Investigation into the circumstances surrounding the death of a man at HMP Woodhill in March 2009

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

This is the report of an investigation into the death of a 56 year old man at HMP Woodhill on 28 March 2009. He first arrived at Woodhill on 2 January 2008 charged with murder and attempted murder, but was moved to HMP Leicester a short time later on 24 January.

After his move to Leicester, the man's mental health deteriorated and he was sent to a secure psychiatric unit under the Mental Health Act, 1983. It was discovered that some of the medicine he was taking for his Parkinson's disease was causing him to be mentally unwell.

On his return to prison in October 2008, he remained well for some months. However, in January 2009 he started to have breathing difficulties and had to be admitted to a local hospital. It was discovered he had a severe case of pneumonia. Following a scan of his lungs, he stopped breathing and had to be put onto a ventilator. He remained in hospital until 20 March, when he was discharged back to prison. When he returned to Woodhill he did not go to the prison healthcare centre, but was sent to the First Night Centre where he would be closer to nursing staff, particularly at night.

Throughout the week following his return from hospital, the man remained somewhat unwell and was seen by a number of doctors and nurses. On 27 March, he remained in prison despite at least one doctor suggesting that he should go to hospital. During the night of 27 and 28 March he collapsed and died of a heart attack. I would like to offer my sincere condolences to the man's family and friends for their loss. I would like to apologise to them for the delay in providing this report.

An investigator conducted the investigation on behalf of the Ombudsman. I thank the Governor of Woodhill and his staff for their co-operation and assistance, in particular I would like to mention members of the Safer Custody Group. In addition, a review of the man's medical care in prison was carried out by a health professional on behalf of the local Primary Care Trust. They also asked for a medical opinion of care provided to the man by doctors involved with him during his time in custody. I am grateful to the clinical reviewers for their assistance.

I find that the man's mental health and Parkinson's disease were well managed by staff at Leicester and Woodhill. Unfortunately, I conclude that more should have been done to monitor his clinical care following his return from hospital on 20 March until his death. The inquest into the man's death has already taken place. I too believe that the absence of oxygen therapy on a more regular basis, coupled with failure to monitor and record the impact of this intervention, contributed to his death. I make five recommendations in my report.

Jane Webb
Deputy Prisons and Probation Ombudsman **February 2010**

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SUMMARY

The man first arrived at Woodhill on 2 January 2008. He had been charged with murdering a relative and attempting to murder two other relatives. Following his arrest he was put under close observation measures because it was felt he was at risk of suicide. The man who is the subject of this report suffered from Parkinson's disease. He had also received treatment as an outpatient from mental health workers in the community.

On 24 January, the man was transferred to HMP Leicester. While at Leicester, his mental health declined further and he became psychiatrically unwell. On 27 May, he was transferred to a secure psychiatric unit where he remained until 7 October. It was discovered whilst he was there that one of the medicines he had been taking for his Parkinson's disease had been having an adverse effect. Once that was stopped his health improved very quickly.

On his return to prison, the man was sent back to Woodhill. Although there were some continuing concerns from him regarding his medication, he remained relatively well as regards his Parkinson's disease for some months. On 8 January 2009, the man complained of breathing difficulties, particularly when he lay down. When the prison doctor saw him on 9 January, he was sent to a local hospital where he was admitted. During one of their routine investigations, the man suffered a respiratory arrest and had to be admitted to the Intensive Therapy Unit and put on a ventilator. He remained on the ventilator until he was weaned off sometime between 17 February and 26 February. He was discharged back to prison on 20 March.

When he returned to prison, he was placed in the First Night Centre as this was felt to be the most appropriate place where he would be closer to nursing staff. The healthcare in-patient unit was not thought suitable as it was undergoing building work. Although the man was well enough to be discharged back to prison, throughout the week following his return from hospital, he was not fully recovered and remained unwell. It is clear from the clinical review that the man should have been more closely monitored following his return from hospital.

On 27 March, the man who died was seen by two doctors and a number of nursing staff. There was a difference of opinion about how best to manage his health problems, but in the end it was agreed to keep him in prison and monitor him closely overnight. The nurse on duty that night was asked to give him his medication at 11.00pm and remove the oxygen cylinder from his cell. He was also expected to monitor him closely throughout the night and administer oxygen to the man if his oxygen levels dropped below 85 percent.

At about 1.00am on 28 March, staff on the First Night Centre heard a loud noise from the man's cell. On investigating they discovered that he had collapsed and did not respond to their shouts. They summoned assistance using the emergency radio and called the night nurse to attend. Although staff were at his cell very promptly, they were told to await the arrival of senior officers before going inside. When they did go in the cell they tried to resuscitate him but were unsuccessful.

