Investigation into the circumstances surrounding the death of a man at hospital, while a prisoner at HMP Wymott, in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the circumstances surrounding the death of a man who died from natural causes aged 81 years. He was recalled to prison in 2009 for breaching the terms of his licence. He transferred to HMP Wymott in June 2010. He became increasingly frail in prison and, in December 2010, he was transferred to an in-patient bed in the healthcare centre at HMP Preston. He was taken to hospital on 29 May 2011 after becoming gravely ill. He died two days later in hospital.

The investigation was led by one of my colleagues and a family liaison officer was appointed. The man had not been in touch with his family for many years. The family liaison officer wrote to his brother to explain the nature of my investigation and to offer him the opportunity to ask questions about his brother's care in prison. I hope this report answers the families questions.

A clinical review of the health care given to him was commissioned from the local Primary Care Trust. A clinical reviewer was appointed to write the review and I am grateful for his report.

I am also grateful to the liaison for the investigator at HMP Wymott, and to the liaison at HMP Preston, for their help and co-operation with the investigation.

The man was an elderly and frail man with a number of health problems. I conclude that the care he received in both Wymott and Preston was appropriate and at least equitable with that he could have expected to receive in the community. I make four recommendations relating to administrative procedures in healthcare at Preston. I also make a single recommendation about management reviews of the levels of escort and restraint of seriously and terminally ill prisoners on bedwatch.

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

Thea Walton
Acting Deputy Ombudsman **November 2011**

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SUMMARY

1. The man died in May 2011 aged 81 from natural causes in hospital. The primary cause of death was severe bleeding in the lungs as a result of a ruptured aortic aneurysm (a weakening of the main artery leading from the heart).

2. In October 2008, he was sentenced to three years imprisonment for five counts of indecent assault on children. It was his first time in custody. He was released on licence from HMP Stafford on 16 April 2010. His licence was revoked a few days later, on 19 April 2010, after he breached five of the conditions. He was taken to HMP Hewell and transferred to HMP Wymott on 25 June 2010.

3. He suffered from a number of chronic health problems. He had osteoporosis in his spine, gall stones, an enlarged prostate and high cholesterol. Some ten years previously he had an operation to repair an aortic aneurysm. He had limited mobility and suffered progressive incontinence.

4. On 24 November 2010, he was admitted to hospital after becoming jaundiced (indicating poor liver function). He remained there until 13 December. His discharge notes showed that he was suffering with congested cardiac failure, liver failure, fluid in the lungs, bleeding in the gastro-intestinal tract and enlarged lymph nodes in his throat. He was transferred to an in-patient bed in HMP Preston on 15 December because Wymott could not provide sufficiently for his needs.

5. He settled at Preston. He was given a zimmer frame to help him maintain independence. He had a number of falls in his cell and his health remained frail. Between 16 and 20 April 2011 he was admitted to hospital with viral gastro-enteritis. On 28 May he was noticed to have a distended upper abdomen. When this had not improved the next day he was admitted to hospital.

6. On 29 May, the hospital informed Wymott that he might have pneumonia and had a 50:50 chance of survival. Wymott began the process for identifying his next of kin. On Sunday 31 May, he quite suddenly began to cough up blood. Escort staff immediately alerted hospital staff but he died some 20 minutes later.

7. I conclude that he received appropriate and timely medical care at Wymott and Preston and that this was equitable with that he could have expected in the community. I make four recommendations relating to administrative procedure in Preston healthcare.

8. I consider that there was scope to review his level of escort and restraint during his last two days and make a recommendation about this.

THE INVESTIGATION PROCESS

9. We were notified of the man's death on 31 May 2011. The investigation was allocated to an investigator the next day. Notices were issued to staff and prisoners at Preston telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. She did not receive any response to these notices.

10. Another investigator visited Preston to open the investigation on 6 June. He visited the healthcare centre and spoke to the chronic disease lead for the Primary Care team. He also spoke to a prisoner who had shared a dormitory room with the man. The prisoner was very positive about the level of care he had received at Preston. The investigator arranged for the man's medical record to be posted to the lead investigator.

11. The investigator visited HMP Wymott on 14 June. She examined the man's prison record and took copies of relevant documents. She spoke to two members of staff from HMP Preston and on the telephone to the Security Senior Officer from HMP Wymott. She fed back progress on the investigation to the Head of Healthcare at Preston.

12. A clinical review of the man's medical care was requested from the local Primary Care Trust. The Deputy Head of Healthcare at HMP Kennett was appointed to undertake the review.

13. The senior family liaison officer wrote to the man's brother to tell him about the investigation and offer him the opportunity to ask any questions about his brother's death. He did not raise anything at the outset of the investigation but after reading the draft report he commented that the use of restraints at hospital seemed "over-zealous in the circumstances".

