Investigation into the death of a man at Queen’s Hospital Burton, whilst in the custody of HMP Dovegate, in March 2009

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is the report of an investigation into the circumstances surrounding the death of a man who died in hospital after several years of very poor health. In common with far too many deaths of prisoners from natural causes, he was a relatively young man.

The investigation was originally led by one of my investigators. One of my senior family liaison officers contacted the man's family and discussed their questions and concerns about the man's death. I offer them, and all those affected by his death, my sincere condolences. I apologise for the extreme delay in issuing my final report and the additional distress I know this has caused to his family.

I am grateful to the two clinical reviewers from South Staffordshire Primary Care Trust for their work in providing a clinical review of the medical care received by the man.

This is a sad story of a man whose life and health were blighted by addictions to heroin and crack cocaine. The man's health was further compromised when he contracted tuberculosis in HMP Dovegate in 2005. I am disappointed to once again read of poor record keeping and delays and cancellations of hospital appointments. I trust that the Director of Offender Management and the Regional Offender Health team will consider the implications of my comments. However, I am pleased to see sensitive treatment of the man's family while he was in hospital and appropriate judgement of when restraints are unnecessary.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **December 2011**

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SUMMARY

The man was serving an 11 year six month sentence imposed in 2002. He was a cooperative and popular prisoner with a supportive family.

The man had a history of chronic substance misuse since the age of 29 and was a heavy smoker. He suffered from a duodenal ulcer, diagnosed in 2002, and associated digestive problems. In 2005, he contracted tuberculosis while in HMP Dovegate. Although he recovered, he was left with chronic respiratory damage that reduced his mobility.

The man received treatment as an out-patient at Queen's Hospital Burton from 2005 to 2006. In November 2008, he reported that he had been told by his consultant that he had a life expectancy of only four or five years. I have not been able to find any evidence of this.

In December 2008, the man became ill with a bladder infection. He remained unwell and on 30 January 2009 was unable to attend an appointment with his prison drugs worker because of a chest infection. On 13 February, he was found collapsed in his cell in great pain. He was taken by ambulance to Queen's Hospital Burton and the next day was put on a ventilator in the intensive care unit.

The man was moved in and out of the intensive care unit for the next several weeks. He was diagnosed as having suffered a spontaneous rupture of the oesophagus and a torn bowel. His condition deteriorated and his death was confirmed shortly after midnight in March.

The clinical review criticises the standard of record keeping at Dovegate. On one occasion this resulted in the man not having his medication changed when this should have happened. Also, on another occasion, he appears to have waited three months for an X-ray deemed urgent by his doctor. Unfortunately these are themes common to previous investigations in Dovegate.

Despite this criticism the review concludes that the general level of care received by the man was consistent with that he would have received in the community. The review also concludes that earlier diagnosis of his impending oesophageal rupture would not have changed his prognosis or the outcome.

I conclude that, from the record I have seen, the bedwatch logs, risk assessments and management checks were all completed appropriately. I highlight one area of good practice in guidance to bedwatch escort staff.

I make four recommendations and endorse those made by the clinical review panel.

THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death on 30 March 2009. The case was allocated to one of my investigators on 31 March. My Assistant Ombudsman, contacted HMP Dovegate as my investigator was on annual leave. As was our practice at the time the investigation was not formally opened. The relevant paperwork was sent by post to my office.

2. My investigator spoke subsequently to the Senior Clinical Governance Manager of South Staffordshire Primary Care Trust (SSPCT). The Senior Clinical Governance was nominated by the Chief Executive of SSPCT to undertake a clinical review of the man's medical care while in Dovegate. A review group was established and led by the Quality officer for SPCT. We received the final report of the review panel in early February 2010. The draft report was issued in March 2010. We did not receive Dovegate's action plan in response to our recommendations until October 2011.

3. One of my family liaison officer visited the man's mother, sister and son at the family solicitor's office. The man's family are pursuing a separate legal action for neglect against the prison. Their main grievance concerns the man's contraction of tuberculosis (TB) in Dovegate in 2005. Because of the length of time that has passed, we did not examine this in this investigation. We acknowledge however that TB had a devastating effect on the man's general health. The family expressed several concerns about the level of care provided to the man while he was in Dovegate. The man's family said they were only told he had been taken to hospital on the evening of the following day. This information came from the police, rather than staff at Dovegate.

4. Following the publication of the draft report, the man's family raised a number of issues. They asked us to contact three prisoners who had known the man in Dovegate. From the information provided we managed to trace the whereabouts of only one of them. We wrote to him but received no reply. A number of the family's issues concerned the man's medical care and the clinical review. These have been addressed by South Staffordshire PCT and sent to the family separately. We have reflected further comments made by the family in the issues section of this report.