Paramedics arrived in an ambulance and took the man to a local hospital, but they and the doctors at the hospital were unable to revive him and he was pronounced dead at 2.00am.

The post mortem report and the subsequent Coroner's inquest highlight aspects of the man's care that lead me to conclude that he was not looked after well enough from the time he returned from hospital on 20 March. It seems clear that nursing staff working on the First Night Centre were not expecting to carry out nursing care responsibilities that extended to monitoring a patients wellbeing. They did not view him as a patient in an in-patient setting, rather as an occupant of a cell on ordinary location. The consequence was that the man was not monitored daily, hourly or four hourly for his vital signs, in particular his oxygen saturation levels were not monitored. He may have become confused because of lack of oxygen to his brain. He became anxious and at times aggressive. It is not clear that he was eating and drinking sufficiently, and this may have added to his confusion. In short, his treatment was not equitable to that that he would have received in the community.

I make recommendations about the roles of nursing staff who look after physically unwell prisoners who are located on the First Night Centre. I also make a recommendation about assessing the health and social needs of prisoners returning to the prison from a stay in outside hospital and about completing a plan of care for those patients. I have asked that the Governor review the arrangements for prisoners who require regular clinical observation and monitoring during the night.

THE INVESTIGATION PROCESS

1. My colleague visited Woodhill and spoke to staff who came into contact with the man who died during his time at the prison. Notices were posted to staff and prisoners about the investigation, inviting contributions if necessary. The investigator interviewed eight members of staff and one prisoner. The staff interviews were recorded, whereas contemporaneous notes were made of the telephone interview with the prisoner. The transcripts and notes of those interviews were annexed to the draft report.

2. My colleague studied all relevant prison records relating to the man who died. They included his main prison record, medical records and statements made by staff. He also visited the First Night Centre, the unit where the man lived until his death.

3. The local Primary Care Trust identified a health professional to carry out a review of the man's clinical care whilst he was at Woodhill. I am grateful to them for undertaking this review. My colleague discussed aspects of his treatment with the clinical reviewer, and in particular his location in the First Night Centre after his discharge from hospital in March. It was agreed it would be appropriate to extend the clinical review to include the care given to the man during his time in the local hospital. A medical review is attached to her clinical review.

4. My colleague contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, a copy of my report will be sent to the Coroner.

5. One of the Ombudsman's Family Liaison Officers (FLOs) spoke to the man's sister as his listed next of kin. She raised concerns that he deteriorated very quickly after having made a good recovery in his last week in hospital. She wanted to understand more about what had happened and why his health declined so rapidly. She spoke positively about her family's relationship with the prison following the man's death. They felt they had been kept well informed and treated with respect and kindness. The family liaison officer also spoke with the man's ex-wife about the investigation. A copy of the report will be available to his sister and his ex-wife, should they wish to receive this. I hope the findings of this report help them better understand the events leading to his death.

6. Following issue of the draft report, the man's next of kin responded to express their disappointment at a member of staff's poor attitude within an interview. The matter has been raised with the member of staff concerned who made it clear he had not wished to cause offence and would like to offer his apologies to the family.

The Coroner's inquest

7. The inquest into the man's death was held on 9 October. Both the man's ex-wife and his sister, each supported by other family members, attended the inquest. Amongst the witnesses called by the Coroner, was a Consultant in Respiratory Medicine from a local hospital. He described how many people who are admitted to an Intensive Therapy Unit (ITU) and are put on a ventilator as the man was, do not survive. He said that 50 percent of patients with his condition (pneumonia) die before they come out of ITU and a further 10 percent die within 90 days of leaving ITU.

8. The pathologist also gave evidence about his post mortem findings. The main cause of the man's death was given as hypertensive and ischaemic heart disease. The pathologist said that there was extensive evidence of the man having recently had pneumonia, although there was no evidence of him having pneumonia at the time of his death. There was evidence to suggest his heart was not getting enough oxygen to enable it to work properly and this led to him having a heart attack. The pathologist also explained the high levels of ketones found in his system. Ketones are manufactured by the body and are present in the blood when the body has not had sufficient nutrition to maintain a healthy balance.

9. The jury at the inquest on 9 October gave a narrative verdict to their findings which said:

   'The man died after collapsing in his cell at HMP Woodhill in the early hours of 28 March 2009. His death was contributed to by the lack of a health plan, inadequate handover and therefore of communication between members of the prison medical staff so that he was not observed or monitored appropriately during the evening of 27 March 2009 and a lack of access to oxygen contributed to his death. There was also a lost opportunity to render the necessary medical treatment.'

