The Death in Custody of

a man at

HMP Hull – December 2004

Report by the Prisons and Probation Ombudsman for England and Wales

October 2005

This is the report of an investigation into the circumstances of the death of a man at HMP Hull on 13 December 2004. The man's cause of death was an intra-cerebral haemorrhage (bleeding into the brain following rupture of an artery). The man was 55 years old.

The investigation was carried out by one of my colleagues. A clinical review into the man's care and treatment was carried out by the Director of Professional Development at Eastern Hull Primary Care Trust (PCT).

The man complained about a headache on the morning of 12 December 2004 for which he was given painkillers. The clinicians involved could not have been expected to recognise that the man's headache was in fact the onset of an intra-cerebral haemorrhage as this is a difficult condition to diagnose in a primary care setting. However, the investigation has revealed potentially dangerous clinical decision making practices. The standard of clinical record keeping at Hull has also been found to be deficient.

I extend my condolences to the man's friends and family for their loss.

I would like to thank the Governor of HMP Hull, and his staff for their help.

Stephen Shaw **October 2005**
Prisons and Probation Ombudsman

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Summary

The man died in HMP Hull on 13 December 2004, at which time he was 55 years-of-age. His cause of death was an intra-cerebral haemorrhage. The man was serving a seven-year sentence, having been convicted in April 2002 on a number of serious sexual offences.

From the information given by the man during a preliminary health check upon his arrival at Hull, it would seem that he enjoyed reasonably good health. Although the man's clinical records show that he consulted healthcare quite regularly, all his consultations until his final one had been about non-serious clinical conditions such as his condition of chronic psoriasis.

On 12 December 2004, the man complained to staff that he had a headache. The only other time that the man's records contain a direct reference to a headache had been 12 months earlier when he had influenza. A healthcare nurse visited the man at 10.30am and gave him ibruprofen, a painkiller. The Healthcare Nurse was not qualified to prescribe medication, however it seems that a qualified Staff Nurse had issued the ibruprofen to the Healthcare Nurse after the drug had been prescribed by a doctor. The doctor could not, however, recall writing a prescription and no record has been found of the man ever having been prescribed ibruprofen.

The Healthcare Nurse saw the man again at midday in order to take clinical observations of temperature, pulse and blood pressure. The Healthcare Nurse noted that the man was then complaining of feeling nauseous, which had not been the case earlier that morning. The Healthcare Nurse made arrangements for the man to see a doctor two days later.

At 7.30pm that evening, the man was found collapsed on his cell floor. The man was rushed into hospital where a brain scan revealed that he had suffered an intra-cerebral haemorrhage. Unfortunately, the haemorrhage was found to have been too large to allow for an operation and all the hospital could do was to keep the man as comfortable as possible during his final hours. The man died at 5.30am on 13 December.

The clinical review of the man's care and treatment on 12 December points out that an intra-cerebral haemorrhage is a very difficult condition to diagnose. Nevertheless, there are a number of issues relating to the man's treatment that day that give me cause for concern. The first issue relates to how the man came to be prescribed ibruprofen. From the information obtained during the clinical review, it would seem that decisions about the diagnosis and treatment of the

man's condition had already been made before he was visited by the Healthcare Nurse at 10.30am. The information leading to the diagnosis and treatment decisions presumably consisted of a telephoned report from wing staff that the man was complaining of a headache. This would seem to be an extremely unsatisfactory way in which to practice medicine.

Furthermore, the clinical reviewer found from her interviews with nursing staff that they did not use assessment tools, such as decision-making algorithms, in their clinical decision-making. Nor did staff follow Nursing and Midwifery Council (NMC) guidelines, or any other guidelines on the administration of medication. The clinical reviewer also criticised the general standard of record keeping by healthcare staff.

The report makes a number of recommendations relating to the delivery of healthcare at Hull. These include recommendations on medication prescribing practices and on standards of record keeping.

Investigation Process

My practice in cases of deaths from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator visited HMP Hull on 20 December 2004 when he spoke informally with the Governor, the Head of Healthcare and the Healthcare Nurse. The investigator was given access to the man's records, including his medical records.