HMP DOVEGATE

5. Opened in 2001, Dovegate is a category B prison for adult male prisoners sentenced to over four years. It is a private prison managed by Serco under contract to the National Offender Management Service (NOMS). It currently holds up to 1,146 prisoners. This is made up of 946 in the main prison and 200 in the Therapeutic Community (TC). Healthcare services in Dovegate are provided by Serco Health.

6. Her Majesty's Chief Inspector of Prisons last reported on Dovegate following an announced inspection in October 2008. The Chief Inspector made the following comment about healthcare:

> "Primary health services were reasonable, but were compromised by shortages of staff and accommodation, which needed a substantial increase in funding for healthcare to move forward. Chronic disease management was maintained despite staff shortages, but staff needed more time to give a quality service to prisoners. Many NHS appointments were cancelled or rearranged, and pharmacy services needed further development."

7. The latest Independent Monitoring Board Annual Report, for the period 2008-09, made the following comments regarding healthcare services:

> "Applications to the IMB regarding healthcare are the second highest number being 14.01% of all applications. The complaints are about medication, or lack of medication, long waits to see consultants and claims they are ignored by staff.
>
> "During the last reporting year, the healthcare centre has had a reworking of the facility to reduce it from dormitory sized rooms to single cell accommodation. The centre was closed in July 2009 and all in-patients were transferred to HMP Birmingham. Recently re-opened it now has improved facilities, including pharmacy and waiting rooms.
>
> "A new healthcare manager, additional administrative staff, pharmacy assistants and more nurses have been recruited. Hopefully this will bring some much needed stability to this important facility."

8. The Ombudsman has investigated over ten cases in Dovegate since taking on responsibility for investigating deaths in custody in April 2004. In three of my previous investigations I recommended that the Director and Healthcare Manager ensure medical records are to the standard required by the General Medical Council and Nursing and Midwifery Council.

THE MAN

9. The man grew up with his parents and three sisters. He described a happy childhood. The man left school with O levels in maths and English. He served an apprenticeship as a motor mechanic. He then worked for about seven years doing car body repairs and working as a general mechanic. He also worked as a labourer, a gardener and a painter and decorator. Sadly the man's father died while he was in custody. He remained close to his mother and had two children and two grandchildren at the time of his death.

10. The man had a long history of offending starting from the age of 17. Much of his offending was related to motor vehicles and was committed for financial benefit. The man said he started using heroin when he was 29 and moved on to smoking crack cocaine aged 35. He said that he did not take drugs while on holiday or when he was with his family. His addiction was at the root of much of his offending behaviour and was also a contributory factor to the various serious health problems from which he suffered.

11. In November 2002, the man was sentenced to 11 years and six months for six offences of supplying vehicles knowing that they would be used to commit crimes. He was transferred to HMP Dovegate in March 2004. Unfortunately, the man was unable to rid himself of his addiction to illegal substances while in prison. Although a polite and trusted prisoner in many regards, he consistently failed mandatory drug tests.

12. In March 2005, the man contracted tuberculosis (TB). He spent some time in outside hospital and was a regular patient in the prison healthcare centre until his death. Although he recovered from TB, it had a devastating effect on his health and left him with chronic breathing problems and reduced mobility.

13. The man made his most concerted attempt to overcome his drug use in August 2008. He remained largely drug free for the remainder of his life. In November 2008, it was reported that the man was told by a specialist that his life expectancy was only four or five years. I have been unable to independently verify this.

KEY EVENTS

14. The clinical review at annex 1 contains a very detailed history of the medical interventions made in the man's case. The following is a summary of the main events that occurred in the period leading up to his final illness and death. Previous significant factors are that he contracted tuberculosis (TB) in 2005 and suffered from a duodenal ulcer and associated digestive problems. He was treated as an outpatient at Queen’s Hospital Burton for both of these conditions. After March 2006, he man stopped attending his outpatients appointments with his respiratory consultant.

15. In November 2008, the man reported that he had received very bad news from a consultant. Due to the damage done to his lungs from TB, drug use and smoking, he had a life expectancy of only four or five years. Neither I nor the clinical reviewer have been able to trace evidence of this prognosis. Also at this time the process of writing and collating reports for the man's routine parole review was begun.

16. Between October 2008 and February 2009, the man required five separate courses of antibiotics and steroid treatment to cope with his breathing difficulties and chest infections. In December 2008, he developed a bladder infection. On 30 January 2009, he was unable to attend an appointment with his prison drugs worker due to a chest and “water” infection.