10. The Coroner issued a Rule 43 report to the Chief Executive of the local Primary Care Trust. This requires the recipient to respond within 56 days on any actions they intend to take to rectify concerns that a Coroner may have about future deaths under similar circumstances to that which have been found by the inquest (in this case of the man who died). The PCT responded very positively to the Coroner's Rule 43 report.

Parkinson's disease

11. Parkinson's disease is a progressive neurodegenerative condition resulting from the death of the dopamine-containing cells in an area of the brain known as *substantia nigra*. People with Parkinson's disease classically present with symptoms and signs such as slowed movements, rigidity and tremors. Although Parkinson's disease is usually thought of as a movement disorder, other impairments frequently develop including psychiatric problems such as depression and dementia (National Institute for Health and Clinical Excellence clinical guidelines for the management of Parkinson's disease, June 2006).

HMP WOODHILL

12. HMP Woodhill is a local prison (one that has remand prisoners from local courts), purpose built to high security prison standards in the early 1990's. It is rated as performing well (level three out of four levels) against performance rating criteria set by the National Offender Management Service, and has been performing at this level since before the man died. It holds some category A (the highest level of security) prisoners as well as some of the most disruptive prisoners in the system in the close supervision centre. The man who died was a category B prisoner, a slightly lower security level than category A. The First Night Centre is located in the same building as the healthcare centre, outpatients unit. The inpatients unit is situated at the other side of the prison.

13. An inspection by HM Chief Inspector of Prisons in 2005 led to a description of the prison as 'depressing and disappointing'. However, following a subsequent inspection in 2007, she found 'a very different prison'. Safety at Woodhill was said to have 'improved considerably, with extremely good reception and first night procedures'.

14. Before the man's death, there had been six deaths from natural causes at Woodhill since the Ombudsman became responsible in 2004 for investigating all deaths in custody. The circumstances of his death are not similar to any of these earlier deaths.

15. The local Primary Care Trust is responsible for commissioning healthcare at Woodhill. The provider arm of the organisation provides a nursing healthcare team based in the prison, a Mental Health In-Reach Team and x-ray, dental, pharmacy and podiatry services. The local PCT also commissions a number of other agencies to provide healthcare services at Woodhill including:

    - Resuscitate Medical Services Limited, who provide General Medical Services.
    - The Seagrave Trust, who provide Substance Misuse services, and
    - Howcroft and Selly, who provide Ophthalmic services.

    In addition, Woodhill provides some additional staff who support the functions of the healthcare department.

The Secure Psychiatric Unit

16. The secure psychiatric unit is a centre for Forensic Mental Health. It opened in 1983 and was one of the first purpose built Medium Secure Units to become operational in England. The unit therefore is a very experienced provider of Medium Secure Services.

17. The unit provides an in-patient forensic psychiatric service to adults (age from 18 to 65) who are, or who are thought to be, suffering from a mental disorder and because of their seriously disturbed or criminal offending behaviour

cannot be managed by a General Psychiatric Service or Local Forensic Services which have lower levels of security.

18. Referrals to the unit come from throughout the criminal justice system, including courts, prisons, high security hospitals and other mental health units. The unit has 86 beds and also has an outpatient service for those who have been discharged from the in-patient service.

Night time unlock arrangements

19. In the event that a cell has to be unlocked at night time, there are procedures that have to be followed by prison staff. The staff who want to unlock a cell have to radio the night orderly officer (NOO) who is in charge of the prison and ask for permission to open a cell. The NOO must be satisfied that there are sufficient staff available for this to be done safely, often by attending the cell personally. When the cell is occupied by one person, the safe level of staffing for unlocking that cell would usually be at least three members of uniformed staff. With two occupants it would usually require perhaps four uniformed staff. In any event, a dog handler will be available when any cell is unlocked at night at Woodhill. Although staff have the use of a key in a sealed pouch for emergency use, they can only use that if they are given permission to by the officer in charge of the prison. Arrangements for unlocking some prisoners may differ if the prisoner concerned is thought to be a greater security risk, which was not the case for the man who is the subject of this report.

KEY FINDINGS

20. The man who died first arrived at Woodhill on 2 January 2008. He was noted to have Parkinson's disease, for which he was taking medication, and he was referred to the mental health in-reach team (MHIRT) as part of his initial health screening. (When the MHIRT saw him on 4 January they concluded that there was 'little reason for mental health assessment'.) He arrived in prison with a warning from the police that he had tried to harm himself. Staff decided to put him on special observation measures, known as Assessment, Care in Custody and Teamwork (ACCT). (The ACCT document is used to monitor and support prisoners thought to be at risk of suicide or self harm through a period of crisis.) He was admitted to the healthcare unit.

