

**The death of a man, who was a prisoner at HMP Parkhurst,
In 16 March 2006**

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

September 2006

This is the report of an investigation into the death of a man who was a prisoner at HMP Parkhurst. The man died on 16 March 2006 at a hospital close to the prison. The cause of death was recorded as a spontaneous intracerebral haemorrhage.

Unfortunately, the man was estranged from his family, and none of his relatives has been traced. Nevertheless, I wish to take this opportunity to offer my sincere condolences to the man's friends and all of those touched by his loss.

The investigation was carried out on my behalf by one of my investigators. An independent review of the man's medical care in prison was carried out by the Isle of Wight Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of HM Prison Parkhurst for their full and ready co-operation during the course of the investigation.

The investigation has revealed a number of shortcomings in the delivery of healthcare at Parkhurst and at Dorchester (where the man was first held). I make six recommendations and highlight three examples of good practice.

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Contents

Summary

Investigation methodology

HMP Parkhurst

Events prior to and immediately following the man's death

Consideration of issues arising from the investigation

Recommendations and good practice

Summary

The man who died was initially remanded into custody at HM Prison Dorchester on 3 March 2003, before being convicted and sentenced to life imprisonment later that year. He spent time at HM Prison Winchester before transferring to HM Prison Parkhurst on 25 April 2005. He was described by staff there as a quiet man who kept himself to himself.

On 16 March 2004, whilst at Winchester, the man complained of headaches and was prescribed Ibuprofen by the Medical Officer. He continued to complain of headaches intermittently over the next six months, which he linked to hunger. When he was subsequently found to have lost weight on 29 July, the man was commenced on a nutritional supplement and, following a review on 6 September, reported that all was okay.

On 27 July 2005, following his transfer to Parkhurst, the man was seen by a prison doctor who noted that he had had “what sounds like gastro-enteritis”. Two days later, he was seen by a nurse when he complained of a headache and tiredness. The man’s condition deteriorated and he was admitted to a local hospital. He remained in hospital overnight, and was diagnosed with high blood pressure and prescribed Amlodipine 5mg. The man disclosed at this time that he had suffered a stroke or stroke-like episode in 1998.

The man was reviewed at Parkhurst on 3 August by a locum GP. The GP instructed that his blood pressure should be checked every two weeks in future. However, this instruction was not passed onto healthcare staff and the checks never took place.

The locum GP also instructed the man to continue to take Amlodipine for his blood pressure. Sometime in August, however, he stopped taking this medication. The reason for this is not recorded, and it was not picked up by healthcare staff.

On 15 March 2006, at around 9.50am, the man collapsed whilst in the weights room of the gymnasium. He was attended to by an officer, who recalled that the man was semi-conscious and complaining of a “blinding headache”. At the same time, another officer radioed for medical assistance. The call was responded to by a nurse who was in the segregation unit at the time. Before attending, the nurse telephoned the gymnasium for further details and to ascertain what equipment he would need. He then went to healthcare to collect the equipment.

The man was taken by ambulance to a local hospital at 10.20am. His condition deteriorated rapidly and he was pronounced dead at 2.35am on 16 March. The cause of death was recorded as a spontaneous intracerebral haemorrhage.

This report includes six recommendations and draws attention to three examples of good practice.

Investigation methodology

The investigation was opened on 17 March 2006 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result. My investigator interviewed three members of staff during the course of the investigation.

My investigator visited Parkhurst on 8 May 2006, and met with the Governor and toured the prison. He was therefore able to familiarise himself with the gymnasium area in which the man had collapsed. He was also given access to the man's prison files including the Medical Record.

An independent clinical review of the man's health needs whilst he was in custody was carried out by the Isle of Wight Primary Care Trust.

HMP Parkhurst

Parkhurst, situated outside Newport on the Isle of Wight, was originally built as a military hospital in 1805 before becoming a prison in 1835. It has served as a male prison since 1869 and in 1968 became one of the first dispersal prisons. Parkhurst remained a high security prison until the mid-1990s, when it became an establishment for category B prisoners (the second highest security category) serving sentences of over four years. The prison also takes remandees from the Isle of Wight.

Healthcare is commissioned by the Isle of Wight Primary Care Trust. The healthcare centre provides 24 hour cover and has inpatient capacity of 12 beds in single cells. The most recent report by HM Inspector of Prisons, dated August 2005, notes that the healthcare service at Parkhurst was fragmented and understaffed. However, healthcare provision had improved from the previous inspection in 2002.

