Investigation into the death of a man at HMP Hull on 25 May 2004

Report by the Prisons and Probation Ombudsman for England and Wales

November 2005

I commissioned this enquiry and report into the death of a man in the Healthcare Centre of HMP Hull on Tuesday 25 May 2004.

The Head of Residence at HMP Leeds was commissioned as the Senior Investigator. The Yorkshire and Humberside Area Manager's Support Team assisted him. Liaison and support was provided by an investigator from my office.

I offer my sincere condolences to the family and friends of the man who is the subject of this report and to the staff and prisoners of HMP Hull following his tragic death.

Despite being a distressing and difficult time for all those who knew the man or who have assisted in the events surrounding his death, the enquiry team is grateful for the consistent support and co-operation received during their work.

My investigators would like to extend their gratitude to the Director of Professional Development at Eastern Hull Primary Care Trust for undertaking the clinical review.

I thank Humberside Police for their assistance during the course of this enquiry. I am also grateful to the former Governor of HMP Hull and his colleagues for their assistance.

This report includes extensive recommendations to the prison and I have also written to the Governor to express concern about the alleged lack of appropriate action by two of the nurses on duty on the morning of the man's death. Subsequently I have been informed that the prison and Primary Care Trust have jointly commissioned a disciplinary investigation, which is still proceeding.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2005**

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Summary

1 The man was born in November 1958 and was 45 years old at the time of his death. He was a sentenced prisoner serving ten years for arson and was first received at HMP Hull on 26 February 2002. At the time of his death he was subject to F2052SH management, the current document having been open since 10 January 2004.

2 On the evening of 24 May 2004 the man went to bed as normal. He was observed throughout the night and comments were made in his F2052SH indicating he had been moving throughout the night which would have satisfied night staff that he was alive and well.

3 At approximately 7:10am the nursing assistant checked the man's cell and noticed he was a 'funny colour'. This was reported to the night staff, who are also reported to have commented 'he is always an odd colour' and no further action was taken at the time. The nursing assistant then completed the F2052SH and commented 'the man appears to be sleeping on his stomach, breathing evident but had poor colour, slightly bluish'.

4 At approximately 7:40am, during the issue of breakfast packs, the man did not respond when a Prison Officer arrived at his single cell to speak to him. The officer thought something was wrong and went to get help, which was the quickest method of raising support. He entered the cell with a Healthcare Officer who said that the man was dead and the alarm was raised using the radio net. An ambulance was called immediately. The Healthcare Manager also attended the scene.

5 In view of the man's condition (rigor mortis and pooling of blood) a team decision was made not to resuscitate. The Healthcare Manager was supervising at this time. Paramedics attended at 08:08 and pronounced death at the scene.

6 The cell was sealed and investigations into the man's death commenced.

7 On 30 September 2004 a meeting was held at Hull PCT to discuss the procedures and developing practices for Prison investigations within the Hull / Humberside area.

Present at the meeting were representatives from:
Prisons and Probation Ombudsman (PPO)
Eastern Hull Primary Care Trust
HMP Hull
Investigation Team

Note:
Two points cause concern and remain unanswered.

1. If the Nursing Assistant was correct and the man was alive and breathing at 7:10am when she reported to the trained staff on duty that he looked ‘a funny colour’, action at that time might have altered the outcome.

2. Uncertainty about the time of the man’s death questions the accuracy of the Nursing Assistant’s observation that he was alive and breathing at 7:10am.

Background

HMP Hull

8 Hull is a Victorian prison opened in 1870 to hold both men and women. It is now a Category B local prison serving courts in East and North Yorkshire and North Lincolnshire. A major expansion programme, completed in late 2002, added 356 places to the prison's operational capacity and a further 40 places were added in March 2004. The certified normal accommodation is 812 but the operational capacity (the maximum number of prisoners who can be held) is 1071.

9 The Health Care Centre (HCC) at the prison is a new purpose built two storey building which opened in April 2003. The HCC provides 24-hour nursing care with the in-patient unit being located on the upper level of the building.

10 The last audit by the Prison Service Standards of compliance with Suicide Prevention and Self Harm Reduction standards which are incorporated into the standard on Safety were rated as Good 84%. The overall rating for the Establishment was Good.

11 In her recent report, Her Majesty's Chief Inspector of Prisons states:

Some good work was being undertaken in the areas of suicide and self harm prevention and anti-bullying.