21. As part of his remand and trial process the man was transferred to HMP Leicester on 24 January. The ACCT document was closed on 25 January. On 26 January, he refused to take his medication, saying he wanted healthcare staff to 'leave him alone and let him go'. He said that staff were delaying the inevitable because he expected to get a long sentence and be 'shoved in a corner to die'. On 27 January, the man's ACCT document was re-opened.

22. The man smashed his cell on 4 February, damaging the electrical system and flooding the cell. Staff used force to take him out of that cell and put him into another one.

23. A Consultant Forensic Psychiatrist saw the man on 21 February. She noted that he had symptoms of Parkinson's disease and that he was taking specialist medication for his condition. She also noted that this medication can cause major psychotic side effects and, although she judged him to be mentally stable when she saw him, she said that this could quickly change.

24. On 5 March, the prison doctor saw the man and increased his medication for Parkinson's because he was experiencing more muscle cramps. When the doctor saw him again on 18 March, he added diazepam to his medication because the cramps had worsened and he was also suffering from abnormal motor movements of his limbs (a common feature of Parkinson's disease).

25. When the psychiatrist saw the man again on 28 February, he seemed to have improved. However, when she saw him on 3 April, he appeared distracted and was suffering with "pervasive paranoia", saying that he felt threatened by prison staff and other prisoners. When she reviewed the man on 10 April, she noted that he reported sleeping on the floor of his cell, but that he was unable to explain why he did this. She also recorded that he expressed bizarre ideas that people were entering his cell through cracks in the wall.

26. On 14 April, the man told the MHIRT that he had seen people on a church spire with a banner, but that prison staff could not see them.

27. The consultant psychiatrist next saw the man on 17 April, when she thought that his mental health had continued to deteriorate. His behaviour was erratic

and unpredictable and his paranoia was getting worse. She wrote in his medical notes that he had been given a copy of the British National Formulary (BNF) and that this was unhelpful. (The BNF lists all the drugs that doctors prescribe and includes their side effects and contra-indications.) As a result he was 'developing aversions to prescribed medication and becoming hostile about taking them due to his perceptions of what he has read in BNF'.

28. The psychiatrist also completed a Section 48/49 transfer request. (Section 48 of the Mental Health Act 1983 is a direction made on behalf of the Secretary of State for the transfer of a prisoner (not yet sentenced) who is in need of urgent mental health treatment. Section 49 of the Act is a restriction order that effectively means the patient cannot be released from hospital without the Secretary of State's permission.)

29. The man was assessed by a doctor from the secure psychiatric unit on 30 April with a view to admission. This doctor described the man as being unshaven, unkempt and frail when he saw him in the prison. The man told the doctor that prison staff were tormenting him and threatening him. He said the staff were planning to 'take him in an unmarked van with a police escort and interrogate and torture him in a Belfast Police Station'. The man also claimed that staff were carrying out various sexual acts directly in front of his cell window.

30. On 15 May, according to the doctors psychiatric report, the man tried to hang himself three times during the evening. As a result staff began to monitor him constantly within the healthcare unit at Leicester. He transferred to the psychiatric unit on 27 May for psychiatric treatment.

31. During his time at the psychiatric unit, the man's medication for his Parkinson's disease was reviewed. A Consultant Neurologist at the psychiatric unit suggested stopping a drug called Ropinirole which he had been taking six times a day. There was an almost immediate and dramatic effect on his mental state. When the neurologist reviewed him on 28 July he found that his mental health had improved significantly, although his Parkinson's disease was less well controlled. The neurologists view was that the man was in an 'optimal situation' as regards the balance between being mentally well whilst still having some Parkinsonian symptoms. At this time, his anti-Parkinson medication was listed as being Co-careldopa 250mgs six times a day (two 125mg tablets of 25mg carbidopa and 100mgs levodopa), Amantadine 100mgs twice daily and Trihexyylphenidyl 2mg twice daily.

32. Following the man's successful treatment at the secure psychiatric unit, he was transferred back to prison on 7 October. By prior arrangement he did not return to Leicester but instead was sent to HMP Woodhill. A full Care Programme Approach meeting and care package was put in place for the man by the secure psychiatric unit before he left. (The Care Programme Approach is a framework used by mental health workers to help them in the delivery of mental health services. It is based on good practice principles.)

33. When the man who died arrived at Woodhill he underwent an initial health screening by healthcare staff at the prison. The clinical record says that he had Parkinson's disease and Barrett's oesophagitis (acid reflux from the stomach). It also incorrectly says that he had only tried to commit suicide in the past, outside of prison, in reference to his attempt in June 2007. However, the nurses' assessment on this reception screening was that he did not feel like harming himself at that time, and they were not concerned about any risk. The man was, however, referred to the doctor for his medication to be prescribed in line with the instructions from the secure psychiatric unit. He was also referred to the Mental Health In-Reach team.

