INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP HULL ON 1 JULY 2004

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

June 2005

The man who is the subject of this report died in the Healthcare Centre of HMP Hull on Thursday 1 July 2004.

His death occurred at a time when the investigation of deaths in prison custody was subject to transitional arrangements agreed between my office and the Prison Service. Accordingly, I commissioned a governor at HMP Leeds to act on my behalf and investigate the circumstances. A member of the Yorkshire and Humberside Area Manager's Support Team assisted him and an investigator from my office provided liaison and support. I am most grateful to all of them.

I am indebted to the Director of Professional Development, Eastern Hull Primary Care Trust, for the clinical review of the man's healthcare. I would also like to thank Humberside Police for their assistance during the course of this investigation.

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 investigation team has received consistent support and cooperation during their work for which they are very grateful. My thanks must be extended to the Governor of HMP Hull, his appointed Liaison Officer and his colleagues for their assistance with the investigation.

I would like to offer my sincere condolences to the man's family and friends and to the staff and prisoners of HMP Hull following his tragic death. I apologise for the long delay in completing this report that has been caused by factors out of anyone's control.

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 **June 2005**

Contents

1 Summary

2 Conduct of the investigation

3 HMP Hull

4 Key Findings

5 Post-incident Response

6 Conclusion

7 Recommendations

1 Summary

1 The man was born in May 1963 and was 41 years old at the time of his death. He was a sentenced prisoner serving two years two months and two days for possession of drugs, and was first received into HMP Hull on 15 January 2004.

2 At the time of his death, he was subject to F2052SH management (the Prison Service's care system for those at risk of suicide or self-harm); the current F2052SH document having been open since 28 June 2004. However, there was no evidence of any self-harm contributing to his death.

3 Hull’s local policy document for prisoners subject to F2052SH procedures requires six entries to be made in the document during the course of each night. On the evening of 30 June 2004, the man had taken to his bed as normal. He had been observed throughout the night and comments made in his F2052SH indicate that he had been in pain throughout the evening and night-time period. He had been observed asleep and a drink had been given to him at 3:45 am on 1 July 2004. This was the last entry in his F2052SH.

4 At approximately 4:45 am, he was observed lying on the floor of his room, F1-11. This room was in the prison’s Healthcare Centre. Attempts were made to communicate with him and when there was no response the alarm was raised.

5 Security procedures were followed and therefore the room was not entered immediately. Information from the Night Orderly Officer (the most senior member of staff on duty during the night of the man’s death), is that a minimum of three staff must be in attendance before a cell can be entered during the night. As soon as the Night Orderly Officer joined the nurse and Healthcare Officer, who were on duty in the Healthcare Centre, the man’s cell was unlocked. They entered the room at 4:50 am and first aid was immediately administered. An ambulance was called and attended, the paramedics entering the man’s room at 5:05 am. At 5:08 am the paramedics pronounced that he had died. The cell was sealed and investigations into his death commenced.

6 In August 2004 a post-mortem report was supplied to the coroner by the Professor of Forensic Pathology at Sheffield University. Post-mortem examination showed that the man had suffered a massive gastrointestinal tract haemorrhage from a bleeding carcinoma of the stomach. The cancer had spread to his liver, lungs and to the regional lymph nodes. It had also spread to the vertebral bone marrow and he had an inoperable tumour in his spinal column.

2 Conduct of the Investigation

7 This investigation considered written documentation, including:
- main prison record
- history sheets
- F2052SH
- Sentence Plan
- clinical records

8 Interviews were carried out with key witnesses and other interested parties. Prison staff were invited to have a colleague or trade union representative accompany their interview, and a member of the local staff care team was also available. To ensure accurate records were made of the interviews, they were tape recorded.

9 An investigator from my office and the Senior Investigator visited the man's family. It is hoped that the questions they raised have been answered in this report.

10 The investigation team also considered the extent to which the prison complied with local and national procedures for looking after prisoners thought to be at risk of suicide or self-harm and for dealing with deaths in custody.

11 A clinical review of the man's healthcare was undertaken by the Director of Professional Development at the Eastern Hull Primary Care Trust and I am grateful for her report

12 A notice announcing the investigation was issued to staff and prisoners, who were invited to make contact if they wished to contribute any information. I am grateful to the Branch Chairman of the Prison Officers' Association at Hull for his presentation of the views of members.

3 HMP Hull

13 Hull is a predominantly Victorian prison opened in 1870 to hold men and women, two miles east of Hull city centre. In 1939 it was used as a Military Prison and later a Civil Defence Depot. In 1950 it re-opened as a Closed Male Borstal. In 1969, after extensive security work, Hull became one of the first maximum-security dispersal prisons. In 1986 Hull was removed from the dispersal system and assumed its current role as a Male Local Prison/Remand Centre. In 2002, the prison expanded and the site has increased in size. The expansion includes four new wings, a new Healthcare Centre, a new sports hall, a new multi-faith centre and refurbishment to other parts of the prison including the kitchen, education and workshops. In April 2004 the prison's operational capacity (the maximum number of prisoners the prison is permitted to hold) increased to 1,071.