The comprehensive policy relating to the management of those prisoners at risk of suicide and self-harm was reviewed annually and the suicide and self-harm prevention committee met regularly. These meetings were well attended and there was good interrogation of statistics along with clear follow-up action of identified points of concern. F2052SH (self-harm) documentation contained good entries and there were effective management checks. Given that around 40 prisoners were the subject of F2052SH documentation at any time, it was impressive that many staff had a clear understanding of the prisoners for whom they were responsible and who needed support. Reviews were conducted on time but sometimes took place without the required number of staff being present or with staff who were not familiar with the prisoner. Some support plans were poor. A good listener scheme was in place.

It says a great deal for the prison's managers and staff that they had nevertheless managed to retain a largely safe and decent environment in the prison. Hull was a well-run prison, with some good suicide and self-harm, anti-bullying and diversity work. It was providing good quality education, training and PE, and strengthening its resettlement work. A new unit, the Minos centre, had recently been opened to bring together all elements of reintegration work and provide interventions to meet prisoners' needs. A new regime ensured that prisoners were out of their cells for a considerable period each day, unlike in many local prisons that we inspect.

The man who is the subject of this report

12 The man was born in November 1958 and was aged 45 at the time of his death. His details indicate that he had no stable home and was registered as 'no fixed abode'. No details of his next of kin were available to the Prison Service. He was described as a loner who suffered from depression. He had, in the past, taken part in therapeutic programmes aimed at 'beating the blues' and had also participated in counselling groups.

13 From 10 January 2004 he was subject to day-to-day management on a F2052SH. (F2052SH is a Prison Service procedure which provides staff support and vigilance to prisoners thought to be at risk of harming themselves.) He had a history of refusing meals and also anti-depressant medication whilst he was on E Wing.

14 He was located in the Healthcare Centre from 5 April. Since his admission to healthcare he was subject to care planning via three systems – F2052SH support plan and review system, Healthcare PCT care plans and the Risk Management Plans written by the Mental Health In-Reach team (MHIRT). Following his admittance to the Healthcare Centre, formal F2052SH reviews ceased and were replaced by clinical reviews. The last review was on 9 April.

15 Throughout his stay in the Healthcare Centre the man was described as barely eating. He ate and drank just enough to maintain his health. He had a good relationship with the Chaplaincy department and attended services in the Healthcare Centre.

Conduct of the Investigation

16 Conduct of the investigation drew upon both written documentation and interviews with key witnesses and other interested parties. Members of the enquiry team interviewed prison staff, who were given the opportunity to have a work colleague or a trade union representative with them, and a member of the local staff care team was available for support. To ensure the accuracy of the team's recollection of the events, all interviews, with the consent of the staff involved, were taped.

17 Documentation pertaining to the man's custodial history was examined in detail, including:
Main prison record
History Sheets
F2052SH
Sentence Plan
Inmate Medical Records

18 In addition to the documentation relating directly to the man's death, enquiries were made to ascertain the level of compliance with relevant local and national procedures. Further documentation relating to the establishment's policy on managing those thought to be at risk from suicide and self harm was examined to establish its adequacy and the degree to which it was implemented within the establishment.

19 The man's family were visited by my PPO Investigator and the Senior Investigator. My PPO colleague made a note of the concerns and issues that the family wished to bring to the attention of the investigation team.

20 The enquiry team had the opportunity to speak with the Police investigation team and are grateful for their co-operation.

21 My investigator made arrangements for a clinical review of the man's case. I am grateful to the Eastern Hull Primary Care Trust for their report.

22 A notice to both staff and prisoners was issued by the Investigation team, extending an invitation to submit any relevant evidence concerning the death of the man. I am obliged to the Chairman of the Hull branch of the Prison Officers' Association for his contribution.

Post Incident Response

23 The Duty Governor attended the Healthcare Centre when the alarm was raised. The paramedic who attended the scene pronounced the man dead at 8:08am. The prison's contingency plans for a death in custody were activated. The cell door was locked awaiting the arrival of Police Officers.

24 At 9am Police Officers and Scene of Crime Officers attended and the investigation into the death of the man commenced. The death was notified to those persons and organisations listed in Hull's contingency plans. A hot debrief took place at 11.05am. Ongoing support for staff was given by the staff care team.

25 The Police informed family members of the man's death by telephone whilst trying to establish next of kin details.

26 Notification of staff and prisoners took place through internal notices on 25 May and Hull's Death in Custody action checklist was completed.

28 The Senior Investigator and my investigator visited family members on 5 July. The family did not wish to take up an offer to visit the prison.

Compliance with Prison Service procedures

Clinical Care

29 Standards of healthcare in prison are intended to mirror those available in the outside community. The man's prison records indicate that he was given an appropriate level of care. The medical aspects of his case are described in the independent clinical review.

30 There is obvious concern regarding staff's reaction when notified by a nursing assistant of the man looking a"funny colour". The fact that this comment was not delivered with any sense of urgency and contradicted the subsequent entry in his F2052SH of "looking bluish" is a matter of concern dealt with in this report.