17. On 13 February, the man was found collapsed in his cell with acute abdominal pain. He was taken to Queen’s Hospital Burton in an ambulance at 6.00pm. In accordance with prison regulations, the man was escorted by prison staff. A bedwatch security assessment was completed by Officer A. He decided that the man (as a category B prisoner) should be accompanied by two members of staff and hand cuffed to one of them except when he was receiving treatment. It was also decided that the man should not receive any visits from family for the first seven days of his stay in hospital. (Coincidentally on the same day the Parole Board rejected the man's application for early release on parole.)

18. The man underwent emergency surgery on admission to Burton Queen's as it was thought he had suffered a ruptured duodenal ulcer. In fact he had a perforation in his oesophagus but surgery to repair it was deemed impossible because of swelling. On 14 February, the man was placed on a ventilator in the intensive care unit. On 15 February, another bedwatch risk assessment was completed. Given the serious nature of his condition, and the fact that he was heavily sedated, it was decided that the hand cuffs be removed.

19. On Friday 20 February, a caseworker at Partners of Prisoners and Families Support Group (POPS) faxed a letter to the Director of Dovegate. The caseworker said that the man was in a medically induced coma and his health was such that he would be incapable of any concerted attempt to escape. In the light of this, she asked the Director to extend the man's family's visiting entitlement and allow them to spend time with him away from the escort

officers and without hand cuffs. The caseworker acknowledged that the officers had been very understanding in their dealings with the family.

20. The Director of Dovegate replied on 23 February (which was the day he received the fax). He told the caseworker that he would endeavour to facilitate discreet, compassionate visits for the man's family. He said that the family could visit all day, every day unless the situation changed in some way. The Director explained that regular risk assessments were undertaken by managers visiting the hospital and only the minimum level of restraints would be applied to the man.

21. The man underwent further surgery four times in the next month. The operations took place on 26 February, 2 March, 9 March and 18 March. He was described as having multi-organ failure. He was unable to eat and had to be fed via an intravenous feeding line. During this time he was regularly placed on a ventilator. He was unable to move about unaided – and then only for a few seconds before he became exhausted.

22. The bedwatch record and risk assessment for 23 March shows that the man weighed only 28kg (about four stone). On the same day the prison's Director agreed to downgrade the man's security status from category B to category C. A prisoner's security category is based on their risk to the public should they escape. Given the man's physical condition, category C was deemed appropriate.

23. On 24 March, the man was reported to be able to sit up in bed and take a few steps with the aid of a zimmer frame. Two days later Dovegate's Head of Healthcare, wrote in the bedwatch log that the man was, "confused and disorientated and did not recognize staff". He was unable to walk unaided and just about able to stand. The next day, 27 March, the man lapsed into unconsciousness. A scan revealed an infection in his abdomen. He was transferred to back to the intensive care unit.

24. At 5.30pm on 28 March, the Duty Director, received a telephone call from the man's sister at the hospital telling him that her brother's death was imminent. The man's family had been advised to agree to life support systems being turned off. The Duty Director went to the hospital. Hospital staff asked him how long the escort staff would be present, given the seriousness of the man's condition. The Duty Director called the Assistant Director who joined him at the hospital and removed the escort staff to another room.

25. At 8.00pm, the Assistant Director gave the day escort staff permission to return to Dovegate. He instructed the duty officer in charge of running the prison to prepare the night escort staff, but not to send them to the hospital. By 10.00pm the man's condition stabilised. The night escort staff were called to the prison but the man's heart began to fail and he died shortly before midnight on 28 March. His family were at his bedside. His death was officially pronounced at 12.05am on 29 March.

26. The Coroner's interim certificate of the fact of death gives the cause of death as:

> “1a Loculated peritonitis and pleuritis
> b Perforated lower oesophagus”

ISSUES CONSIDERED

The clinical care afforded to the man

27. The clinical review at annex 1 contains a full discussion of the man's medical treatment.

28. The clinical review acknowledged that there were a number of factors that might have contributed to the man suffering a spontaneous rupture of his oesophagus and undermined his ability to survive it. Among these were vomiting and severe coughing. The man's on-going problems with a duodenal ulcer meant that he was prone to vomiting. He had suffered from regular chest infections since he contracted TB in 2005, but continued to smoke cigarettes and heroin. The steroid treatment for his breathing problems and the Subutex prescribed in October and November 2008 for heroin withdrawal may also have compromised his ability to heal naturally. The symptoms from the man's various health problems may have masked any warning signs of impending oesophageal rupture.