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

15 In a recent report, Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, states of Hull:

"There had been an increase in the number of incidents since the introduction of the new regime for prisoners on 29 February 2004. Many of the systems necessary to identify and manage this trend were in place but they needed continued and close management. There was also a particular need to focus on those systems supporting prisoners during their early periods in custody. However, 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."

4 Key Findings

16 The man was born in May 1963 and was 41 years old when he died. He was well known to HMP Hull staff and had good, appropriate relationships with them. He had managed his past periods of custody at Hull well. His list of previous convictions indicates that all his court appearances were in Hull or Beverley. He was sentenced to terms of imprisonment by these local courts on five occasions between 1987 and 2001.

17 He was admitted into the Healthcare Centre for withdrawal observations on 16 January 2004. Standards of healthcare in prison are intended to mirror those available in the outside community. There was a current Care Plan for him, which related to Substance Abuse and Alcohol Detoxification with key interventions documented as relapse, review and management.

18 He was also being treated for infection in the ulcers on his lower legs. There are entries in his Inmate Medical Record (IMR) which state he refused to attend for treatment on 5, 9 and 12 January for his wounds to be dressed and on 15 January and 14, 15 and 16 February for a tetanus injection.

19 He was discharged from the Healthcare Centre on 20 January and the following day he was prescribed a detoxification pack.

20 He was informed of the importance of the tetanus injection and this was administered on 19 April.

21 On 13 May, an entry in his IMR reports he had a pain in his back, that he had past ops and he was prescribed co-codamol. The treatment for leg ulcers continued, but he again declined appointments on 19 and 20 May.

22 The IMR for 27 May reads: 'He has dressing on his L leg now demanding kapake – for pain in his L thigh and left leg.' He was advised to take Brufen or Diclofenac but refused and left the examination room, threatening to make a complaint.

23 At the time of his death there was no protocol for the administration of medication to patients in the Healthcare Centre. The Clinical Review refers to an entry in his Medical Record on 12 June which states: ''Given 16 x 400 Ibuprofen for pain relief by a member of the Healthcare Centre.'' The Director of Professional Development observes, at page 4 of the review, that there was no cross reference available from the man's Prescription and Administration Record Chart.

24 The standard of documentation was reduced further by the fact that some comments and observations in the IMR, Care Plan and F2052SH were illegible.

25 The man complained of pain in his back over some weeks and this was investigated by Prison Healthcare Centre staff and a chain of care can be established which shows outside referrals to Hull Royal Infirmary. He attended the hospital on two occasions, 8 and 25 June, on both occasions because of his complaints of back pain. He was x-rayed there on 8 June and the report states that there was 'No abnormality shown in heart, mediastinum or lung fields. Pulmonary vascularity is normal.' There is no record of that x-ray in the IMR and no apparent local reference to its existence.

26 On 10 June, he told Healthcare Centre staff that he had been using one gram of heroin per day in prison, which was because he did not have the painkillers he said he needed. The nursing staff submitted a Security Information Report. At the same time, he signed a form refusing to be admitted to hospital for treatment of his condition.

27 Two weeks later on 25 June, he again attended Hull Royal Infirmary where he was diagnosed with muscular back pain and co-codamol painkillers were prescribed. It was considered that an x-ray was unnecessary since his history suggested the condition had been present for some time. At both appointments, hospital staff found no evidence of illness other than muscular pain.

28 From early 28 July, he was subject to day-to-day management on a F2052SH, which is the prison's response to indications of suicide or self-harm. A Healthcare Officer opened the F2052SH after the man threatened to kill himself because of the pain he was suffering.

29 Two entries were made in the Continuous Medical Record section of the man's IMR on the afternoon of 28 June. The first entry at 5:10pm reads: ''Demanding pain killers – Brufen – informed that the 'gel' he has been written up for will not be available until tomorrow – said 'if you don't get my painkillers NOW I will kill myself'.''

30 The next entry in the IMR is at 5:15pm and reads: ''Found with shoe lace around his neck – slightly blue in colour – pure manipulative gesture in order to obtain more analgesia.''

31 Comments were made in the F2052SH regarding manipulative behaviour with specific reference to the recent act of self-harm. The member of staff who opened the document made a direct distinction between clinical care and care of prisoners subject to F2052SH management. Although there is no evidence to suggest that the comments made in the document influenced or dictated the future care of the man, information should be recorded professionally and take a balanced view. Wording should be factual, complete and objective and should not cloud the judgement or perception of the next care provider.

32 Although there is clear evidence of management checks of the F2052SH and the IMR, there is no evidence to show that such inappropriate language was addressed.

33 The cause of the man's intense pain was not established until after his death. The coroner has kindly made available the post-mortem report supplied to him by the Professor of Forensic Pathology at the University of Sheffield. The conclusions to the Professor's report are as follows:

- "Post-mortem examination of the man showed that he had suffered a massive gastro intestinal tract haemorrhage from a bleeding carcinoma of the stomach.
- The cancer had spread to the man's liver, lungs and to the regional lymph nodes. It had also spread to the vertebral bone marrow and the tumour in the spinal column would account for the symptoms of back pain.
- It was clear that the tumour had become inoperable at the time of death and would have been inoperable when seen in June.
- Toxicological examination revealed the presence of morphine in the blood, in keeping with the history of self-administered heroin."