14. The investigator spoke to the Coroner's Officer. The cause of death was given as:

> "1a: haemoptysis [coughing up blood]
> 1b: ruptured thoracic aortic aneurysm [swelling of the aorta] with pulmonary haemorrhage [acute bleeding from the lungs].
> 2: coronary artery atherosclerosis [thickening of the artery walls]."

HMP PRESTON

15. HMP Preston accepts adult male prisoners over the age of 20 from the courts serving Lancashire and Cumbria. Mainly Victorian, its wings were built between 1840 and 1895 on a site which had been occupied since 1790. It became a local prison in 1990.

16. The purpose built healthcare centre opened in 2006. Health services are provided by the local Primary Care Trust. The centre has 30 beds and contains the in-patient facility for the north-west region. These beds can also be accessed by HMP Wymott, HMP Risley and HMP Garth. There are 18 beds on the ground floor for mental health patients and 12 beds on the first floor for patients with physical health problems. The beds are arranged in a mixture of single rooms and three bed dormitories. There is no set number of beds for use by Preston or any of the other prisons in the region and they are allocated according to clinical need.

17. The in-patient facility holds prisoners who are too ill for normal location but do not require admission to an outside hospital. Admission is arranged by referral from the original establishment followed by an assessment from the team at Preston. Prisoners in the regional beds remain the responsibility of the prison they originate from. Escorts, bedwatches and constant watches are undertaken by staff from the originating prison but healthcare is provided by Preston.

18. On the physical needs landing (H2), there are five staff on duty during the day, and two at night. This is a mix of nurses and healthcare support workers. There is a full-time doctor in the prison between 9.00am to 8.30pm Monday to Friday. The doctor is not exclusively based on H2. At night and at weekends, on-call cover is available through a contract with the Indigo Agency.

19. There have been 14 deaths at Preston since the Ombudsman took responsibility for investigating fatal incidents in April 2004. In a previous investigation into the death of a man in 2010 I concluded that the standard of care he had received in the in-patient unit at Preston was of a high standard. In that case I also made a recommendation regarding the importance of clear and accurate record keeping.

HMP WYMOTT

20. HMP Wymott is a large prison holding adult male sentenced prisoners to a maximum capacity of 1,174. Mainstream prisoners and vulnerable prisoners are held in separate accommodation meaning Wymott is effectively two separate prisons each with its own range of workshops, education and training facilities. The prison opened in 1979 and new accommodation was added in 1996. Wymott holds a number of elderly prisoners on a dedicated unit known as I wing.

21. Like Preston, healthcare services at Wymott are commissioned and provided by the local Primary Care Trust. The healthcare centre is centrally located.

GP services are provided by a private company, and clinics are run every weekday morning and two afternoons each week. Out-of-hours medical cover is provided by the same company. There are no inpatient beds but nursing cover is provided 24 hours a day.

KEY EVENTS

22. In October 2008, aged 78, the man was sentenced to three years imprisonment for five counts of indecent assault on children. It was his first time in custody. He was released on licence from HMP Stafford on 16 April 2010. His licence was revoked a few days later, on 19 April 2010, after he breached five of the conditions. He was taken to HMP Hewell and transferred to HMP Wymott on 25 June 2010.

23. A number of health issues were noted during his induction interview at Wymott, including the fact that his glasses had been lost and his hearing aid was broken. His initial health screen recorded that he had an operation to repair an aortic aneurysm (the widening and therefore weakening of a section of the large artery leading out of the heart) ten years previously. At Hewell, he had been prescribed anti-inflammatory tablets and a variety of medication for an enlarged prostate, high cholesterol and heartburn. Due to his age and severe lack of mobility he was located immediately on I wing with other elderly prisoners.

24. His prison record shows that he mostly remained in his cell, coming out only to walk to the dining hall for meals. He told staff that he was not anti-social and did not have any problems with his fellow prisoners but his health problems meant he preferred to keep to himself. He did not receive any visits or other contact from people outside the prison while at Wymott.

25. In October 2010, he told staff his lower back was increasingly painful. He was referred for an x-ray and given painkillers. The x-ray results were received on 22 October, and showed the partial or complete collapse of several of his vertebrae due to osteoporosis (a condition causing the bones to become fragile and break easily), and the presence of ten or more calcific densities (gall stones) in his bladder. He was examined by a doctor at Wymott on 3 November who reviewed the x-ray results. He said he had no symptoms indicating bladder problems. He was given a prostate specific antigen blood test and tests to identify any inflammation but, on 15 November, all of these were found to be normal

26. Two days later, he was diagnosed with a urinary infection. On 20 November, he was seen vomiting and looking jaundiced (yellow in colour due to poor liver function). Nursing staff thought he looked dehydrated and encouraged him to drink more fluids. Two days later, he had not improved and was seen by the doctor. The doctor noticed that he had lost some six kilograms since May 2010. He suspected an underlying malignancy and referred him to outside hospital under the two week rule for patients who might have cancer. He continued to look jaundiced and, when a liver function test on 24 November gave an abnormal result, he was admitted to hospital.