29. Whilst a serving prisoner, the man missed a number of hospital appointments from 2006 onwards. This was due to a combination of the hospital and prison cancelling them and his own refusal to attend. The reasons for his non-attendance are not always documented. The review criticises poor record keeping at Dovegate more generally. Many entries in the man's file are illegible or wrongly ordered. In one instance the absence of a record of the outcome of a hospital appointment led to a delay in a change of medication.

30. I am aware that staffing levels often mean that prisons are unable to fulfil hospital appointments. Her Majesty's Chief Inspector comments on this and is referred to in the background section of this report. Difficulties are also caused because of the nature of some appointments, for example those that rely on a space becoming available on a hospital waiting list. This can make the production of a prisoner at a particular time a complicated logistical juggling act. The prisoner too must bear some responsibility for willingly attending his or her appointments. Nevertheless, it is of the highest importance that prisoners are taken to outside hospital if they need treatment and I therefore recommend:

    In the next three months, the Head of Healthcare should audit hospital appointments, both fulfilled and unfulfilled, for all prisoners in Dovegate between April 2009 and March 2010. The information should be analysed and used to plan a strategy for minimising the number of unfulfilled appointments. Included in this strategy should be a traffic light system for prioritising prisoners with the most serious health needs.

31. Of equal concern is the fact that in 2006 the man waited for three months for an X-ray that his doctor considered urgent. The reasons for the delay appear to be entirely administrative. This is an unacceptable reason for any delay, especially for an urgent matter. I am disappointed to see, once again,

criticism of medical record keeping at Dovegate. This is the fourth case in which I find myself making a similar recommendation.

The Head of Healthcare should remind staff of the importance of record keeping and the requirement to adhere to national standards. Regular audits of medical records should take place in an effort to drive up standards.

32. These criticisms notwithstanding, the clinical review concludes that the healthcare given to the man while in Dovegate and at Queen's Hospital Burton (during his final illness) was appropriate. There was no indication that he was experiencing acute abdominal pain prior to collapsing on 13 February. It was only after surgery involving an incision through his abdominal wall that the full extent of his illness became clear. In respect of his general healthcare while he was in Dovegate, the review concludes that it was equitable with that he would have received in the community.

33. I note that the Parole Refusal Notification issued to the man on 13 February 2009 complains that the panel required a detailed medical report about his severe health problems. Only a very brief and "unhelpful" one was provided by the prison. Clearly a prisoner's health has an impact on the level of risk to the public they are judged to pose and this in turn has an impact on whether the Parole Board are minded to recommend early release. It is important that the Parole Board are in possession of the most accurate and up to date information on prisoners. The man's health had been fragile for some time and his breathing difficulties had a great impact on his mobility. This is exactly the kind of information that the Parole Board needs to know. Had a fuller report been supplied, it is likely that parole would have been granted and his death would not have occurred whilst he was a serving prisoner. It is disappointing that this opportunity was missed, especially as he presented no risk to the public and need not have been in custody when he died.

The Director should remind staff of their obligation to provide up to date and comprehensive reports on prisoners when required to do so by the Parole Board.

34. The clinical review makes a number of recommendations which I endorse and have listed in the final section of this report.

<u>The use of restraints and bedwatch assessments</u>

35. I have not seen a bedwatch risk assessment for the period between 15 February and 20 March. It appears from the records that I have seen that restraints were not applied to the man when medical treatment was taking place or when he was on a ventilator in the intensive care unit (as he was intermittently throughout his stay). A bedwatch security assessment completed by the Assistant Director on 20 March refers to the man "remaining uncuffed".

36. I have seen a complete bedwatch record and risk assessments for the period between 23 and 28 March. All the records, management checks and risk assessments were appropriately completed. Members of the senior management team and the head of healthcare were regular visitors to the man during his time in hospital.

37. At the front of the bedwatch pack is a handwritten note from the Head of Healthcare at Dovegate, entitled 'Additional instructions for staff'. Her note advises staff on the procedure for taking breaks and refreshments. It also advises staff to be as discreet as possible and be mindful that they are guests at the hospital. She advised staff to accede to requests from medical staff to speak confidentially to the man and to move away from the bed to allow them to do so. This is good practice.

38. The bedwatch records that I have seen indicate that regular risk assessments and regular visits by management were made. I am pleased to confirm that the man spent the majority of his stay in hospital without restraints.