Two points cause concern and remain unanswered.

1. If the Nursing Assistant was correct and the man was alive and breathing at 7:10am when she reported to the trained staff on duty that he looked 'a funny colour', action at that time might have altered the outcome.

31 Uncertainty about the time of the man's death questions the accuracy of the Nursing Assistant's observation that he was alive and breathing at 7:10am.

Follow up to a Death in Custody

32 Prison Service Order (PSO) 2710 refers to each prison's responsibilities following a death in custody. These had to be addressed in a letter from the author of this report with an apology when the paperwork was reviewed on the investigation team's arrival. More care in relation to details supplied to external bodies should be taken by managers completing this paperwork, as errors are embarrassing to the Prison Service and cause distress to the family.

Contact with Family

32 There has been criticism from a family member over the way she was informed of the man's death, which was during a telephone call from the police. The police, however, argue that this was unavoidable. The man's family was somewhat estranged from him. It was while investigations were underway to establish next of kin details that the

police found themselves talking with one of the man's sisters. This put them, again, in the unavoidable position of having to disclose his death over the telephone. Once next of kin details were established these were passed on to the prison, which made prompt contact and established a liaison person.

Notifying other Prisoners

34 It is mandatory to notify other prisoners of a death, especially friends and associates of the deceased in the establishment (PSO 2710.32.18).

35 It is clear that staff communicated the news of the man's death to other inpatients in the health care centre promptly. A notice to prisoners was subsequently published notifying the rest of the establishment.

Support for Staff

PSO 2710 states at Chapter 5 that the prison's Care Team must establish contact with any member of staff who was involved in, or might be affected by, a death to offer support. Some staff have complained that they were offered insufficient support. The same chapter of the PSO goes on to say that:
'' If required, the Staff Care and Welfare Service will arrange for a Critical Incident Debrief to take place – this is an opportunity for staff involved to meet together informally with trained debriefers to review what they know of the incident, their thoughts, impressions and feelings. Participants will have the opportunity to talk about how they are coping and any concerns that they may have for the future.'' There is no evidence that a Critical Incident Debrief took place or was even considered.

Record Management and Incident Recording

36 Investigators were given copies of the man's Inmate Medical Record, Main record, previous and current F2052SH booklets, incident logs and contingency action plans. In the event of a death it is good practice for Prison Service staff who have been involved in the episode to prepare a written statement promptly after the event.

37 These statements also assist the inquest at which staff might be required to give evidence, as well as enabling the Prison Service to demonstrate accurately the care provided to a prisoner who has died. In this particular case there was a time delay of some days before health care staff wrote accounts of the incident.

Policies / Protocols

38 Suicide and Self-Harm
A current suicide and self-harm prevention policy document is in place. Regular suicide prevention meetings take place, which are appropriately minuted and circulated.

39 Medication
At the time of the man's death there was no available protocol covering the administration of medication to patients resident in the Healthcare Centre. No written guidance was available to Healthcare staff on action to take if there was doubt regarding the patient actually digesting his medication.

40 Case reviews were conducted and recorded in care plans. The details of these reviews were not transferred into the F2052SH, which would have demonstrated appropriate interaction between medical and non-medical staff who were involved in the man's care.

Extract from PSO 2700
Routine case reviews are not required when a prisoner is located in the HCC on a regular scheduled basis in recognition of the fact that the prisoner will in this circumstance have a nursing care plan. However, it is good practice to do so when possible, and *a nursing care plan must not be used in place of the F2052SH. A case review must be conducted in the HCC:*

- *When a prisoner harms themselves (unless an alternative review level in the event of further self-harming is specified in the support plan).*
- *Prior to the prisoner's discharge to normal residential accommodation.*

Contingency Plans

41 The establishment had in place contingency plans adequate for the purpose. On being alerted to the incident the emergency services were contacted. Following the man's death the cell was sealed pending the arrival of the police. A hot debrief was conducted for staff involved in the incident.

42 Procedures following a death in custody as set out in PSO 2710 were followed. The incident was reported as required, support for staff and prisoners was in place, and follow up support for the family was offered.

Findings

43 The effective management of those at risk of self harm and suicide within the Healthcare Centre is flawed due to the separation of PCT Clinical reviews, support plans, MHIRT assessment and support plans from the F2052SH process. Continuity of communication and support does not appear to be adequate.

44 Comments and observations in F2052SH were, in some cases, inappropriate and incomplete. Subsequent management checks failed to highlight or challenge these issues.

45 There is a blurring of boundaries, accountability and responsibilities regarding the management of PCT nurses, prison employed nurses and Healthcare Officers, which should be addressed to ensure clarity. A standardised approach to working practices and protocols and a more balanced and focused method of operation and delivery are required.