27. His condition was described as “unstable” on 27 November. He had a high temperature and pleural effusion (fluid in his lungs). On 10 December, his personal officer visited him. He reported that the man was very unwell and

had received a full blood transfusion. On 12 December however the hospital contacted Wymott to say that he could be discharged back to prison.

28. On 13 December, Nurse A, a staff nurse from Wymott, visited him in hospital to review his needs. Hospital staff told her that he had heart failure, could not feed himself, had poor mobility and was incontinent. She concluded that given the intensity of care he required, it would not be possible for staff to look after him at Wymott. An in-patient bed at Preston was requested and he transferred there on 15 December.

29. His discharge notes showed he was suffering from congested cardiac failure, liver failure, bleeding in the gastro-intestinal tract, fluid and congestion in his lungs and enlarged lymph nodes in his throat. He was not found to be suffering from cancer. His electronic medical record shows that he settled on the in-patient unit at Preston. He was able to feed himself and move short distances using a zimmer frame. He remained incontinent and needed encouragement to do as much for himself as possible. On 25 December, staff noticed that he was not taking his medication but was secreting it in his bedding. On the same day, he overbalanced in his cell but was able to pick himself up unaided when staff encouraged him to do so.

30. The following day, he had a full review with Nurse B. On 27 December, he was again found on the floor of his cell and had to be helped back to bed. There were no signs of injury and he did not complain of any pain. Prison Doctor A examined him the same day and advised staff to observe him regularly.

31. He fell out of bed on 31 December and sustained small cuts to his right eyebrow and elbow. He was reviewed regularly and his care plan was updated. On 6 January 2011, he transferred back to HMP Wymott after being assessed as self-caring and mobile.

32. Nurse C raised concerns about his condition when she gave him his morning medication on 7 January. He was reviewed by Nurse D who concluded that he needed daily care that could not be provided by the healthcare assistants on I wing. She spoke to staff at Preston and he returned to the in-patient unit there the same afternoon.

33. He continued to be looked after at Preston with regular reviews and updates to his care plan. He was assisted with showering and personal hygiene. He continued to be incontinent and wore pads on a permanent basis. His mobility remained poor but he was encouraged to be as independent as possible. He was provided with a zimmer frame to help him take himself to the toilet. On 18 January, he moved to a cell with a raised toilet and electric bed. He had further falls in his cell on 23, 24 and 25 January, but only sustained minor injuries. He regularly complained of back pain and this was treated with painkillers and reviewed by the doctor. In February, he was also provided with a wheelchair so staff could take him outside for fresh air.

34. His general health was poor but he remained stable until 28 March when he was diagnosed with a lower respiratory tract infection and prescribed anti-biotics. He was unsteady on his feet and staff reported that he appeared very weak. The next day he was described as looking very frail but recovered over the next few days and by 4 April staff reported that he had returned to his normal level of mobility.

35. On 16 April, Healthcare Support Worker (HCSW) A was called into his cell. He had vomited and was pale and shaking. As it was a weekend, staff called an emergency doctor from the out of hours service. He diagnosed viral gastroenteritis (stomach flu) and decided that the man needed to be in hospital. He was taken to hospital by ambulance within an hour of seeing the doctor.

36. Staff at Preston rang the hospital daily for updates on his condition. He was reported to be poorly and continuing to vomit. Scans and ultrasound showed that he had gallstones. He stopped vomiting on 19 April and was discharged back to Preston on 20 April.

37. On Saturday 28 May, the emergency doctor was again called in to see him as an emergency after staff became concerned that he did not seem himself. The doctor thought that he had an infection – either an unresolved one in his lower respiratory tract or a urinary tract infection. He prescribed anti-biotics and advised staff to call him back or call an ambulance if he did not improve.

38. The next day, the Head of Healthcare reviewed him. She reported that he was very “chesty” and the upper part of his abdomen was distended. He appeared very weak but did not complain of any pain. HCSW A told her that he had coughed up blood when she gave him his morning medication. She called the emergency doctor who advised her to send him to hospital immediately.

