Investigation into the circumstances surrounding the death of a man at HMP Whitemoor in August 2006

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the death of a man. The man died from apparently natural causes on 14 August 2006 at HMP Whitemoor. He was 50 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation has been undertaken by one of my investigators. I would like to thank the Governor of HMP Whitemoor and his staff for their co-operation in the investigation. Cambridgeshire Primary Care Trust identified a doctor to undertake a review of the man's clinical care, and I also much appreciate her assistance.

As is the case in many of my investigations following a death from natural causes, I am much influenced by the findings of the clinical review. In the case of the man, the review finds that he received good care whilst in prison. However, the clinical reviewer raises a number of concerns about the quality of record keeping that the prison and its health provider will need to consider seriously. I endorse the recommendations made in the clinical review and urge the Primary Care Trust and prison to develop an action plan to address them in a timely manner.

The man had a significant medical history of chronic illnesses, including Parkinson's disease, diabetes and asthma. His health problems required 24 hour nursing care which was provided by housing him in the prison's healthcare centre. It would appear that the man's treatment in prison was, if anything, superior to that which he would have received in the community. However, the report draws attention to a number of issues – including access to cells at night – that would benefit from further consideration.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2007**

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SUMMARY

The man was born in 1956. He was 50 years old when he died on 14 August 2006 at HMP Whitemoor. The man had been sentenced to seven years imprisonment in 1999. He was released on licence in 2004, but recalled into custody after he re-offended.

After spending some time in HMP Woodhill, the man arrived at Whitemoor on 11 January 2006. During his first health screen, it was noted that the man had Parkinson's disease, diabetes and asthma. Due to the seriousness of his condition, and the limitations it placed upon him, the man required and received 24 hour nursing care.

During the early hours of 14 August, prison staff discovered that the man had passed away. A doctor was called and death was pronounced at 3:35am.

The clinical review concludes that the man received high quality and attentive care whilst he was in the healthcare wing at Whitemoor. The reviewer notes that doctors treated the man appropriately, and consulted with colleagues in the local district hospital and other health professionals about his treatment. However, the reviewer judges that the standards of record keeping could be improved. She makes five recommendations, and identifies two examples of good practice, all of which I endorse.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by prisoners and staff.

2. The Cambridgeshire Primary Care Trust identified a doctor to carry out a review of the man's clinical care. I am grateful for this review being undertaken in a most timely manner.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to meet with the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that they would like explored and addressed. In the event, the family raised no specific matters of concern about the man's care and treatment whilst he was in custody.

5. My investigator discussed aspects of the man's treatment with staff at Whitemoor and with the clinical reviewer.

HMP WHITEMOOR

6. Whitemoor is a high security prison for Category A and B male prisoners. It is one of eight high security prisons within the prison system. Whitemoor will not accept prisoners who have sentences of less than four years. The prison is located on the outskirts of March in Cambridgeshire. The maximum number of prisoners who can currently be held at Whitemoor is 425.

7. The prison includes a pilot assessment spur examining links between dangerousness and severe personality disorder. The unit has been developed in partnership with the Department of Health and Mental Health Unit. In February 2002, this was complemented by the opening of an intervention spur developing a pilot regime for the management and treatment of dangerous and severe personality disorder. Whitemoor also has a Close Supervision Centre which opened in October 2004. The unit is a small therapeutic centre aiming to provide a supportive, safe, structured and consistent environment for prisoners considered particularly disruptive in the mainstream.

8. Provision of healthcare within Whitemoor is the responsibility of the Cambridgeshire Primary Care Trust. The healthcare centre has nine in-patient beds and includes a therapy room. It is envisaged that the therapy room will be used in the future to enhance the rehabilitative services provided by the prison. The healthcare centre employs a full-time doctor and provides 24 hour nursing care. Various out-patient clinics are run on a regular basis including: dental care, optical care, diagnostic x-ray, chiropody care and physiotherapy. Visiting Consultant Forensic Psychiatrists attend on a regular basis too. Orthopaedic, Medical, Surgical, Dermatology, Urology and Audiology specialists visit on request. Healthcare staff run nurse-led clinics such as: Diabetes, Asthma and Wellman. An out of hours service (OOH) is provided to the prison by Suffolk doctors on call (Sufdoc).

9. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable for holding it in their own possession. It is administered on a daily basis to other prisoners, when they are considered to be at risk or the medication is considered unsuitable to be held in their possession.

