Investigation into the circumstances surrounding the death of a man from HMP Wakefield, who died in February 2010 at Leeds General Infirmary

Report by the Prisons and Probation Ombudsman for England and Wales

August 2010

A man was in his sixties when he died in February 2010, in Leeds General Infirmary. He had been transferred to hospital from HMP Wakefield the previous day, after being taken ill in his cell. A Senior Investigator, Family Liaison Officer and I offer our sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of HMP Wakefield for making the necessary facilities and information available to our investigator.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. A Registered General Nurse (RGN) was appointed by Wakefield District Primary Care Trust to undertake a clinical review on my behalf. I am grateful for their assistance and her report.

Since taking over responsibility in April 2004 for the investigation of all deaths in custody, there have been 25 deaths in custody at Wakefield, including that of the man. Although the number appears high, it should be recognised that the prison holds a number of elderly prisoners, which inevitably brings about a higher incidence of deaths.

For the purpose of this report I concentrate in the main on events from when the man became ill on 30 January 2010. However, I have included a brief chronology of his custodial and medical history prior to that date.

This report makes seven recommendations, all of which relate to medical matters. I also identify two areas of good practice.

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

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SUMMARY

The man had a number of complex medical needs. He had previously had his right leg amputated below the knee, was totally deaf in one ear and partially deaf in the other. He had a prosthetic leg and wheelchair, although he was able to walk with the aid of sticks. He experienced some discomfort with the residual limb and treatment was ongoing.

On 30 January 2010, he became ill during the night and was assessed by a nurse on duty in the prison. He told an officer and the nurse that he had a stomach problem which caused him to produce too much acid and that his discomfort was of a similar nature. The nurse prescribed an antacid medication and advised the man to see a doctor in the morning.

The man's condition did not improve and, following further examination by the duty nurse later that morning, an electro cardiograph (ECG) reading was carried out and the reading sent for analysis. The result of the analysis was that he had suffered a heart attack and an emergency ambulance was required.

The man was initially taken to the Coronary Unit at Leeds General Infirmary (LGI), but then transferred to a hospital in Dewsbury. He remained at Dewsbury for a short time before returning to the LGI. (The reason why he was transferred is currently under investigation by the management at the LGI.)

When the man returned to LGI and due the seriousness of his condition, a temporary pump was inserted into his heart to help increase his heart output. (I explain this in greater detail later.) About two hours after removing the pump, the man had a further heart attack and, despite attempts by doctors to resuscitate him, he died. The post mortem report states that the cause of death was a heart attack, with a secondary cause of heart disease.

This report makes seven recommendations relating to medical care. It also identifies two areas of good practice which also relate to medical care.

THE INVESTIGATION PROCESS

1. After receiving notification from the Prison Service on 3 February that the man had died, the Ombudsman appointed a Senior Investigator to carry out the investigation. The investigator contacted the prison and arranged to travel there for the purpose of opening the investigation.

2. On 4 February, the investigator opened the investigation by meeting the Deputy Governor. Also at that meeting was an officer representing the Prison Officers Association, and Healthcare Principal Officer.

3. A clinical review into the care the man received while he was in Wakefield was commissioned from NHS Wakefield District Primary Care Trust. The Trust appointed an RGN to conduct the review.

4. The investigator returned to the prison on 17 February to continue the investigation and, on this occasion, he was joined by the clinical reviewer. They carried out a number of informal interviews with prison staff which were not recorded. Before leaving the prison the investigator met a senior prison manager to feedback what had been identified. He followed up the feedback by writing to the Governor.

5. A family liaison officer wrote to three separate members of the man's family to inform them of the investigation and provide them with an opportunity to ask any questions or raise any concerns about the care the man received. At the time of issuing this report the man's family have not raised any specific issues. The draft report has been shared with those members of his family who wished to receive it, and an additional comment added as a result. The final version of the report will also be shared with the family. I hope this report helps his family better understand the events leading to his death.