My investigator also met a member of the Independent Monitoring Board (IMB) who said that he had spoken with the IMB Chair about the man's death. The IMB had no issues of concern to raise either about HMP Hull in general, or about the man's care and treatment in particular.

The man's appointed next-of-kin was a friend. One of my Family Liaison Officers spoke to the friend by telephone. The friend said that that she had last visited the man in November 2004, two weeks before his death. The man told her that day that he had been suffering from severe headaches, but medical staff would only give him one pain-killing tablet at a time which did not seem to help. After this visit, the friend spoke with the man by telephone on two occasions when he said his headaches were no better. He said his headache was coming and going and the friend thought he said that it was centred over his right eye.

The Director of Professional Development at Eastern Hull Primary Care Trust (PCT) carried out a clinical review.

No formal interviews with staff were conducted. This report is based upon a thorough review of all relevant paperwork, informal discussion with two members of staff and the clinical review.

HMP Hull

HMP Hull is a predominantly Victorian prison that first opened in 1870. Hull is a local prison holding remand, sentenced and convicted adult males (except category A prisoners) and young offenders. It has an operational capacity (maximum crowded capacity) just in excess of 1,000.

Healthcare provision at Hull includes 18 in-patient beds. The unit is staffed 24 hours per day by a range of nursing staff supported by healthcare officers. All clinical staff in healthcare have the authority to admit a prisoner into an in-patient bed. Since 1 April 2005, the local PCT has assumed commissioning responsibility for the provision of healthcare.

If a prisoner asks at a medication round for non-prescribed one-off medication, for instance because of a headache, he should only be given medication following examination by a doctor or based upon telephone advice from a doctor following an assessment by a nurse. If medication is issued in this way, a prescription must be written-up within 24 hours of the medication being issued.

When my investigator visited Hull, he had an informal discussion with the healthcare Clinical Team Manager. She told him, among other things, that she was concerned about standards of clinical record-keeping by healthcare staff.

The man

The man was born in June 1949 and grew up in West Yorkshire. The man's mother had many children whom she found difficult to raise and several, including the man, were taken into care. The man, together with one of his brothers, was placed in a children's home, where he remained from the age of five up to the age of 16. During this time, the man had minimal contact with his parents.

The man left the children's home in 1965 at the age of 16 without qualifications. He was taken into a foster home, but he was unable to settle there so he was moved into a second foster home where he did settle and where he remained for around 10 years. In 1976, the man was befriended by the mother of a friend. The man moved into the family home and that remained his home from then onwards. His friend's mother is the person who the man nominated as his next-of-kin when he entered the prison system.

The man worked in both light and heavy industry.

In April 2002, the man was convicted on a number of counts of rape and sexual assault against the same victim – offences which had occurred between 1972 and 1979. The man was sentenced to seven years imprisonment.

The man had one previous conviction for which he was sentenced to three years imprisonment in 1979. The man had pleaded guilty at trial for this offence, but always maintained that he was innocent of the offences that resulted in his conviction in 2002.

When interviewed by a probation officer in 2002, the man said that he believed that both of his parents were deceased.

The Events Leading up to the Man's Death

The man was received at Hull in April 2002. During his first reception health screen interview, the man reported that he smoked 20 cigarettes per day, had never used illicit drugs and drank only a moderate amount of alcohol. The man said he had no worries about his health and the only clinical condition from which he suffered was psoriasis.

During his time in Hull, the man consulted clinical staff infrequently and always for minor ailments, most often in connection with his skin condition. The man consulted healthcare about this condition on 12 November 2004 and again on 10 December 2004. On this second occasion, which was three days before his death, the man also reported that he was suffering from a cold for which he was given two paracetamol tablets.

