and that the prison had not taken it seriously. Her solicitor wanted to know what was written in the Medical Record about his headaches and the treatment he received.

21. His mother had no complaint about the contact from the prison at the time her son was taken into hospital and after his death.

22. My investigator spoke with the man's brother, separately. He explained the progress of the investigation and the brother was then content to await the draft report. Subsequently, my investigator met with the brother again and after talking through the investigation, left a copy of the draft report with him.

HMP Lindholme

23. HMP Lindholme was previously an RAF airfield and opened as a prison in 1985. Now a split site, it houses category C male prisoners in single and multiple occupancy cells and also immigration detainees. It has a total population approaching 700 men.

24. Lindholme was the subject of an unannounced inspection by Her Majesty's Inspectorate of Prisons in June 2004. The report, which was published in September 2004, was mixed. A concern was that a number of the recommendations made in the 2003 inspection report had not been implemented. One recommendation, *'With the introduction of wing-based care, there should be more than one nurse on duty during the evening shift and consideration given to the introduction of a 'twilight' service,*' should be considered as a matter of urgency.

Events prior to the man's death

25. The man was arrested on 22 August 2004, for breaching his bail. He appeared at Nottingham Magistrates Court on 23 August, and was remanded in custody to HMP Leeds where during the reception process he tested positive for methadone. On 24 August, he was sentenced to three years and one month for offences of dishonesty and breaching his bail. He went to HMP Nottingham for further induction and to await a decision as to which prison he would serve out his sentence.

26. The man's Medical Record shows that he said that he was on methadone, but had not had any since Saturday 21 August. He declined to go onto a detoxification regime, as he was feeling "ok".

27. On 28 August, he complained of a backache and was given brufen and paracetamol. It is noted on his Medical Record that he is 'ok with brufen although claims to be asthmatic'.

28. On 29 August, he complained of gastric discomfort. He was given medication to relieve the symptoms. The details are listed in the Medical Record along with a decision to take blood to test for helicobacter pylori.

29. The following day, he was still experiencing gastric discomfort and was given further medication. Blood samples were taken for testing by the local hospital.

30. Attached to the Medical Record is a microbiology report from the City and University Hospital in Nottingham, stating that the blood sample was positive for helicobacter pylori. It is dated 3 September 2004. It has 'list for MO please' written on it.

31. The next mention of this gastric problem is in the man's Medical Record, dated 13 September. There is an apparently hastily written note, 'H.pylori: heliclear'.

32. The next entry, dated 14 September, has an arrow pointing to heliclear above and the written comment, 'Medication (as above) not received from Boots pharmacy will need to re-order at next establishment. This entry would appear to be contrary to a Prescription and Administration Record Chart in the Medical Record stating that heliclear was issued to the man on the day before.

33. The man was transferred to HMP Lindholme, to complete his sentence, on 14 September. A Reception Health Screen was completed when he arrived. The answers noted on the proforma document came from the man. He stated that he had no medical problems and had not suffered from any stomach disorder within the last seven days. A Healthcare nurse and the man signed the document.

34. The next Medical Record entry is dated 23 October. However, on another prescription chart, there is an entry dated 28 September stating that paracetamol were issued to the man, the nature of the complaint is not noted.

35. On the same chart is an entry dated 14 October stating that Gaviscon and paracetamol were given to him for a headache. There is another undated entry below stating that he was given brufen, again for a headache. Also, in the 'in possession' section, Gaviscon is prescribed, and issued on 24 October.

36. On 22 October 2004, the man injured his right hand. He told staff the following morning, that the injury was caused whilst he was training in the gym. He was taken to the Accident and Emergency department at the local hospital. His hand was swollen and tender. His hand was x-rayed to rule out any bone damage. He was given some painkillers and his hand was strapped.

37. On 25 October, the man attended the fracture clinic. He was found to have a minimally displaced fracture of the neck of the 5th metacarpal. He was comfortable with the strapping and he was discharged. On 1 November, he was given another seven days supply of painkillers for his hand injury.

38. At 3.30 am on 4 November, the man complained to night staff that he had a bad headache. He was seen by healthcare later that morning when he complained of pain in his back and neck, and of pulsating behind his eyes. He also said that he had felt sick during the night but that had worn off.