HMP WAKEFIELD

6. The prison is located in Wakefield very close to the city centre. There has been a prison on the site since 1594. It is a high security prison and most of the prisoners are serving life sentences or have been convicted of serious offences.

7. There have been 24 previous deaths in custody at Wakefield since the Ombudsman began investigating such cases in 2004. There are no similarities between those cases and the circumstances of the man's death, although the clinical reviewer has pointed out that, in a report into a death in 2007, a similar recommendation was made about the importance of clinical leads.

Her Majesty's Chief Inspector of Prisons

8. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. The majority of inspections are pre-announced and allow the prison being reported on to prepare for inspection. The most recent inspection was carried out in December 2008.

9. In the introduction to her latest report, published in February 2009, Her Majesty's Chief Inspector of Prisons said the prison had improved considerably over the previous five years and that she was pleased the improvement had been sustained. She said there was still work to do in aspects of safety and staff prisoner relationships and activities, including engaging offenders in treatment programmes.

10. In the main body of the inspection report, it was noted that, despite provision for five hospital visits per day, "too many" outside hospital appointments were cancelled with no record kept of the reasons why. (The man missed a hospital appointment because of staff shortages on 21 January 2010.) The inspection team also noted that many "older prisoners and those with disabilities were dissatisfied with the support they received".

Independent Monitoring Board (IMB)

11. Each prison has an Independent Monitoring Board (IMB) which is made up of members from the local community. Their role is to monitor the prison and report any concerns that they have regarding the prison or how prisoners are treated. In the first instance, the Board report to the Governor, or, if necessary, can report directly to Parliament. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

12. In its most recent report, covering the period 1 May 2008 to 30 April 2009, the Board said they were concerned at the available accommodation for elderly

prisoners. They added that many improvements had taken place in the healthcare centre and made special mention of the quality of the good service in the treatment clinics. The Board were positive about the provision of healthcare, adding that patients appeared to be well cared for.

FINDINGS

13. The man had his leg amputated below the knee following an industrial accident in 1992. Although he had a wheelchair he was able to walk with the aid of walking sticks. In addition to that injury and as a result of a motorcycle accident, he was totally deaf in his right ear and partially deaf in his left.

14. In January 1999, the man was sentenced to life imprisonment for a serious offence. After receiving his sentence he was taken to HMP Hull where he remained until November 2000, when he was transferred to HMP Wakefield.

15. His medical record shows that he attended a National Health Service Prosthetic Clinic as and when necessary, but does appear to have had ongoing pain in his residual limb. Additionally it appears that he occasionally had difficulty obtaining the correct size residual limb socks. The man's ex-wife wrote to the prison twice offering to send a spare box of socks. This offer was refused, however, for security reasons.

16. Initially he was prescribed ibuprofen (an anti-inflammatory tablet) on a regular basis for pain in his residual limb, but this was discontinued in 2003 when he began experiencing severe abdominal pain and heartburn. He was later diagnosed as suffering from helicobacter pylori, a bacterial stomach condition, and received treatment for this.

17. In January 2008, he was diagnosed with Carpal Tunnel Syndrome, which was successfully operated on the following September. (Carpal Tunnel Syndrome is a compression of the median nerve, which caused problems in his right hand.) He received post operative physiotherapy within the prison. Two months later, in November 2008, the man was diagnosed as having hypertension (high blood pressure) and prescribed medication to treat his symptoms.

18. According to his medical records, from August 2009 the man received physiotherapy to his left shoulder although there is no information why it was needed. Later that year he was given influenza and swine flu vaccinations and, from the medical records, it appears he felt unwell with cold symptoms afterwards.

19. Access to a physiotherapist within the prison enabled the man to receive the correct follow up following his operation for Carpal Tunnel Syndrome. The clinical reviewer adds the assessment also included treatment for a shoulder problem which, had it not been treated, could have impacted on his mobility as a wheelchair user.