KEY FINDINGS

10. The man arrived at Whitemoor on 11 January 2006, after being previously held in the healthcare centre at Woodhill prison. During his health screen, it was noted that the man had been diagnosed with Parkinson's disease (a progressive disease which is due to degenerative changes in the ganglia in the base of the cerebrum), diabetes and asthma. The man had also been prescribed a range of medications to treat and manage his various conditions.

11. Due to his health problems, the man was unable to look after himself. He was often confined to bed and he required a wheelchair to enable him to get around. He was looked after on a 24 hour basis by healthcare staff. The man was moved from Woodhill as they were in the process of refurbishing their healthcare centre. On his arrival at Whitemoor, the man was immediately moved to the healthcare centre because of the nature of his illnesses.

12. On 12 January, the man was seen by the prison doctor who made a brief record of the diagnosis of Parkinson's disease, and of the man's personal care needs and medication. The man was assigned 24 hour carers, who were always male, and put on constant supervision because of his tendency to fall, and his poor mobility. Care was taken to keep him warm, and a heater was put in his cell. Two carers were required to move him and help him with feeding when necessary, and to assist with his personal hygiene needs.

13. On 4 June, a doctor from Suffolk doctors on call (Sufdoc) out of hours service visited the prison and examined the man. Although this attendance is recorded in the prison control room records, there is no record in the man's medical record of any findings.

14. The man was admitted to hospital on two occasions in the three months before his death. On both occasions, he was seen by the prison doctor and assessed before admission either personally by the doctor or following a verbal discussion with nursing staff.

15. The first admission was from 31 May to 10 June following a rapid deterioration of his condition and vomiting of brown granulated fluid, suggesting a gastrointestinal bleed (in his stomach and intestines). The diagnoses on his discharge from hospital were Parkinson's disease, bradycardia (slow pulse rate) and hypotension (low blood pressure).

16. On 20 June, the man became drowsy, refusing to drink or talk. Examination showed he had low blood pressure and slow pulse. The prison doctor discussed the man's condition with a member of the medical team at a nearby hospital. After he reviewed the man's condition later in the day and found no improvement, the prison doctor arranged the man's admission to hospital. The man was discharged on 21 June, having had an ultrasound scan which was normal.

17. On 19 July, one of the man's carers recorded that he appeared to be having hallucinations, was coughing and had a "rattly chest". The carer asked the prison doctor to assess him. There is no record of the doctor having done so, and he cannot recall whether he did see the man on that day.

18. On 20 July, the care record states that the prison doctor saw the man after appointments. However, the doctor did not record this examination in the medical notes. When he was interviewed by the clinical reviewer, the doctor thought that he might have reduced the man's medication as a result of his findings, but the drug record does not show any reduction. The doctor also recalled discussing such a reduction with the community psychiatric nurse on the telephone.

19. On 29 July, the prison doctor took blood for glucose and thyroid function levels. There is a result in the notes for the blood sugar, which was normal, as was the thyroid stimulating hormone (TSH). The doctor has said that he took the blood tests because of the man's drowsiness. There is no record of the doctor's actions on this date in the medical record, although the care record notes that he took blood tests.

20. On 31 July, the carers recorded that the man was uncooperative, violent and refusing medication. The man was started on a course of antibiotics, which the prison doctor stated were for a urinary tract infection which he diagnosed after dip testing the man's urine. The doctor also sent a urine sample for laboratory testing. There is no record of this or of the doctor's examination in the medical notes. On 3 August, the carer recorded that the man was brighter and looking well.

21. On 6 August, the carer recorded that the man was less chesty than before, and in a pleasant mood. The records showed that on 7 August, the carer noted that the man had foul smelling urine and, on 9 August, there is a record of the results of urine analysis by dipstick. The prison doctor also sent a further sample for laboratory testing. The doctor did this test, but again did not record his examination in the medical record.

22. On 12 August, results of the laboratory urine test confirmed the dipstick findings, but no growth. Later that night, the carer recorded that the man had breathing problems but these were not bad enough to call the duty doctor. There is no record of any assessment by the nurse on duty.

23. On 13 August, one of the man's carers recorded that at 8:30pm he was concerned about the man's condition as he was wheezing and had foam around his mouth. The carer was advised to observe the man closely until 10:45pm when the gate to his cell would be unlocked.