34. There were problems with the manufacture of Co-careldopa which meant that the man's tablets had to be changed on 18 November so that he took four tablets six times a day. (Each tablet was 62.5mgs of 12.5mgs carbidopa and 50mgs levodopa manufactured under the trade name Sinemet.) He was not happy about the change and it took several attempts by doctors and nurses to explain that the tablets were basically the same drug he had been taking since he was at the secure psychiatric unit.

35. He was assessed by the prison doctor on 19 November because he had high blood pressure. The doctor requested that his blood pressure was monitored over the following few weeks. Entries in the clinical record show that his blood pressure was monitored and remained high until 24 November, although no action seems to have been taken by the doctor when he reviewed him that day.

36. On 5 January 2009, the man was seen by a tuberculosis (TB) nurse specialist because it was thought he had been in contact with someone who had TB. He had had a BCG injection when he was younger but the specialist nurse requested an x-ray as a precaution.

37. He was seen by a prison doctor on 8 January because he was finding it difficult to breathe. The doctor felt that the man was mostly suffering with anxiety and that his breathing was fine. However, he asked to see him the following day.

38. The next day, 9 January, he was seen by a nurse at the request of prison staff because he was again having difficulty breathing. The nurse was concerned about his condition and asked the doctor to go and see him. The doctor assessed him and asked for an ambulance to take him to hospital. He was admitted to a local hospital.

39. While the man was having a routine bronchoscopy on 13 January, he suddenly suffered a respiratory arrest (he stopped breathing) and was put on a ventilator machine. He was moved to the intensive therapy unit (ITU) where he stayed until he was weaned off the ventilator and admitted to a general ward on 11 March. Over the following week he improved sufficiently for him to be transferred back to Woodhill on 20 March. A summary of the care he received whilst he was in hospital was prepared for the Coroner by a Consultant Physician and Lead Clinician for respiratory and general medicine

at the local hospital. The consultant said that the man was admitted with a dry cough and breathlessness because part of his right lung had collapsed. He had a bronchoscopy (a camera into the lungs) which did not show any tumour present to be the cause of his problems. It transpired that he had contracted pneumonia in both lungs because of the bacterium Streptococcus pneumonia. He made a slow recovery from this and left hospital after having received ten days of physiotherapy and rehabilitation on a general ward.

40. When the man arrived back at Woodhill it was felt inappropriate to put him in the healthcare in-patient unit because there was dusty building work going on. He was therefore located in the First Night Centre which is close to the healthcare centre outpatients' unit, giving him easy access to doctors and nurses.

41. The day after his return to Woodhill, on 21 March, he reported that the swelling in his legs (oedema) was getting worse. The doctor was informed but it does not appear that, if he saw him, he was concerned about his condition as no entry was made in the clinical record. A prison doctor saw him on 23 March. He noted the oedema in both legs and suggested that he should raise his legs to help reduce the swelling.

42. The man does not appear to have been seen on 24 March, but was reviewed by the same doctor on 25 March. The doctor said that the man was not short of breath and that he did not see any clinical reason for a full clinical examination. The clinical record does not say whether his legs were still swollen.

43. In the early hours of 27 March, he became very agitated and started behaving bizarrely. He was confused about where he was, thinking he was at home and strangers were coming into his house. He became aggressive because of his agitation. The night staff were concerned about his condition and opened an ACCT as a precaution so that he could be more closely observed.

44. Later that morning, he was seen by the doctor who took a sample of his blood and asked for a urine sample to be obtained. The urine sample could not be obtained, but the blood results were available to the doctor at 12.30pm. Only one of the readings showed anything abnormal, and this was not significant to his condition. The doctor decided that the man might not be taking his medication properly. He therefore stopped all the medication being held in his own possession except the co-careldopa. The doctor wanted to review him later that day.

45. Another of the prison doctors visited the First Night Centre at approximately 3.30pm and saw the man in passing. She was very concerned about his condition and telephoned the male doctor who had been looking after the man. The male doctor told the female doctor that he would come to the First Night Centre to review him. The female doctor in the meantime had examined the man. She recorded that he was having difficulty breathing, agitated, had tremors and oedema up to the knees with some reddening indicating that he had an infection (known as cellulites). She wanted him to

have oxygen immediately and would have liked him admitted to the healthcare unit. When it was explained by a nurse that admission to the healthcare unit would not be possible, the doctor suggested that he should go to hospital. She waited, though, until the male doctor arrived.

46. The male doctor was of the view that the man was not significantly worse than when he had first arrived back at Woodhill, in terms of his oxygen saturations, and therefore did not warrant admission to hospital. This appears to have been accepted by the female doctor who asked nursing staff to maintain a closer level of physical observation on the man. She expected that nursing staff would monitor him throughout the night and administer oxygen if his oxygen saturations dropped below 85 percent. She originally requested monitoring to be done every 15 minutes, but was told by nursing staff that this was not possible within the prison environment.