20. On 17 December, he saw the prison doctor, and complained that the foot on his prosthesis was loose. The doctor referred him to Prosthesis Clinic so that the foot could be repaired or replaced. In addition he complained of cold symptoms and right sided chest pain following his swine flu vaccination. The medical record shows that when examined, his chest was clear and that his "air exchange" (the process in the alveoli in the lungs where oxygen is

absorbed into the body as carbon dioxide is expelled) was good. However the doctor was unable to check his blood pressure because a sphygmomanometer (blood pressure monitor) was not available. (I understand the reason was that another investigation concerning healthcare was ongoing and it had not been replaced.) It was noted in the man's medical record that he was at high risk of cardio-vascular disease and had been given smoking cessation advice.

21. Later that month, on 31 December, he was seen by a nurse at the prison complaining of cold symptoms, sore throat and a cough. The nurse carried out an examination and recorded his temperature as normal. Although his throat appeared normal, he had a slight inflammation in his left ear.

2010

22. On 21 January, the man was due to attend an appointment at the Prosthetic Clinic but, due to staff shortages within the prison, he was unable to go. It is not clear whether an alternative appointment date was scheduled.

23. At about 1.30am on 30 January, he pressed his in cell emergency button to alert staff that he required assistance. A prison officer told the investigator that he went to the cell and looked in through the door observation panel. He saw the man sitting up on his bed. The officer said the man told him he had pain across his chest and that he had a medical condition which caused him to produce too much acid. He also told the officer that the pain was stomach cramp.

24. The officer told the investigator that it was unusual for the man to press his cell call button and so he decided to contact the healthcare centre to speak to the night nurse. The nurse went into the cell and carried out her own checks, after which she gave the man Gaviscon (a medication for indigestion) and told him to see a doctor that morning.

25. The nurse told the investigator that before going to see the man she had looked at his medical notes. She said there were no significant issues other than he had only one leg. When she arrived at the cell the man was sitting in a chair. She said he was talking and breathing normally and told her that he had indigestion. The nurse noted that his skin colour was normal, but that he was "anxious". She did not know why he was anxious but explained that the man said he had had indigestion for about two weeks.

26. The man confirmed to the nurse that he did not have any pain in his left arm. The nurse said his blood pressure was slightly raised, but that it was within normal range for him. She said she did not suspect from his symptoms that he had any cardiac problems.

27. After leaving the cell, the officer when carrying out his routine wing patrol, looked in the man's cell from time to time to ensure his wellbeing. The officer said he spoke to him to ask how he was and he replied that he was okay.

28. At about 6.00am, the officer completed his morning roll check. He said he spoke again to the man and reminded him to see a doctor. Before leaving the prison for the day, the officer told the wing staff coming on duty what had happened during the night. In the meantime the nurse had arranged for the man to be seen by a nurse and, if necessary, a doctor.

29. Later that morning a Registered General Nurse was on duty. She had been told that the man had been ill during the night and said she had been asked to follow up and check his condition. The nurse told our investigator that her plan was to see the man after she had completed her morning treatment work.

30. At about 10.10am, the RGN was contacted by a member of the wing staff who asked her to see the man. She said the officer told her the man was complaining of chest pain. The nurse said that, although the request was not urgent, she went straight away as she was aware that he had been ill during the night.

31. The RGN told the investigator that when she went into the cell the man was sitting up and complaining of pain which he said was due to a duodenal ulcer. She said he coughed and that it was a chesty cough. He also told her he had pain down his left arm.

32. An ECG (electrocardiogram, a measure of electrical activity in the heart) was carried out and the results sent by telephone line to Bromwell Health Watch for analysis. (Bromwell Health Watch analyse the ECG readings and advise on the appropriate course of action.) The RGN said that the assessor told her the man had suffered a heart attack and an emergency ambulance should be called. Due to the level of pain he was experiencing, the nurse gave him glyceril trinitrate (used to treat angina).