24. The carer sat outside the man's cell for about 30 minutes during which time he noted that the man's eyes were open, and that he was quiet but wheezing. When the carer was able to enter the cell, he was still concerned and he called the duty nurse who checked the man's breathing and air passages. On the duty nurse's advice, the carer then raised the man's sleeping position, gave him some water and continued his usual care routine. The carer recorded that the man became more alert and his breathing improved.

25. On 14 August at 00:05am, the cell gate was relocked. The carer observed the man at roughly 20 minute intervals, on each occasion shining a light and waiting for a response from the man. At 1:30am, he found no sign of movement and no breathing sounds. There was no reaction from the man to the light, shouting or knocking on the door. The carer then called the duty nurse who was next door in the segregation unit. A prison officer, who was also in the segregation unit, was called to open the cell gate. Both the nurse and carer estimated that it took less than two minutes for the officer to arrive and unlock the gate.

26. The nurse said that she found the man looking greyish white, with very pale extremities. She checked for vital signs and found none. Because of the man's appearance she deduced that he had been dead for a while. The nurse therefore decided appropriately not to attempt resuscitation as she felt it would have been unsuccessful. Suffolk doctors on call (Sufdoc) out of hours service were contacted and asked to send a doctor to confirm death. The doctor refused to attend the prison stating that it was Sufdoc policy not to do this. The police surgeon was therefore contacted and death was pronounced at 3:35am

27. The prison contacted the man's family to inform them of his death and to offer condolences and support. The prison's family liaison officers maintained contact with the family and assisted with arrangements for the funeral. They also attended the man's funeral. The prison provided financial assistance with the funeral costs.

28. The post mortem report records the cause of death as due to natural causes as a consequence of bronchopneumonia and Parkinson's disease.

CLINICAL REVIEW

29. A clinical review was undertaken on behalf of Cambridgeshire Primary Care Trust. The reviewer finds that the man had very poor health, with fluctuating mobility and mood, and was very dependent on his carers. He was known to have difficulty maintaining his blood pressure and body temperature, and it was accepted that his condition was likely to be terminal. While in hospital, the doctors decided that it would not be in his interests to attempt resuscitation and communicated this to the prison healthcare staff on two separate occasions.

30. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The reviewer concludes that the man received high quality and attentive social and personal care in the healthcare centre during his stay. Carers treated him with respect, despite his regular violence towards them. They considered his recreational and dietary needs, and delivered a high level of personal care that he would have been unlikely to have received in the wider community.

31. The man was transferred from the healthcare wing at Woodhill with a current care plan, and therefore a full examination and induction was deemed inappropriate when he arrived at Whitemoor. He was seen both by the nursing staff and by the prison doctor in the first 36 hours. His mental state was assessed and he was deemed not to be at risk of self-harm or suicide.

32. The prison doctor treated the man appropriately, and consulted with colleagues in the local district hospital and other health professionals about his treatment. The prison doctor was quick to refer the man to hospital when his condition gave cause for concern.

33. When interviewed by the clinical reviewer, both the man's carer and the head of prison healthcare, said that the prison doctor attended the man regularly and always when requested by the carers or nursing staff. After her interview with the prison doctor, the clinical reviewer thought that it was clear that he was conversant with the man's condition and history.

34. However, the clinical reviewer finds evidence that the prison doctor did not always record his contacts with the man in the medical record. Some investigations, concerns, examinations and treatment are missing from the medical record, although contacts are clearly stated in the carers' record. The last entry by the doctor in the man's medical records was dated 20 June 2006, despite evidence that he saw the man on 20 July, 26 July, and on 9 and 10 August 2006. The clinical reviewer notes that, during her interview with the prison doctor, it was clear that his memory for the exact dates and chronology of events was vague, which makes it difficult to be sure about when and why certain actions were taken. However, the reviewer does not think that the failure to record contacts contributed to the man's death.

All contacts, whether personal or on the telephone, by a doctor with or about a patient should be recorded fully in the medical record. This should be audited.

35. The reviewer notes that, when the man's carer arrived on duty on 13 August, he was unable to enter the man's cell immediately despite his concerns about his condition. The cell was locked for over two hours following the carer raising his concerns with the nursing staff. Normally at night, in the event of serious concerns, it might take up to 15 minutes for the prison officer with keys to get to the healthcare wing to unlock a cell. On the occasion when the carer raised further concerns, the keyholder was close by so there was minimal delay. In this case, the procedure for unlocking the cell did not contribute to the man's death. However, as resuscitation should ideally be started as soon after apparent death as possible, there is the risk that this delay in unlocking a cell at night could contribute to a patient's death by significantly delaying the onset of resuscitation.