Events prior to and immediately following the man's death

When he was first remanded into custody at Dorchester on 3 March 2003, the man reported that he had poor eyesight but spoke of no other outstanding issues at his reception health screening. He said that he was a former drug user but had been clean for a period of 12 months. Over the course of the next year, the man reported a couple of minor complaints but his health was generally good in this period.

On 16 March 2004, the man was seen by a Medical Officer at Winchester and complained of a headache, for which he was prescribed Ibuprofen. He was seen again on 31 March, when he complained that his headaches were getting worse, especially at night. He was therefore prescribed a stronger painkiller.

On 21 April, the man was seen by a different Medical Officer. On this occasion he specifically requested Tramadol for his headaches. The Medical Officer said, however, that they did not consider it appropriate to use Tramadol on a regular basis for headaches and therefore prescribed Nefopam as an alternative. The man only took Nefopam for one week before returning his supply. He gave reasons for returning his supply at a review on 5 May, but this particular entry in the clinical record is illegible.

At the review, the man said that the headaches had only been occurring for a period of six months since his arrival at Winchester. He said that they did not occur every day, perhaps four days out of five, that they did not make him nauseous but did sometimes affect his appetite. The Medical Officer therefore prescribed a further course of Ibuprofen.

The man again complained of headaches on 22 July, which he now said were due to hunger. Two weeks previously, on 7 July, he had requested food supplements due to a problem with basil in his food which he said upset his gut and appetite. The man was therefore scheduled for weekly weighing and on 29 July, when he was found to have lost weight, he was commenced on Fortisip (a nutritional supplement). His weight subsequently stabilised and, at a review on 6 September, the Medical Officer reported that "all was ok".

The man reported no further medical problems prior to his transfer to Parkhurst on 25 April 2005. On 27 July, he was seen by a locum GP, who noted that the man had "had what sounds like viral gastro-enteritis", but that he was better now. None of the man's symptoms were recorded at the time.

On 29 July, the man was seen by a nurse. He complained of a headache and tiredness. The nurse recorded that all of the man's observations were within normal limits and advised him to see the doctor the following week if his symptoms persisted.

The man was seen again by the same nurse on 30 July. The nurse recorded that he appeared to have deteriorated overnight, was now unable to walk properly and appeared dehydrated. The nurse therefore arranged for the man

to be admitted to a local hospital. He remained in hospital overnight, and was diagnosed with hypertension (persistently high blood pressure) and prescribed Amlodipine 5mg to be taken once a day. Whilst in hospital, the man disclosed that he had had a cerebro-vascular accident (a stroke or stroke-like episode) in 1998.

The man returned to Parkhurst on 31 July and, at a review at 12.15pm, all of his observations were recorded as normal. He was, however, reported as being very weak and was offered a cell on the ground floor which he refused. He therefore stayed on his landing and was permitted to have his food brought up to him for one week.

The man was subsequently reviewed by a different locum GP on 3 August. He was now complaining of a persistent headache which the doctor noted as probably being due to dehydration. The doctor instructed that the man should continue with Amlodipine as per the hospital's request, and that his blood pressure be checked every two weeks in future. It does not appear that these checks took place. The doctor also prescribed paracetamol for the man's headaches and requested a urea and electrolytes check (a measure of how the kidney is functioning) in two weeks. There is no documented evidence to support that these tests were carried out.

Three days later, on 6 August, the man was seen on the wing by a healthcare officer. He was again complaining of headaches, which the HCO said appeared to be due to dehydration. The man was advised to drink plenty of water, to take paracetamol for the headaches, and to apply to see the doctor if his headaches continued. The HCO asked the wing staff to remind the man to drink plenty.

On 17 August, the man was seen by a doctor and complained of persistent constipation and overflow incontinence for a period of two weeks, which he said was since he started taking Movicol (a treatment for constipation). The entry on 17 August also states that the man had attended hospital in the last week and was awaiting blood results. There is no entry regarding this appointment in his medical record, other than a printout from a local hospital stating that a full blood count had been taken on 11 August. The doctor subsequently stopped the man's course of Movicol and started him on Senna instead. The doctor noted that he should return for a review in two weeks if still constipated.

No further request was received from the man to see a doctor or healthcare staff throughout the rest of his time at Parkhurst. It would also appear that healthcare staff made no effort to follow the man up for his headaches, blood pressure or constipation. At some time in August 2005, he stopped taking his medication for hypertension. The reason for this is not recorded and it was not picked up by healthcare staff.