33. In the meantime, an ambulance was called and, when it arrived, the paramedics carried out their own checks. After attaching a 12 lead ECG machine to the man's they were able to say that he had "right bundle branch block [a defect in the heart's electrical activity], acute myocardial infarction [heart attack] and a history of myocardial infarction". The man was transferred by emergency ambulance to the Coronary Care Unit at Leeds General Infirmary (LGI).

34. The clinical review shows that, after being examined at LGI he was taken to the Cardiac Unit at Dewsbury District Hospital. He remained there for a short period and was then taken back to the LGI. (It is not clear why the transfer took place, and the matter is being investigated separately by LGI and does not form part of this report or the clinical review.)

35. When the man returned to the LGI, and because of the serious nature of his condition, a "balloon pump" was inserted into his heart. (The pump is a mechanical device used to reduce the demand on the heart and increase cardiac output.) The intention was to leave the pump in place for about 24 hours and then review the situation. A registrar at the hospital told the man's

family that the pump could not remain for longer than 24 hours and there was a risk that his heart could not manage without it and he would die. (The man's ex-wife and stepdaughter had been contacted by Wakefield at 11.40am. Although they were surprised to be named as next of kin by the man, they visited him in hospital.)

36. The following morning at about 3.00am, the pump was removed. About two hours later he collapsed without regaining consciousness and despite emergency resuscitation attempts he died. His family, who were not with him at the time, were informed by the hospital at around 9.00am. The family liaison officer from Wakefield, visited the family at the same time as they wished to break the news in person.

ISSUES

Clinical Care

37. The clinical reviewer said that the man's overall health care appears to have been adequate, although for someone with complex and chronic health needs there was no identified clinician to co-ordinate his care. She adds that this is an observation that has been made in relation to a previous death in custody at Wakefield.

Hypertension

38. The clinical reviewer said the man's initial diagnosis of hypertension in November 2008 appears to have been made on a single reading, which she explained is not in line with National Institute for Clinical Excellence (NICE) guidelines. She said the guidelines suggest that two further readings should be made at monthly intervals before a diagnosis is made and treatment begins. The treatment should then be reviewed annually.

39. Additionally the clinical reviewer said the man was reviewed after 13 months, but that it appeared to have been more by chance than design. She went on to say that although protocols and guidelines are available to healthcare staff, not all staff appeared to be aware where they are located.

The Head of Healthcare should review the protocols for the management of hypertension and conduct an audit of clinical staff awareness of the protocols and guidance.

Sphygmomanometer

40. In December 2009, the prison doctor was unable to use the sphygmomanometer to record the man's blood pressure as there was another ongoing investigation. It is not clear why another one was not available to use. The clinical reviewer also recorded in her review that the sphygmomanometers were not regularly calibrated or maintained, which could limit their usefulness in future tests.

The Head of Healthcare should ensure that a sphygmomanometer is always available for use, and that there is a protocol for the routine maintenance and calibration of sphygmomanometers.

Health records

41. SystmOne is the electronic health record in use at Wakefield. As well as recording details of interactions between healthcare staff and patients, it enables clinicians to record health problems and consultations, using a range of clinical templates, some of which have been specifically designed to support management of long term conditions. Information can be stored in different ways, with different template options. Providing the correct template is used, it can alert the user when reviews are due and assess specific health

risks, for example cardio-vascular risk. The clinical reviewer said there appears to be no agreed approach to the use of SystmOne within the prison and not all of the clinicians fully understand the functions available.

42. SystmOne has the potential to support clinicians in the management of patient care. It would appear that an agreement has not yet been reached in relation to which templates to use to record information. Additionally the clinical reviewer identifies significant training issues for staff. This too is also an area that has been identified in a previous clinical report.

43. Whilst I acknowledge the difficulties attached to using two different electronic systems (SystmOne and the pharmacy record) and hard copy, for prescribing, dispensing and administering medication, I am aware that steps have been taken to reduce the risk.