Consideration should be given to reducing the delay in unlocking cells at night. This delay could in the future compromise good medical care.

36. The reviewer notes that the policy regarding resuscitation of prisoners at Whitemoor is that all should be resuscitated unless the doctor has made a clear instruction in cases of terminal illness, or where there are conditions unequivocally associated with death. Neither of these conditions applied to the man. The duty nurse gave clear reasons for her decision not to resuscitate the man. In the reviewer's opinion, these reasons are acceptable. However, the nurse was not aware of the prison policy on resuscitation in these circumstances.

All nursing and care staff should be fully conversant with the prison policy on resuscitation decisions.

37. The man's carer was aware of the do not resuscitate (DNR) instructions initiated while the man was in hospital, but would have resuscitated him in the prison had the duty nurse not made the decision not to resuscitate. However, the carer accepted this decision as reasonable. The carer is trained in resuscitation.

Consideration should be given to discussing do not resuscitate (DNR) decisions about patients considered terminally ill. The prison policy on resuscitation allows for a doctor to make such a decision in consultation with the patient or his representative, if the condition of the patient warrants it.

38. The reviewer draws attention to the out of hours medical service supplied by Suffolk doctors on call (Sufdoc). On 4 June 2006, a doctor from Sufdoc visited the prison and examined the man. This attendance is documented in the prison control room records. However, there is nothing in the man's medical record of any findings, and under the present system Sufdoc would not send the record of this consultation to the prison healthcare centre. The reviewer accepts that security issues make it essential that names of prisoners are not used when contacting the out of hours service. However, the reviewer also notes that Sufdoc does not send details of contacts with their service to the prison healthcare team, other than monthly reports of the numbers of such contacts. As a result, no clinical details are available to the prison doctor or other prison medical staff following a consultation. The reviewer notes that the head of prison healthcare is in the process of working out a system of unique numerical identifiers for patients in the prison, so that there can be better communication and exchange of clinical records between Sufdoc and prison healthcare. The reviewer also notes that all calls from Sufdoc are directed to the control room, and are recorded.

There should be a system for communicating the clinical record of a consultation by a doctor working for the out of hours service within 24 hours of the patient being seen. This must not compromise security.

39. The reviewer draws attention to the good practice adopted by the prison in relation to the man. She judges that the quality of social and personal care given to the man was of a high standard, and probably beyond that which he would have had in the general community. The reviewer also concludes that the man was referred promptly to hospital when necessary, and communication with the hospital was maintained throughout his admission.

CONCLUSION

40. The man returned to prison in April 2004. He died of apparently natural causes in August 2006. The man had arrived in prison with a number of heath problems. He had a history of Parkinson's disease, diabetes and asthma.

41. In light of the findings of the clinical review, and my own investigation, I conclude that the man's medical care was entirely satisfactory. I have endorsed the five recommendations (and two indications of good practice) from the clinical review to be addressed by the Cambridgeshire Primary Care Trust in partnership with the Governor of Whitemoor.

RECOMMENDATIONS

Medical

1. **All contacts, whether personal or on the telephone, by a doctor with or about a patient should be recorded fully in the medical record. This should be audited.**

   Accepted by the Prison Service

2. **Consideration should be given to reducing the delay in unlocking cells at night. This delay could in the future compromise good medical care.**

   Accepted by the Prison Service

3. **All nursing and care staff should be fully conversant with the prison policy on resuscitation decisions.**

   Accepted by the Prison Service

4. **Consideration should be given to discussing do not resuscitate (DNR) decisions about patients considered terminally ill. The prison policy on resuscitation allows for a doctor to make such a decision in consultation with the patient or his representative if the condition of the patient warrants it.**

   Accepted by the Prison Service

5. **There should be a system for communicating the clinical record of a consultation by a doctor working for the out of hours (OOH) service within 24 hours of the patient being seen. This must not compromise security.**

   Accepted by the Prison Service

Good Practice

The quality of social and personal care given to the man was of a high standard, and probably beyond that which he would have had in the community.

The man was referred promptly to hospital when necessary and communication with the hospital was maintained throughout his admission.