At 10.30am on Sunday 12 December 2004, the Healthcare Nurse was called to see the man in his cell. This was a single cell. The Healthcare Nurse noted that the man was complaining about a headache, but also noted that the man's colour was satisfactory, his speech was not slurred, he had movement in all his limbs and he was able to grasp with his hands. The Healthcare Nurse gave the man ibruprofen and asked the wing staff to contact healthcare if they had any concerns about the man's condition.

At midday, The Healthcare Nurse returned to see the man again. It is not entirely clear why the Healthcare Nurse went to see the man for a second time. When my investigator visited Hull on 20 December he spoke to the Healthcare Nurse who said that he had gone back to the man in order to take clinical observations. He said that he had not been carrying the equipment needed for taking observations when he visited the man at 10.30am. However, there is some suggestion that the Healthcare Nurse's return might have been prompted following a further call to healthcare by the wing staff. In his record of this second visit, the Healthcare Nurse recorded the man's temperature, pulse and blood pressure. He also noted that the man was then complaining about feeling nauseous. However, the Healthcare Nurse also recorded that the man still had no slurring of speech and that there was no deformity in his facial expression. The Healthcare Nurse made an appointment for the man to see a doctor two days later.

Wing staff had not noticed anything untoward during that afternoon, however at roll call at 7.30pm, the man was found collapsed on his cell floor. He was breathing very loudly, his eyes were fixed and dilated and staff could not rouse him. An emergency ambulance was called and the man was taken to Hull Royal Infirmary where a computed

tomography (CT) scan revealed that the man had suffered a brain haemorrhage.

The man was accompanied to the hospital by two prison officers. Hand-cuffs were not used. At 10.35pm, one of the prison officers accompanying the man made a note that he had been moved into the acute assessment unit and a doctor had advised that the man's haemorrhage had been too large to allow for surgical intervention. All that could be done would be to keep him comfortable until he passed away.

At this point, a senior officer from the prison spoke by telephone to the adult daughter of the man's friend to inform her that the man was in hospital and that the doctors had given him little time to live. The officer gave the friend's daughter the telephone number of the ward in which the man was being nursed.

The man was pronounced dead at 5.30am on 13 December. His death having been caused by an intra-cerebral haemorrhage.

The clinical reviewer interviewed a number of healthcare staff. She was told at interview that, before going to see the man, the Healthcare Nurse had spoken with the Staff Nurse, who is a more experienced nurse (the Staff Nurse is a level one nurse and the Healthcare Nurse is a level two nurse). The Staff Nurse gave the Healthcare Nurse ibruprofen tablets for the man that had been prescribed by a prison doctor. When contacted by the clinical reviewer, the doctor was unable to recall prescribing ibruprofen for the man and no record of that prescription has been found. Nor do the prison's pharmacy records show the man ever having been issued ibruprofen.

After the man's Death

In compliance with its contingency plan relating to the deaths of prisoners, Hull notified the coroner, the IMB and other official parties of the man's death.

Hull's Head of Residence and one of its chaplains spoke by telephone to both the man's friend and her daughter. The Head of Residence also wrote to the friend with his condolences and to offer her the opportunity to visit the prison and to meet with staff who knew the man. Hull appropriately assisted with funeral expenses.

When my investigator visited Hull on 20 December, all necessary information had been gathered together for the purposes of the investigation. Arrangements were made for my investigator to speak with relevant members of staff.

Level of Compliance with Prison Service Requirements

Standards of clinical care in prison are intended to mirror those available in the outside community. The clinical review has identified clinical assessment practices and prescribing systems at Hull that are less than adequate. The review acknowledges, however, that an intra-cerebral haemorrhage is a difficult condition to diagnose, particularly in a primary care setting.

The post-incident response by Hull was fully compliant with Prison Service instructions and policies on managing a death in custody.

Findings and Conclusions

The man was of middle-age and seemingly had no major clinical problems. Over the course of the man's 20 months at Hull, all of his healthcare consultations before his final one had been for minor complaints.

At 10.30am on 12 December 2004, the Healthcare Nurse was called to see the man who was complaining about a headache. The Healthcare Nurse examined the man and gave him ibruprofen.