The Head of Healthcare should review the templates available to clinicians to support care management and agree how they should be used.

Drug sensitivities

44. The man's medical record shows that, on several occasions, he had a reaction to a number of drugs and food which usually took the form of a skin rash. There appears to have been some discussion regarding potential drug allergies and sensitivities but they do not appear to have been definitively addressed. Informal interviews with clinical staff suggest that not all clinicians felt confident about finding clinical information stored on SystmOne, or how to use the various templates.

45. The clinical reviewer said it is important to include self reports from patients of previous health problems and drug sensitivities. However there does not appear to have been any clarification as to the exact nature of all the man's gastric problems.

The Head of Healthcare should conduct an audit of staff awareness and understanding of SystmOne and develop a programme to meet individual training needs

Issuing drugs

46. The clinical reviewer said that the man had been allowed to hold his own medication which meant that after the first issue, any subsequent supplies would only be dispensed at his request. She said his pharmacy record shows one issue of bendroflumethiazide (a diuretic used to treat high blood pressure) for 28 days, which was given to him in November 2008. However the SystmOne report shows the prescription was for 84 days prescribed in November 2008 and discontinued until September 2009. The clinical reviewer said there is no reason documented for the bendroflumethiazide being discontinued. However, there had been an audit of repeat prescriptions

and as the man's medication had not been dispensed for ten months, this may be the reason for it being discontinued.

47. The clinical reviewer notes the disparity between the medication recorded information held on SystmOne and the pharmacy record. She said the prison and NHS Wakefield District had taken action to minimise the risks.

48. Additionally she said that when prisoners attend for planned health appointments, pharmacy records provide a list of the medication they were currently prescribed. However, in emergency situations and out of hours, this service is not available. The clinical reviewer said that it means that clinicians do not have access to the patient's current medication record, as was the case with the man.

49. The man appears to have made choices about whether or not to take the medication prescribed for his hypertension. The clinical reviewer said it is unlikely that better maintenance of his hypertension over a 12 month period would have prevented his myocardial infarction.

The Head of Healthcare should review the current system for providing access to the patient's medication record in emergency situations and out of hours.

Gastric ulcer

50. The man appears to have told medical staff that since having an 'ulcer' he often suffered from heartburn. The clinical reviewer said he was quite convinced that the ulcer was the cause of his pain on 30 January. She adds that there is no information to support any history of a duodenal ulcer, although he had been diagnosed with, and treated for, helicobacter pylori (a stomach condition). The clinical reviewer goes on to say that the man's medical record does not show that he ever asked for medication for gastric pain. It is important that staff accurately record when patients report health problems and also then confirm that the information they have been given is correct.

The Head of Healthcare should develop a protocol for confirming that all self reported health problems and ensuring information is recorded in the medical record.

51. Despite the man's complex health needs, the clinical reviewer comments that a multi-disciplinary approach to the management of his care does not appear to have been taken. There were no management plans evident for his ongoing problems and no identified clinician to oversee or co-ordinate his care.

The Head of Healthcare should review clinical leadership within the Primary Health Care setting, and conduct an audit of current roles, responsibilities and working practices and that a structured case management approach is taken for prisoners with complex long term conditions.

Events on 30 January 2010

52. The clinical reviewer said that, based on the information the man gave to medical staff on 30 January, the assessment of his medical condition appears to have been satisfactory. She said that appropriate action was taken, including a request for follow up assessment, although it was not regarded as urgent.

53. At about 10.00am, when a full assessment was undertaken, an emergency ambulance was requested. The clinical reviewer said the RGN demonstrated an excellent understanding of the man's health status and requirements. The ECG report from Bromwell Health Watch confirmed that he was suffering from an acute myocardial infarction and the RGN asked for the man to be taken to hospital.

54. The clinical reviewer said the RGN should be commended for her knowledge and understanding of the true cause of the man's chest pain despite his obvious suggestion that it was 'gastric' pain. She ensured that a thorough examination was made, provided appropriate care and requested the paramedics to take him to the LGI. Whilst I make no formal recommendation, the Governor may wish to share the comments with the RGN and her employer.