On 15 March 2006, at approximately 9.50am, the man collapsed in the weights room of the gym at Parkhurst. He was attended to by a physical education officer. In his statement to the Governor, the officer said that the

man was semi-conscious when he first spoke to him, and complained of having a “blinding headache”. The man then began to vomit and the officer therefore placed him in the recovery position.

At the same time, another officer radioed for assistance. At interview, he said that he made the call to the control room and asked for medical assistance to the gymnasium. The response nurse responded to the call, but first telephoned the gym for further details as the radio call gave no indication of the type of incident.

On arrival at the gym, the response nurse applied oxygen to the man and commenced an initial assessment. In his statement to the Governor, the response nurse noted that the man was able to speak but was incoherent, and that his left pupil was sluggish in response to light. He also noted that the man was again vomiting and therefore asked for an ambulance to be called.

The ambulance left Parkhurst at approximately 10.20am to take the man to Accident and Emergency at a local hospital. On arrival at hospital, the man's condition deteriorated rapidly and he lost consciousness. His condition continued to deteriorate through the course of the day and he was pronounced dead at 2.35am on the morning of 16 March. The cause of death was recorded as a spontaneous intracerebral haemorrhage (a stroke resulting from the bursting of a blood vessel in his brain).

Sadly, none of the man's relatives has been traced. His funeral was held on 18 April 2006. A former cellmate of the man was traced through his visits record and attended the funeral along with prison staff. A memorial service was held at the prison on the same day.

Following the man's death, the healthcare manager reviewed his treatment and produced a summary report and action plan. This plan included a number of learning points for healthcare staff and subsequent corrective actions and targets.

6. Consideration of issues arising from the investigation

The man's reception health screening

During his one night stay as an inpatient at hospital on 30 July 2005, the man was diagnosed with hypertension (persistently high blood pressure). The clinical review, conducted by the Isle of Wight Primary Care Trust, expresses reservations that his high blood pressure was not diagnosed prior to this occasion.

On his first reception at Dorchester on 3 March 2003, the man was interviewed by healthcare staff as part of the reception process. A 'First Reception Health Screen' form was completed. This form contains a box of standard observations that are required to be completed within 24 hours of a prisoner's arrival at the establishment. In the man's case, a number of these observations, including his blood pressure, were not taken.

The clinical review also expresses reservations that prison healthcare did not know that the man had suffered a stroke or stroke-like episode in 1998. It is true that he did not disclose this episode when questioned about his medical history at his reception health screening. Furthermore, the man said that he was not registered with a GP. However, it was known that the man had previously been in prison, having been released on life licence in 1998. No efforts were apparently made to obtain his previous prison medical records.

A copy of this report will be sent to the Governor at Dorchester and he should remind staff of the importance of completing the 'First Reception Health Screen' thoroughly.

Quality of healthcare provided at Parkhurst

On balance, the clinical review concludes that the man received equivalent healthcare to that which he would have received in the community. As noted above, however, the review expresses reservations that his high blood pressure was not diagnosed prior to 30 July 2005. It notes that his blood pressure was not taken on a number of occasions when he saw the prison medical services complaining of headache.

At interview, the Team Leader of Primary Healthcare at Parkhurst, said that all prisoners who report to healthcare now have their blood pressure taken as standard. All those who are found to have raised blood pressure are now referred to the prison's Hypertensive Clinic. An action plan produced following the man's death states that it is required that all notes are audited to ensure that no patients with high blood pressure have "fallen out of the loop". I consider this to be good practice.

The healthcare manager should continue to ensure that blood pressure checks occur before each healthcare appointment, and that the clinical audit results are shared amongst the clinical team.

On 3 August 2005, the man was seen by a locum GP and complained of a persistent headache. The GP produced a four-part action plan for the man's treatment which included the request that his blood pressure be checked every two weeks. These checks did not take place. At interview, the Team Leader of Primary Healthcare said that the checks did not take place because the instruction was not passed onto anyone in healthcare by the locum GP.

In the light of this communication failure, GPs at Parkhurst have now been asked to pass on explicit instructions to a nominated member of healthcare staff each day. Staff have also been reminded to check GP entries on Vision (a computerised medical recording system) by the end of each surgery.

The healthcare manager should ensure that systems for passing GP's instructions onto nursing staff are regularly audited, and the results of such audits published for evidence and compliance.

At his review on 3 August, the locum GP also requested that the man continue to take Amlodipine 5mg for his hypertension. However, the man did not apply for a renewal of his prescription later that month and therefore stopped taking the medication. It is not known why he failed to repeat his prescription, and this failure was not picked up by healthcare staff.