39. The man was checked over, and his blood pressure was found to be within normal limits. There was no sign of neck rigidity and his pupils were normal. He was given a seven day supply of ibuprofen. It was noted in his Medical Record that his blood pressure was to be checked again in two weeks. For some reason, this entry was not on a continuous Medical Record sheet but written on the rear of the reception health screen form.

40. On 16 November, he was seen by Healthcare and given paracetamol for a headache and some Gaviscon tablets for acid. There is no mention of this in the Medical Records other than on one of the three prescription charts forms. He was given further Gaviscon tablets on 18 November. His blood pressure was also checked that day and found to be within normal limits.

41. On 19 November, staff at the prison had been conducting some cell searches in the blocks, which had caused some disquiet amongst some of the prisoners. At 7.00 pm, the man and a number of other prisoners were outside for exercise when prison staff entered E wing. The man was seen by a Senior Officer to throw something at the E wing office window, possibly mud or a duck egg. The officer later identified the man on the wing. He informed him that he was to be charged with the offence and

taken to the segregation unit to await adjudication. He was escorted to the segregation unit without incident.

Events surrounding the death

42. On Sunday 21 November, at about 4.55 am, an Officer Support Grade (OSG) responded to a cell call bell from the man's cell. He saw him lying on his bed, his body was twitching and he was groaning. He appeared to be having a fit. The OSG immediately rang the Orderly Office and spoke with an Officer, telling him the situation with the man. The Officer arrived a few minutes later with another Officer and a Senior Officer.

43. The man's cell was opened and the SO could get no response when he spoke to the man. He did respond by groaning when the officer touched him. After telling the other officers to place mattresses onto the cell floor in case the man fell off of the bed, The SO contacted the Control Room to page the on-call doctor. The Doctor rang the prison and spoke to the SO within 15 minutes. The SO explained the situation and the Doctors immediate response was to tell the officer to arrange for the man to be taken to hospital. Whilst they were talking, however, an Officer reported that the man had calmed down and had fallen asleep. The Doctor said that if he was sleeping and breathing normally then he should be monitored until healthcare staff came on duty in a few hours time. He stipulated that if there was any change or the man began to fit again, he should be taken to hospital immediately.

44. The man was made comfortable on the mattresses on the cell floor and placed into the recovery position. The SO gave instructions that someone was to remain in the cell observing the man until relieved by the day staff. The first Officer said that it was him.

45. The early shift Senior Officer, came on duty at 7 am and was briefed by the OSG about the night's events and the man's condition in particular. The SO checked on him through the cell door and noted that he was asleep and breathing heavily but regularly. An Officer checked the man, in his cell, at 7.15 am, 7.50 am and 8.05 am. Each time he noted that he was breathing heavily and lying on his side.

46. Two Healthcare Senior Staff Nurses arrived at the prison about 8 am and were advised that the man had been ill during the night. When they entered his cell they found him lying chest down on a mattress with his head facing to the right. He was breathing but he had vomited. They found that he was unresponsive to voice commands or touch. They told the Officer to immediately call 999 for paramedic and ambulance assistance. The paramedics arrived about 8.30 am and took over his care.

47. When attempting to gain intravenous access into the man's left arm, the paramedic noticed two puncture marks on the lower part of his left arm. They were not bleeding but there appeared to be a small amount of bruising around one of them.

48. The Man left Lindholme by ambulance just after 9 am and was taken to Doncaster Royal Infirmary. After a period in the Accident and Emergency department where his condition was stabilised, he was transferred to the Intensive Care Unit.

49. At 1 pm, following advice from hospital staff, the man was temporarily released on licence on compassionate grounds. The two prison officers on bed watch were withdrawn, giving his family time alone with him.

50. He was pronounced dead at 12.45 pm on Monday 22 November.

Events after the death

51. Following the man's death, a Post Mortem examination was carried out. The conclusion was that he had died of natural causes, a spontaneous intracerebral haemorrhage due to, or as a consequence of polycystic disease of the kidneys. The Coroner did not request a toxicology report. Subsequently, the Coroner decided that as he had died from natural causes he would not hold an inquest into his death.