55. Since carrying out a clinical review, the reviewer has learned that after an initial assessment at LGI the man was transferred to the Cardiac Unit at Dewsbury District Hospital. He was later taken back to LGI.

CONCLUSION

56. This case has highlighted a number of issues relating to medical care. That said, I am satisfied that the man believed that his symptoms were of a gastric nature and something he had experienced previously. Additionally I am satisfied that the nurse who attended him during the night made satisfactory arrangements for him to be followed up by the doctor the next morning.

57. Once the ECG report had been sent for analysis, the situation was found to be far worse than expected. Arrangements were made very quickly to transfer him to hospital as an emergency patient.

58. However, it does concern me that after being taken to the LGI he was then taken to Dewsbury before returning to Leeds. Whilst I do not want to speculate on what the outcome might have been had he received emergency treatment sooner, it is worrying that there may have been delays in his treatment. I am satisfied that the matter is under investigation by managers at the LGI and I encourage them to share their findings with me.

RECOMMENDATIONS

1. The Head of Healthcare should review the protocols for the management of hypertension and conduct an audit of clinical staff awareness of the protocols and guidance.

   Accepted – "Practice Development Facilitator working with GP's via the GP Clinical meeting to implement a protocol and framework for the management of those Offenders with Hypertension in line with NICE Guidance."

2. The Head of Healthcare should ensure that a sphygmomanometer is always available for use, and that there is a protocol for the routine maintenance and calibration of sphygmomanometers.

   Partially accepted – "A Sphygmomanometer is always available for Clinical Staff, however, on the day in question, the HCC was "locked down" to facilitate a search of all clinical areas, therefore staff were prevented from accessing clinical equipment.

   "Wakefield do accept that there should be a protocol in place for the routine maintenance and calibration of equipment. This will be taken forward by the Practice Development Facilitator."

3. The Head of Healthcare should review the templates available to clinicians to support care management and agree how they should be used.

   Accepted – "Funding through the PCT / Prison SLA has now been agreed for 2010/11. One day per month has been allocated for SystmOne Training for healthcare staff. This will concentrate on up-skilling staff as well as record keeping information. Training for staff in respect of SystmOne has now commenced on a monthly basis, and will continue throughout 2010/11."

4. The Head of Healthcare should conduct an audit of staff awareness and understanding of SystmOne and develop a programme to meet individual training needs.

   Accepted – "Funding through the PCT / Prison SLA has now been agreed for 2010/11. One day per month has been allocated for SystmOne Training for healthcare staff. This will concentrate on up-skilling staff as well as record keeping information. Training for staff in respect of SystmOne has now commenced on a monthly basis, and will continue throughout 2010/11."

5. The Head of Healthcare should review the current system for providing access to the patient's medication record in emergency situations and out of hours.

   Accepted – "A review of processes has been conducted, and in line with SystmOne developments, Electronic prescribing initiatives will be taken forward which will improve access to medication records."

6. The Head of Healthcare should develop a protocol for confirming that all self reported health problems and ensuring information is recorded in the medical record.

   Accepted – “Protocol for self reported problems being developed around initial health screening on Reception. The secondary Health screen will explore further the issues of self reported health problems.”

7. The Head of Healthcare should review clinical leadership within the Primary Health Care setting, and conduct an audit of current roles, responsibilities and working practices and ensure that a structured case management approach is taken for prisoners with complex long term conditions.

   Accepted – “A review was undertaken of clinical leadership within HMP Wakefield and two posts were successfully filled in late 2009. One post concentrates on Clinical Leadership and the other being Clinical Governance and practice improvement issues.

   “Band 5 nurse training in respiratory care. Diabetic services to be improved with the Integrated Diabetic services coming into the prison. Coronary Heart Disease management being reviewed with a view to commission a Community Model into the Prison.”