Informing the family that the man was in hospital

39. The man’s family told the Ombudsman’s senior family liaison officer that they were upset about not being told until the evening of the next day that he had been admitted to hospital. I have sympathy with their point of view, particularly as he had been poorly for a long time and was already frail. There is no formal guidance to prisons as to when it is appropriate to inform the next of kin that a prisoner has been taken to outside hospital.

40. Clearly the prison has a duty to be mindful of security considerations and protecting the public. However I believe that the decent thing to do is to inform the family as soon as possible if their relative is seriously ill. In this case it was obvious from the first admission that the man was seriously ill. He underwent emergency surgery at the earliest opportunity and the next day was on a ventilator in the intensive care unit. In this case I consider that the prison could have informed his family on the evening that he was taken ill. I echo a recommendation made in a different case at another prison:

The Director should issue local guidance requiring healthcare staff and security staff to identify when a prisoner's condition is sufficiently serious to warrant the notification of their next of kin. The guidance should identify who is responsible for notifying the next of kin.

Family comments

41. The man’s family told us that the man was seen by various different locum GPs at Dovegate who recommended that he be taken to outside hospital due to his condition. They told us that he was too ill to attend some appointments and on more than one occasion there was a break in his medication and delays in him seeing a doctor.

42. The man’s family have asked us to point out that they strongly disagree with the conclusion of the clinical review that the man’s general healthcare at Dovegate was equitable with that he would have received in the community.

CONCLUSION

43. The man had evidently suffered from very poor health for some time. Although there are criticisms of record keeping, delays and missed appointments in this report, neither I nor the clinical reviewer conclude that they affected the outcome of what was to be his final illness. I am satisfied that he was taken to hospital promptly when he collapsed on 13 February and thereafter received consistently appropriate care. I am pleased to see that his family were allowed unrestricted access to him in his last few weeks and that the prison helped financially with the cost of their travel.

RECOMMENDATIONS

1. In the next three months, the Head of Healthcare should audit hospital appointments, both fulfilled and unfulfilled, for all prisoners in Dovegate between April 2009 and March 2010. The information should be analysed and used to plan a strategy for minimising the number of unfulfilled appointments. Included in this strategy should be a traffic light system for prioritising prisoners with the most serious health needs.

   This recommendation was accepted by Dovegate at draft report stage and they responded:

   "The escort and bedwatch data is analysed frequently by the local PCT and a full review has in fact taken place in HMP Dovegate. This data is analysed and monitored weekly in HMP Dovegate and the healthcare manager is linked in to the local PCT to support and develop a longer term strategy aimed at meeting the needs of those prisoners referred to secondary and acute care services."

2. The Head of Healthcare should remind staff of the importance of record keeping and the requirement to adhere to national standards. Regular audits of medical records should take place in an effort to drive up standards.

   This recommendation was accepted by Dovegate at draft report stage and they responded:

   "NMC guidelines have been distributed to all staff. Electronic record systems have now been put in place (system one) that addresses all concerns relating to this recommendation."

3. The Director should remind staff of their obligation to provide up to date and comprehensive reports on prisoners when required to do so by the Parole Board.

   This recommendation was partially accepted by Dovegate at draft report stage and they responded:

   "Serco Health is not commissioned to complete parole reports or make recommendations within reports. As recognised by central DH, these reports require a capability not normally found within a prison healthcare setting and are therefore separately commissioned by the service requiring the reports. However, we do recognise that parole reports may need to be completed on compassionate grounds to effect a speedy release and as such we will ensure that each case is considered on its own merits."

4. The Director should issue local guidance requiring healthcare staff and security staff to identify when a prisoner's condition is sufficiently serious to warrant the notification of their next of kin. The guidance should identify who is responsible for notifying the next of kin.

This recommendation was accepted by Dovegate at draft report stage and they responded:

"Local contingency plans make reference to the notification of next of kin. A family liason officer is in post who is responsible for making contact with the named next of kin when the prisoner's condition is identified by a member of the healthcare team (either internal or external) as being sufficiently serious."

From the clinical review:

1. When a prisoner receives a positive diagnosis of tuberculosis, a full report of any actions taken by prison staff and investigation details should be made in their records.

   This recommendation was accepted by Dovegate at draft report stage and they responded:

   "The recommendations utilises the terminology 'prison staff'. I accept that Nursing Staff should complete a full report. This does in fact happen and detailed records are maintained on System One."

2. A daily record should be maintained detailing conversations with hospital staff when a patient is in hospital in order that a full picture of their progress is maintained.

   This recommendation was accepted by Dovegate at draft report stage and they responded:

   "All conversations with Hospitals are detailed on system one."

A copy of the six month action plan provided by Dovegate is at annex six.