5 Post-Incident Response

34 The paramedic who attended the scene pronounced the man dead at 5:08 am and the prison's contingency plans for a death in custody were activated, the cell door being locked to await the arrival of the police. The death was notified to those persons and organisations listed in the contingency plans, including the Duty Governor who attended the Healthcare Centre at 6:05 am. PSO 2710 sets out the prison's responsibilities following a death in custody and it was complied with in full.

35 At 9:00 am the police and scene of crime officers attended the Healthcare Centre where the man died.

36 A debriefing meeting for all the staff involved took place later in the day and the staff care team provided further support.

37 Other staff and prisoners were informed of the man's death by internal notices issued the same day, as required in PSO 2710. It is clear that staff communicated the news of the man's death to other inpatients in the Healthcare Centre promptly. A notice to prisoners was subsequently published notifying the rest of the establishment. All prisoners on current F2052SHs were reviewed following his death.

38 The man's family were informed of his death by the Governor who also visited them on 1 July. They were invited to visit the prison but decided not to take up the offer. Contact with the man's family has been in accordance with PSO 2710.

6 Conclusion

39 HMP Hull was making every effort to provide a stable and safe environment for men with a history of drug abuse and associated health problems. According to the toxicology report, the man's death was not linked to excess/additional toxic substances prevalent in his body.

40 It is clear from the number of entries in the man's IMR and F2052SH that he was receiving regular attention and care. In particular, he was appropriately referred to outside hospital for investigation of his recurrent back pain.

41 The contingency planning procedure was also good and proved effective in this case. Post-Incident Response following the confirmation of death was effective.

42 However, the Healthcare Centre, which is an essential part of the prison, seems to have been left to function almost independently and without an effective and supportive link. Close links between the Healthcare Centre and the rest of the prison are necessary to ensure complete compliance with Prison Service Standards and integration with the prison regime.

43 From interviews with Healthcare Centre staff, it appeared that there was some blurring of responsibilities and an inconsistency of practice standards amongst staff working there who are a mixture of Prison Hospital Officers, Prison Nurses and PCT Nurses. For example, the staff member who opened the F2052SH made a clear distinction between clinical care and care of prisoners subject to F2052SH management. Also there was evidence of differences of delivery style and methods of record keeping.

44 Comments in the man's F2052SH regarding his 'manipulative behaviour' specifically referred to his recent act of self-harm. The comments were based on opinion rather than being factually correct and there was no reference to the pain which he experienced. Furthermore, although there is clear evidence of management checks in the F2052SH and the IMR, there is no evidence to show that inappropriate comments are challenged and addressed.

45 Although there is no evidence to suggest that these comments influenced the future care of the man, they were regrettable. Care should be taken to present information in a professional way and to take an objective view of the patient's situation. The wording used should be factual, complete and not likely to cloud the judgement or perception of the next care provider.

7 Recommendations

Local

The Governor should design an action plan to remedy deficiencies, particularly in healthcare, revealed by this investigation. In particular:

- Baseline information is essential to monitor improvement or deterioration of a medical condition including mental health status and therefore all sections of documents should be completed and if not relevant then this should be stated, not left blank. Nursing and Midwifery Council's Guidelines for records and record keeping should be adhered to.

- The management of in-patients' care was observed to be administered inconsistently across the Healthcare Centre. Responsibilities appeared to be blurred and practice standards were not uniform, including different styles of delivery and methods of documentation keeping.

- More care should be taken to record information professionally and objectively. This issue should be addressed through staff training and performance management.

- A system should be put in place for routine checks of F2052SH records throughout the working day which should assess whether observations of a prisoner are compatible with the support plan and whether risk should be re-assessed.

- A specific member of the prison's senior management team should be designated to act as a Mentor/Supporter and, in addition to the PCT Healthcare Management Team, ensure total integration of PCT nursing staff into the regime.

- The discrepancies in the administration of pain relief should be dealt with according to the procedures appropriate to the professionals concerned.

- All nursing staff should adhere to the principles set out in the Nursing and Midwifery Council's Guideline for the administration of medicine for both administration and recording.

- Under the Nursing and Midwifery Council's code of conduct, Registered Nurses have a duty of care to prisoners to ensure that they receive safe and competent care including respecting the dignity and uniqueness of each prisoner and any actions taken by the nurse are recorded factually. Healthcare staff should adhere to this code of conduct.

* A full review of the systems, protocols and processes within the Healthcare Centre should be a priority for the Management Team (as laid out above) including a review of the integration of current Prison Service systems and initiatives. All these protocols should have management checks built into them to ensure they are overseen, managed and auditable.

* All aspects of Prison Service Standards and local audit that apply to the Healthcare Centre should be managed separately as part of the local audit system.

* An audit of the F2052SH system should be completed and the results fed into the local training plan.