47. The male doctor left the prison at teatime and the female doctor left at about 8.30pm. The nurse who was the duty night nurse, was told by day staff that he needed to take the oxygen bottle out of the man's cell and give him his last tablets for the day at 11.00pm. The man was being monitored and observed by prison staff hourly, in accordance with the instructions of his ACCT document. It appears from the ACCT record that the night nurse removed the oxygen cylinder and also gave him his tablets at about 9.15pm. He said in interview that the man was alright when he last saw him.

48. An Officer and Officer Support Grade (OSG) were on duty in the First Night Centre on the evening of 27/28 March. In the early hours of the morning, at approximately 1.00am, the OSG was completing her security checks when she heard a loud noise coming from the man's cell. She rushed to the cell and the Officer arrived at the same time. They looked through the observation hatch and saw that he was collapsed on the floor. He was still breathing, but he did not respond to their calls. The OSG went and summoned assistance from the night nurse who was in the healthcare centre some ten metres away, whilst the Officer summoned assistance from Oscar 3 (Oscar 3 is one of the officers in charge of the prison for the night).

49. The night nurse arrived at the man's cell and then collected emergency equipment, including a defibrillator. He asked if further help had been summoned and was told it had. He then asked the control room if they could enter the man's cell and was told to wait until more staff arrived. He also asked for an ambulance to be called. Other staff arrived at about 1.05am, five minutes after the noise was heard from the cell, including Oscar 3, a Principal Officer (Oscar 1) and a dog handler. (The security instructions at Woodhill say that a dog handler should be present when a cell is opened at night time.) The officers (but not the dog handler) and the night nurse went into his cell. The nurse found that the man did not respond and had no pulse.

50. The nurse and the Officer began cardio pulmonary resuscitation (CPR). The nurse also applied the defibrillator pads to the man, but the defibrillator machine could find no shockable rhythm and therefore instructed staff to continue CPR. Staff continued CPR until the paramedics arrived at

approximately 1.10am. When they checked him, they decided to move him to hospital. The paramedics could not resuscitate him and he was pronounced dead at 2.00am by doctors at a local hospital.

ISSUES

51. The man who died was in a very vulnerable state when he first arrived in prison. He had thought about killing himself just prior to his arrest, he was facing a lengthy prison sentence if convicted of his alleged crimes and he had Parkinson's disease. His initial health screen at Woodhill was not full and comprehensive, but nevertheless, he was referred to the doctor and staff opened an ACCT which gave increased observation and support from staff.

52. Shortly after his arrival at Woodhill, he was transferred to Leicester where, over the next few months, his mental health declined steadily. On 27 May 2008, he was transferred to the secure psychiatric unit. It is clear from the chronology of events that the healthcare team at Leicester took prompt and appropriate action in referring him to mental health services at the secure psychiatric unit.

53. The medical review undertaken concludes that the care the man received whilst he was a patient at the secure psychiatric unit was 'exemplary and equitable with the wider community'. I would concur with that view.

54. At the secure psychiatric unit on 7 October, the man had a full Care Programme Approach (CPA) package put in place for his ongoing mental health care needs. When he arrived at Woodhill his tablets were prescribed by the prison doctor and nursing staff referred him to the Mental Health In-Reach Team (MHIRT). It does not appear that he was ever seen by the MHIRT. The clinical review points out that he was not suicidal or actively psychotic after his return from the secure psychiatric unit and therefore would not have been assessed by MHIRT as meeting the criteria for their services. However, because the man was on CPA arrangements, it is expected under the Department of Health's 'Refocusing the Care Programme Approach' guidance that a care co-ordinator should have been appointed either within the prison or from within the MHIRT. This is to monitor patients on CPA and co-ordinate multi-disciplinary teams who might be required to provide services to such patients. The man would have benefited from such an approach.

    The Primary Care Trust should ensure that all patients on Care Programme Approach have a care co-ordinator appointed within HMP Woodhill.

55. The tablets prescribed for the man on his discharge from the secure psychiatric unit had to be altered on 18 November. This was due to manufacturing problems and meant that he had to take four tablets six times a day, rather than two tablets six times a day to which he was accustomed. This was unfortunate, but unavoidable in the circumstances. He found this change difficult to comprehend and staff at Woodhill did well to reassure him that he was receiving the correct medication. The pharmacist and doctors spent time explaining matters to him and promised they would give him his usual tablets as soon as they became available again.

56. In January 2009, the man began to feel breathless, particularly when he lay down. After being seen on 9 January by the prison doctor, he was admitted to a local hospital. The medical reviewers described the care he received whilst he was at the local hospital as ‘exemplary and equitable with the wider community’.