52. When my investigator went to Lindholme to open the investigation, he spoke with a representative of the Prison Officers Association (POA) and a member of the Independent Monitoring Board (IMB). The only real concern that either of them raised was the lack of 24 hour healthcare at the prison. The issue was also raised by a number of staff during interviews. Lindholme have an arrangement with HMP Moorland, which has a 24 hour healthcare facility, and is a short distance away. However, the POA, the IMB and some staff thought that, with the increasing numbers of prisoners and immigration detainees held at Lindholme, having healthcare staff on duty all the time was a necessity.

53. My investigator interviewed the officers who were on duty on the night of the 20/21 November 2004 and the SO that came on duty later that morning. There are conflicting accounts about the quality of monitoring the man received during the latter hours of the night shift.

54. The early shift SO said that when he came on duty he was briefed about the man by the night OSG. He then went to the man's cell and looked through the locked cell door and saw him lying on the mattress. He said that he did not see any other officer in the segregation area. The night duty officers said, both to the Police and my investigator that the first Officer remained in the cell until relieved.

55. The SO on night duty was first aid trained and both of the other officers had had some first aid training in the past, though neither was currently qualified.

56. After the man was taken to hospital a fellow prisoner told staff that the man had taken drugs whilst on normal location the previous week. He stated that on the first occasion he took about 20 co-proxamol tablets at once without any apparent effect. On a subsequent occasion the prisoner saw him 'smoke' what he believed was heroin using a foil tube and a lighter. The prison told the hospital of this information in case it had any bearing on the man's current state.

Clinical Review

57. The Head of Clinical Governance for the Doncaster Primary Care Trust, carried out a clinical review of the medical care. His full report is in Annex B of this report, but there are some points raised that I wish to include here.

58. As part of his review, he interviewed the Doctor, who acknowledges that he should have stuck with his first inclination and admitted the man to hospital. He admitted that whilst it was not unusual for patients to be sleepy following a fit, it was inappropriate to expect prison staff to make the decision whether he was fit to remain at the prison or to transfer him. The reviewer makes it clear in his review that the delay did not affect the outcome.

59. Another point raised during that interview was that doctors visiting the prison 'out of hours' do not have access to emergency equipment. Any equipment needs to be brought into the prison by the visiting practitioner. The prisoners Medical Record's are similarly not available.

60. The reviewer makes comment on the man's Medical Record, in particular the legibility of some entries. He also notes that the entry for 4 November 2004 was not on the correct form. In fact it was written on the rear of the First Reception Health Screen document.

Findings and Conclusions

61. Some of the entries in the Medical Record are unclear and incomplete, and a total of three prescription chart forms had been used. That made it difficult to track the medical care the man had been given. For example, when the Medical Record is read the impression given is that the man complained of a headache only on 4 November 2004 when in fact he was prescribed medication to relieve headaches on four occasions. Also it was often difficult to read the signatures of the various staff members who had made notes in the document. My investigator spoke with the Clinical Reviewer about the number of times the man was prescribed headache medication. He did not believe that the prison was negligent in any way for not diagnosing his underlying medical condition even with the other headache complaints.

62. I believe that there is a training need for some healthcare staff in the standards required for records and record keeping, and as a matter of routine for staff to print their names after their signatures.

63. Lindholme has a dual population approaching 700, comprising prisoners and Immigration Detainees, held in separate sections of the prison. I am concerned that neither the Medical Records of patients nor emergency medical equipment can be accessed 'out of hours'.

64. A number of staff interviewed considered there was a need for 24 hour on-site healthcare cover at the prison. I believe that the man's unfortunate death has highlighted the issue around the current out of hours medical cover arrangements.

65. When the man was found in his cell apparently having a fit, the night duty staff followed procedure and contacted the duty doctor. The doctor's initial reaction was to have him sent to hospital. He changed his mind, however, upon being told that the man had calmed and was sleeping. He then left instructions that he was to be monitored by the prison staff and if his condition changed he was then to be taken to hospital.