The Healthcare Nurse returned to the man at midday and recorded his temperature, pulse and blood pressure. The man was complaining by then that he was feeling nauseous, however the Healthcare Nurse also recorded that that there was no slurring in the man's speech and no deformity in his facial expression. The Healthcare Nurse made an appointment for the man to see a doctor two days later, but he clearly did not consider that the situation was serious.

At 7.30pm, the man was found collapsed in his cell and he was rushed to outside hospital. A CT scan showed that the man had had a brain haemorrhage and it quickly became apparent that he would not survive. He died in the early morning of 13 December.

When the clinical reviewer interviewed healthcare staff for the purpose of her clinical review, she was told that before visiting the man for the first time the Healthcare Nurse had spoken with the Staff Nurse who is more experienced nurse. The clinical reviewer was told that the Staff Nurse had given the Healthcare Nurse the ibruprofen to take to the man; the drug having been prescribed by a healthcare doctor. When the clinical reviewer spoke with the doctor, he was unable to recall prescribing ibruprofen and no record of the prescription has been found either in the man's medical records or in the prison's pharmacy records.

If the information given to the clinical reviewer about the way in which the man came to be prescribed ibruprofen is correct, it means that his treatment had been decided upon before he was seen by a clinician. The only information that healthcare staff would have had before the Healthcare Nurse's visit at 10.30am would have been a message from wing staff, presumably none of whom are medically qualified, that the man had a headache. This seems to be a rather unsatisfactory, even dangerous, way of practising medicine.

The clinical reviewer is critical of a number of issues relating to standards of healthcare at Hull. None of the healthcare staff interviewed were found to use any screening tools, such as decision-

making algorithms, to support the clinical assessment process. In particular, neither the Healthcare Nurse nor the Staff Nurse followed the principles for the administration of medication set out in NMC guidelines or in any other guideline or directive. Instead, the Healthcare Nurse, a second level nurse, administered the medication following oral instruction from the Staff Nurse. The clinical reviewer also expressed concern in her report about the general standard of record keeping by healthcare staff.

Having made those comments about the shortcomings she had identified, the clinical reviewer went on to point out that the condition from which the man died, intra-cerebral haemorrhage, is a difficult condition to recognise unless the health professional is trained to look for the specific symptoms associated with it. The clinical reviewer added that an intra-cerebral haemorrhage is a fairly rare event that can be easily missed by primary care practitioners.

The man's friend said that he had been complaining of headaches for several weeks before his death. The man consulted healthcare on 12 November 2004, and again on 10 December 2004, in connection with his condition of psoriasis. On neither occasion is any reference made in his healthcare record of him also reporting a headache. However, at the second of those consultations, the man had reported a cold and he was given paracetamol. The paracetamol was given, I assume, for the symptoms often associated with a cold, such as general aches and pains which can include headache. Whether or not the man's symptoms on 10 December did include a headache, there is certainly no specific reference to that symptom and no written evidence to suggest that he had been complaining of headaches over a period of time.

Recommendations

I make the following recommendations, all of which have been taken from the clinical review:

1. The PCT and Head of Healthcare should ensure that validated screening/triage tools and/or algorithms are used to support the clinical decision-making process.

2. The PCT and Head of Healthcare should take steps to raise awareness of healthcare staff to the use of other agencies to support clinical decision-making, such as NHS Direct, Emergency Care Practitioners and Tees, East and North Yorkshire Ambulance Service (TENYAS).

3. The PCT and Head of Healthcare should remind healthcare staff about the requirements set out in the NMC's guidelines for records and record keeping. In particular, that each entry in the records should be legible, signed, dated, timed and name of practitioner printed with grade or job title. Also, that medical record note and data sheets should be clearly identifiable to the prison premises.

4. The PCT and Head of Healthcare should remind healthcare staff of the requirements set out in the NMC's guidelines for administration of medicines.

5. The PCT and Head of Healthcare should arrange a review of the training needs of the Staff Nurse and the Healthcare Nurse. The training needs identified should be reflected in the specific performance and development objectives of these staff.