The clinical review states that, "even if [the man] had been maintained on blood pressure drugs, in view of the abnormality that he had an artery of his brain, a stroke at some point in time was likely". Despite this, it concerns me that, when he chose not to repeat his prescription, the man's failure to do so was not noted by staff.

My investigator spoke to the head of healthcare at Parkhurst, on this matter. She said that, at the time, the responsibility was with the prisoner to request a repeat prescription, as in the community. However, following the introduction of the computerised system, a review date should now be automatically generated for prisoners on repeat prescriptions.

The healthcare manager should ensure that electronic reminders of the review date for prisoners with repeat prescriptions are regularly monitored and audited.

Radio procedures on the morning that the man collapsed

The man collapsed in the gymnasium at around 9.50am on 15 March 2006. Following his collapse, an officer radioed for assistance to the control room. At interview, the officer said that his call asked for “medical assistance to the gymnasium”. The control room log sheet shows that at 9.50am a call was made which said, “healthcare required in gym”. The officer said that it was an option for him to ask for ‘urgent’ assistance over the radio. He did not ask for ‘urgent’ assistance, however, as he believed that as he was near to a telephone he could explain the situation in greater detail over the phone. There does not appear to have been any consideration given to also requesting an emergency ambulance at this stage.

The joint Prison Service and Department of Health letter of March 2004 implicitly states that internal procedures should not waste undue time summoning emergency assistance and there is no requirement for a member of the healthcare team to attend before such action is taken.

The Governor, Head of Healthcare and PCT should ensure that internal procedures facilitate prompt requests for emergency ambulances and that this procedure is communicated to all staff.

The call for assistance was heard by the response nurse who was, at the time, in the segregation block distributing medication. At interview, the response nurse said that, as there was no indication of the type of incident in the radio call, it was necessary for him to telephone the gymnasium so that he could decide what equipment he needed.

The response nurse was of the opinion that the need to make a telephone call to the gymnasium did not have a serious effect on the care he was able to provide on this occasion. However, he expressed concern to my investigator that, in different circumstances, this may have adversely affected his timeliness and the quality of care that he could provide. I share this concern. Given the circumstances of the man’s collapse and the condition that he was in when found by officers in the gymnasium, I consider that it would have been justified to call for ‘urgent’ assistance over the radio and request an emergency ambulance be called.

At interview, the response nurse said that there is a code system in place for classifying different types of medical emergency. He subsequently provided a copy for my investigator. The system used is as follows:

- 1 – Hanging
- 2 – Bleeding
- 3 – Unconscious

The response nurse said that this system has not been deemed useful by healthcare staff and is not therefore generally used. At his interview, the officer who radioed for assistance was unaware of such a system being in existence. He did not therefore use a radio emergency code on the morning

that the man collapsed. The head of security and operations was also unaware of the existence of such a system. He confirmed that those control room staff to whom he had spoken were also unaware of such a system.

I consider it essential that healthcare staff are able to respond to a medical emergency as quickly as possible. Moreover, it is particularly advantageous if healthcare staff have an idea of the type of emergency that they are facing prior to their arrival so that they can prepare accordingly.

The Governor should ensure that the system for summoning emergency medical assistance enables the healthcare team to have some understanding of the type of emergency they are attending and the likely emergency equipment needed. This system must be communicated to all staff.

7. Recommendations and Good Practice

Recommendations

A copy of this report will be sent to the Governor at Dorchester and he should remind staff of the importance of completing the 'First Reception Health Screen' thoroughly.

The healthcare manager should continue to ensure that blood pressure checks occur before each healthcare appointment, and that the clinical audit results are shared amongst the clinical team.

The healthcare manager should ensure that systems for passing GP's instructions onto nursing staff are regularly audited, and the results of such audits published for evidence and compliance.

The healthcare manager should ensure that electronic reminders of the review date for prisoners with repeat prescriptions are regularly monitored and audited.

The Governor, Head of Healthcare and PCT should ensure that internal procedures facilitate prompt requests for emergency ambulances and that this procedure is communicated to all staff.

The Governor should ensure that the system for summoning emergency medical assistance enables the healthcare team to have some understanding of the type of emergency they are attending and the likely emergency equipment needed. This system must be communicated to all staff.

Good Practice

A summary report and subsequent action plan was produced by the healthcare manager following the man's death.

The man's funeral was arranged and paid for by the establishment, and a memorial service was held at the prison.

Staff used the man's visits record to locate a former cellmate who was subsequently able to attend his funeral.