46 There are no working protocols for the issuing of medication within the Healthcare Centre.

47 There are systems in place where prisoners are allocated the status of special unlock procedure where two and three discipline staff are required to unlock and supervise prisoners. It has been found that the Inpatient Centre has operated on a regular daily basis with a single Prison Officer on duty.

48 The Healthcare Centre is an important part of the establishment but it seems to have been left to function independently, devoid of a tangible link to provide effective support, which is necessary to ensure complete compliance with Prison Service standards and integration into the wider regime at the prison.

49 The written reports of the incident by staff at the scene and those who had managed the man over the weeks were brief and lacked clarity and detail.

Conclusions

50 According to the published post mortem report the man's death was due to a Chlorpromazine overdose. This is not completely in accord with the toxicology report, which does not confirm death due to overdose but the enquiry team accepts the view of the Post Mortem that the cause of death was a Chlorpromazine overdose.

51 There is serious concern over the response of healthcare professionals when the initial indication of a potential medical emergency was raised. This should be considered by the appropriate regulating professional body.

52 The arrangements for issuing medication to inpatients were not standardised nor do they refer to any increase in risk to prisoners who may be identified for not taking, storing or abusing medication. The breakdown in the successful identification of an increase in risk, regarding formal assessments, lies within the communication problems between the PCT, MHIRT and Hull Prison.

53 Management of the F2052SH documentation within the Healthcare centre is flawed by a lack of coordination and understanding. During the course of this investigation the Senior Investigator found repeated errors. He addressed these with the individuals and departments concerned and the Suicide Prevention Coordinator.

54 The contingency planning procedure at Hull is good and was effective in this case. The Post Incident response following the confirmation of death was generally good. However, arrangements for attending to the care and welfare of staff involved have been difficult to confirm and there is no evidence that consideration was given to holding a Critical Incident or operational debrief.

Recommendations

Local

1. Eastern Hull Primary Care Trust should take full responsibility for the management of the provision of nursing resources within HMP Hull.

Prison Officers should be retained within the Healthcare Centre to provide the necessary application of mandatory systems regarding security, order and control and compliance to Prison Service Standards, Audit requirements and KPT delivery.

Pending implementation of recommendation 1, immediate action should be taken by PCT Nurses, Healthcare Officers and the prison employed nurses to standardise the practice, management, enquiry and accountability for the following issues:

- Duty of Care
- Healthcare standards
- Clinical Governance
- Prison Security
- Prison Service Standards and Audit procedures
- Mandatory Training

2. Consideration must be given to the commissioning of a full discipline investigation to enquire into any lack of care given by the two Grade E Nurses, in accordance with the professional standards laid down by the Nursing and Midwifery Council.

3. Complete and comprehensive multi – disciplinary F2052SH reviews should be conducted while prisoners are in-patients in Healthcare with appropriate representation from all concerned.

4. A system should be put in place for routine checks of F2052SH documentation throughout the working day by managers working in the area. Checks should consider the compliance of observations against the support plan, and risks reassessed.

5. A named member of the prison's Senior Management Team should be provided as a formal mentor/supporter in addition to the PCT Healthcare Management Team, ensuring that nursing is fully integrated into the establishment. Clear terms of reference for mentorship/support should be drawn up and agreed by both parties. The mentor should attend the monthly healthcare meetings to assist with the management of any issues that may crossover or compromise different healthcare and prison priorities.

6. The mentor should participate in the compilation of action plans in response to Prison Service and PCT audits and reports, ensuring that neither body is compromised by failing to understand each others governance responsibilities.

7. A joint review of systems, protocols and procedures within the Healthcare Centre should be a priority for the Management Team in partnership with the PCT. All these protocols should incorporate management checks to ensure they are overseen, managed and auditable.

8. All Prison Service standards and local audit applicable to the Healthcare centre should be managed as part of the local self - audit system. Information gained during the self – audit process must be shared with the relevant agencies involved in the delivery of care.

9. Prisoners deemed to be subject to special unlock procedure should be appropriately risk assessed and allocated achievable levels of supervision. Where supervision cannot be sustained for any reason, alternative systems must be introduced which ensure continuity of care.

10. An audit of the F2052SH system should be completed and the results included in the training plan.

11 The training plan should also include training on report writing and standards for record keeping and should be available to all staff.

12 The Governor should review arrangements for attending to the care and welfare of staff after the death of a prisoner. In particular he should ensure that the prison is compliant with the requirement set out at paragraph 5 of Chapter 5 of PSO 2710 for consideration to be given to setting up a Critical Incident or operational debrief after any such incident.