57. Before the man returned from hospital to Woodhill, one of the prison doctors and a nurse visited him to gauge for themselves how well he had recovered. The prison doctor spoke with the registrar who had been looking after the man who died and was given a verbal handover of his progress and needs. It was established that he needed some oxygen, particularly after exerting himself, to maintain his oxygen saturation levels (optimally above 90 percent). The prison doctor’s opinion was that the man should be able to lie down without becoming breathless before he was discharged back to prison. The Consultant in Respiratory Medicine at the local hospital, said at the inquest that this was unreasonable in the time span before discharge. He said it would take longer for the man to be able to breathe properly when lying down, probably several months.

58. The consultant also told the inquest that the man had been “lucky to survive” (the consultant’s own expression at the inquest) his stay in ITU. He explained that 50 percent of patients who enter ITU with severe pneumonia, such as the man had, would die before leaving ITU. He also said a further 10 percent would not survive the 90 days after they left ITU. I therefore echo the medical reviewer’s comment that he received exemplary care whilst at the local hospital.

59. When the man returned to Woodhill on 20 March, he was not able to go to the healthcare in-patient unit because it was undergoing refurbishment. Clinical staff on duty at the time felt that the dusty condition of the unit made it an inappropriate location for him because his lungs were severely compromised at the time. He was therefore looked after in the First Night Centre.

60. The First Night Centre is located adjacent to the main healthcare outpatient facilities, including the main office where nurses are based at night time. The in-patient unit is located on the other side of the prison. In addition, a nurse is assigned to the First Night Centre throughout each day to see new receptions to the prison. It was assumed by healthcare staff that he would have more access to healthcare services by being placed there.

61. In the event, the man’s full medical needs were not fully communicated to the healthcare staff responsible for him on the First Night Centre. Nursing staff would come to see him when requested by prison officers working on the unit and would give him his medication when he did not have it in his own possession. The clinical review says that he was supposed to be encouraged to mobilise on his return from hospital. There is no evidence to suggest this need was met by nursing staff. Similarly, the clinical review says there is no evidence of any other nursing care being given to the man, save for dispensing medication. This includes the complete lack of any assessment of the man’s medical and nursing needs upon his return from hospital except to

recommend encouragement of mobilization. Staff at Woodhill were not helped by the lack of any discharge letter from the hospital, but as a prison doctor and nurse had both visited him prior to his return, healthcare staff at the prison had some notion of what to expect when he arrived back. In any event, it would have been more appropriate had the nursing staff on the First Night Centre completed their own health needs assessment (using a tool such as the Activities of Daily Living document) of the man in his new environment.

The PCT should ensure that all patients returning from a stay in hospital of more than 24 hours should have a full health and social needs assessment in order to facilitate an appropriate plan of care.

62. The clinical reviewer, points out that there was confusion on the part of nursing staff about their role in caring for physically unwell people on the First Night Centre. She feels that there should be a review of this and a protocol developed which makes it clear exactly what their role is in respect of individuals who are looked after there rather than within the healthcare in-patient unit.

The PCT should devise a protocol for the nurses' role in caring for patients who are located in the First Night Centre.

63. There is also an issue regarding the extent and quality of written records for the man's healthcare. Two doctors discussed the man on the afternoon of 27 March. One (the female doctor) felt that the man required hospitalisation, but was subsequently persuaded otherwise by the other doctor (the male doctor). The female doctor also felt that he would have benefited from admission to Woodhill's in-patient unit. Healthcare staff counselled against this, advising that he was as well off, if not better, on the First Night Centre. The doctor felt that if the man was to stay on the First Night Centre then he should be more closely monitored by nursing staff. She said in interview that her instructions were that if his oxygen saturations were to drop to 85 percent then he would require oxygen therapy. The nurse on duty overnight said that he was given no detailed plan of care for his patient overnight, except to supply him his medication at 11.00pm and remove the oxygen cylinder. The written records of these events are scant to say the least.

The PCT should remind all healthcare staff of the importance of maintaining full, complete, accurate and legible records for patients. An audit of clinical records should be held at least annually by the PCT.

64. At the Coroner's inquest, the nurse on duty that night said that to monitor the man's vital signs (including his oxygen saturation levels) at 15 minute intervals throughout the night would have been impossible. He also said that more regular clinical observations, such as hourly, would have been difficult, but not impossible. Although he was being monitored under the ACCT procedures hourly, to monitor him clinically would have required prison officers with keys to access his cell. In practice this would have been one of the officers in charge of the prison (Oscar 1, 2 or 3) accompanied by other uniformed colleagues. It may also have been necessary to have the presence of a dog

handler with his dog. This would be a very significant staff commitment in a high security prison. I accordingly make the following recommendation.