66. The doctor was unaware of what training, if any, the night staff had received in dealing with medical emergencies, yet he accepted their assessment of the man's condition and left them to monitor his condition. In his interview with the Clinical Reviewer, the doctor accepted his mistake and said that he has learned from the incident.

67. In this case the Clinical Reviewer has indicated that the delay in the man reaching hospital did not affect the outcome, as his condition was untreatable. If he had arrived at hospital earlier, it is likely that his family would have had more time alone with him before he died.

68. The night duty SO gave verbal instructions that an officer was to remain in the man's cell until relieved by the early shift. There is no written record of which officer kept watch, or for how long. There is a record of

observations carried out by the early shift officer. One of the night shift officers told the Police and then my investigator that he remained in the open cell with the man until relieved, which was confirmed by the night duty OSG. However, the early shift SO who was briefed by the OSG, said that he did not see the officer when he checked on the man who was locked in his cell. It has not been possible to establish which version of events is correct.

69. When the paramedic examined the man he noted what he believed was a recent puncture wound on his forearm. After the man was taken to hospital prison staff correctly passed on information that another prisoner had just given them. The information was that the prisoner had seen the man take drugs the previous week. In this case, after the man's death, the Coroner did not order a toxicology report. It has therefore not been possible to determine whether he had any illegal drugs in his system when he died.

Recommendations

HEALTH

The PCT in partnership with Lindholme should undertake a review of the on-site and out of hours clinical cover.

Prison Service response : *Medical cover is available from 8am to 8pm; outside of these times HMP Lindholme has access to a comprehensive out of hours services (OoH) service.*

HMP Lindholme did have in place, at the time of the man's death, 24-hour cover for medical emergencies delivered by a third party contract. A prisoner who needed an increased level of medical care would be transferred to either another prison establishment or to an NHS hospital. HMP Lindholme does not have an in-patient facility but does have a robust protocol in place for the transfer of prisoners to HMP & YOI Moorland should the clinical need arise; these prisoners usually have mental health problems or are at risk of self-harm or suicide.

However, this particular case has highlighted the need to review and strengthen the existing protocols and the prison has updated the transfer protocol and the OoH protocol accordingly. Guidance on accessing the OoH service has been issued to all staff and the OoH protocol has been strengthened and revised, in partnership with the third party contractor providing the service. In addition, guidance has been given to all on-call doctors to ensure that when contacted by phone from the prison, they are aware that they are dealing with non-medically trained staff.

Regular healthcare staff meetings take place, which are attended by the Head of Healthcare who raises any issues at Senior Management Team meetings. There are guidelines for action in a medical emergency during patrol state, including lines of accountability. Protocols are in place for response to an acute emergency in the form of the code red/blue call system during the hours of 8am and 8pm when nursing staff are present.

The prison has well trained first-aiders who are regularly updated and a nursing staff who are all trained in CPR.

The PCT should introduce a system of clinical audit for standards of records and record keeping.

The prison should ensure that an auditable system is in place to allow prompt access to emergency clinical equipment and medical records by attending clinicians out of hours.

Prison Service response : *Every attempt is made to ensure that full history is taken at reception, but rapid prisoner movement between establishments and the lack of IT resources are limiting factors. Many prisoners are not registered with a GP prior to coming into prison and, in addition, prisoners come to HMP Lindholme from all over the country and not just the local area, which makes locating hospital records problematic. All Doncaster prisons are part of local information sharing protocols and are now included in the National Programme for IT (NPfIT).*

Record keeping training has been arranged via the PCT and should be available to all staff. In addition, the prisoners will undertake regular notes audit as part of in-house staff team meetings and training. The Commissioning Manger will liaise with the third party contactor providing GP services to ensure that all doctors are aware of guidelines on record keeping, including locums and OoH. The Prison will undertake to ensure that there are appropriate policies and procedures on record keeping in place

OPERATIONAL

All staff should be reminded of the importance of documenting their actions and instructions, to ensure effective communication amongst the multi-disciplinary team and effective prisoner care.

Prison Service response : *A procedure is in place to ensure that regular checks of medical equipment are undertaken and recorded to provide an audit trail. A review of the equipment provided is underway. We will review OoH access to medical records with local management and the PCT.*