The Governor should make arrangements for patients' needs to be met adequately during the night. These instructions should be contained within the Local Security Strategy and should include regular clinical observation and monitoring of patients who are acutely unwell.

CONCLUSION

65. The man was discharged from the local hospital having spent 70 days there, including 56 in ITU. He returned to Woodhill on 20 March 2009. He was put onto the First Night Centre rather than the prison in-patient unit because there was some building work going on and it was felt he would be closer to healthcare staff.

66. Healthcare staff from Woodhill had visited him whilst he was out in hospital and had spoken with hospital doctors who were looking after him. They had a good idea of what his health needs would be when he returned to Woodhill. This included the use of oxygen to counteract the effects of his poor breathing. He was also taking Parkinson's medication that had caused him to be admitted to a psychiatric hospital in the past.

67. The man's health began to deteriorate within a few days of his return to Woodhill. He became confused and distressed. It appeared to doctors at the prison that this might be due to an infection as his legs were swollen and red. They treated him with antibiotics and also diuretic medicines to get rid of some of the swelling. He continued to be confused and became aggressive at one point. Staff on the First Night Centre felt he needed closer observation and therefore opened an ACCT document on him. They also removed all medicines he had in his possession.

68. On 27 March, he was seen by a number of healthcare staff and there was a variance of opinion on how best to manage him. One doctor wanted to send him to hospital, but her view was overruled. The nurse on duty overnight was asked to monitor him closely and to give him oxygen if his oxygen saturation levels dropped below 85 percent. This close monitoring was not done – indeed that level of clinical observation had not been carried out since his return from hospital one week earlier.

69. It emerged at the inquest that the man had suffered a heart attack because his heart had been working too hard without sufficient oxygen. It was also highlighted that some of his behaviour could well have been attributable to hypoxia (a lack of oxygen to the brain) rather than any infection. Similarly, it was discovered at post mortem that the man had high levels of ketones in his system which is usually attributable to not having eaten or drunk enough. It is difficult to say whether his altered behaviour was due to poor nutrition or poor oxygen levels, but one thing is clear. Closer monitoring and greater administration of oxygen would have improved his condition in the last few days of his life. I believe that placing him in the First Night Centre, without sufficient nursing staff to look after him was inappropriate and deprived him of proper clinical care.

RECOMMENDATIONS

The recommendations were all accepted and a record of the response is recorded below each recommendation.

1. The Primary Care Trust should ensure that all patients on Care Programme Approach have a care co-ordinator appointed within HMP Woodhill.

   The implementation of the full integration of CPA is a fundamental element of the PHQPI and as such has separate action points on the Prison Health Delivery Plan. Currently a workforce review is being conducted which will consider Mental Health provision to the establishment. At present the MHIT do undertake some aspects of the Care Programme Approach, there does however need to be a strategy developed around this to ensure comprehensive delivery. To be completed by 31 March 2010.

2. The PCT should ensure that all patients returning from a stay in hospital of more than 24 hours should have a full health and social needs assessment in order to facilitate an appropriate plan of care.

   All returning patients from admission to hospital will be assessed and a plan implemented which will be entered onto the electronic patient record so all clinicians can access it. A policy has been agreed with the Prison, PCT and Acute Trust which stipulates that a full health and social needs assessment will take place after 48hrs of admission whilst in hospital before discharge as of 31 December 2009.

3. The PCT should remind all healthcare staff of the importance of maintaining full, complete, accurate and legible records for patients. An audit of clinical records should be held at least annually by the PCT.

   Information Governance has been prioritised with the implementation of the electronic patient record system. A records management audit has taken place in November and will thereafter be held annually. Completed 30 November 2009.

4. The PCT should review and develop a protocol for the nurses' role in caring for physically unwell prisoners who are located on the First Night Centre.

   Aftercare is included in the Secondary Admission Policy. Nurses' roles are currently being reviewed as part of the workforce planning process which is due for completion by 31 March 2010.

5. The Governor should make arrangements for patients' needs to be met adequately during the night. These instructions should be contained within the Local Security Strategy and should include regular clinical observation and monitoring of patients who are acutely unwell.

   A policy has been agreed with the Prison, PCT and Acute Trust which stipulates that a full health and social needs assessment will take place after

48hrs of admission whilst in hospital before discharge. Details of the above (and of any other patient who requires such levels of care) will be effectively communicated to night staff as required by daytime Healthcare staff in order to ensure all patient needs are met during the night. The LSS will be reviewed and updated with instructions relating to regular clinical observation and monitoring of patients who are acutely unwell. This has been implemented as of 31 December 2009.