39. A hospital/bedwatch risk assessment was completed. The Head of Healthcare completed the section on medical information. She wrote that she had no medical objection to him being handcuffed on escort but that he would need an escort chain if further investigations were required. In the section on ability to escape, she wrote that he did possess the ability to escape but his mobility was very poor and he used a zimmer frame. She told my investigator that if the patient is at all mobile she is obliged to write that he has the ability to escape, however she always adds more information about the level of mobility so the security officer who decides on the level of handcuffing and escort can make a suitable assessment.

40. At about 3.00pm, two officers from Wymott went to Preston to collect him and escort him to hospital in the ambulance. He was handcuffed to one of the officers during the escort, which is standard practice for escorting a category C prisoner. The Senior Officer in the security department at Wymott confirmed to my investigator that, once he had been admitted to a ward, the handcuffs were removed and replaced with an escort chain (a length of chain one end of which is cuffed to an officer and the other to the prisoner).

41. At about 4.00pm, the Head of the category C prison at Wymott was told by Preston that the hospital suspected that he had pneumonia and that his chances of surviving were “50-50”. The Head decided to try to establish the identity of the next of kin. The bedwatch staff were contacted and reported that he had told them that he did not want his family to be contacted. The Head asked them to keep checking with him that this remained the case.

42. The bedwatch log shows that he slept for long periods during 30 and 31 May. A management check took place at 6.55pm on 30 May but no reduction in the level of escort or restraint was made. He complained of being cold but was found to have a temperature. Officer A was on bedwatch duty from 1.00pm on 31 May. In his statement he said that he slept until about 3.30pm. He talked a little to him and Officer B, who was also on duty. He asked repeatedly for a cigarette but was not allowed one. A further management check took place at 4.00pm but again no reduction in the levels of escort or restraint was made.

43. Officer A said he complained of feeling uncomfortable and so he told a nurse who spent some time trying to change his position. At about 5.25pm, he started coughing and the officer noticed blood coming from his mouth. Nurses were called and the officer removed the escort chain. The officers waited outside the curtained bay while hospital staff attended to him. At 5.46pm doctor told them that he had died of severe bleeding in the lungs.

Family liaison

44. He had no contact with his family while in prison. He had told staff at Wymott that he did not want his family told that he was in hospital. When he died, the Duty Governor at Wymott contacted the Duty Governor at Preston to find out details of his next of kin. He had given the name and address of his brother but no telephone contact. The Acting Deputy Governor at Wymott, asked Leicestershire Police to go to the address given and break the news to the family. The police, however, found that his brother did not in fact live at this address.

45. The next morning, the Acting Deputy Governor telephoned his Offender Manager, who was able to give her the brother’s telephone number. She then contacted him to tell him the news. He confirmed that the address given by his brother was in fact wrong.

46. A family liaison officer was appointed for the prison. He visited the man’s brother to return his prison property. The prison assisted the family with the cost of the funeral.

ISSUES

The management of the man's health issues

47. The clinical review contains an analysis of the treatment of the man's different health issues at HMP Wymott and HMP Preston. Clearly, he was chronically ill at Wymott and Preston. The clinical reviewer concludes that staff at both prisons addressed his health issues appropriately and that the care he received was equitable with that he could have expected to receive in the community.

48. The Post Mortem report shows that he died as a result of coughing up blood due to a ruptured thoracic aortic aneurysm and bleeding in the lungs. On his return to prison in 2008, he informed healthcare staff that he had had an operation some ten years previously to repair an aortic aneurysm. In November 2010, a scan at hospital showed that his aorta was calcified, dilated (ectatic) and that blood clots (mural thrombi) were present. The hospital did not recommend any intervention following this discovery.

49. On 28 May, staff noticed he appeared unwell and he was examined by a doctor. The clinical reviewer concludes that his symptoms and baseline observations did not point to a possible haemorrhage and the doctor's decision to treat a possible infection and transfer him to hospital if he did not improve was reasonable. The next day, at 9.47am, the Head of Healthcare recorded that his upper abdomen was still distended and that he had blood in his sputum. She called the emergency doctor who called back at 12.42pm and advised that he should be taken to hospital. An ambulance was arranged and he was taken to hospital at 3.00pm. In his report, the clinical reviewer says he does not think this delay of some two and a quarter hours made a difference to his chances of survival.

50. The clinical reviewer concludes that the man's urinary incontinence, urinary infections, and lower back pain were treated appropriately throughout his time in Preston. He notes that he had several falls while in Preston and that his vital signs were only recorded on two occasions immediately afterwards. He believes that his history of low blood pressure could have been explored further to establish whether this had any relation to his falling. He also observes that the form F213 Report of Injury to Inmate was not completed on two of the seven occasions he had a fall. Accordingly we make the following recommendations:

The Head of Healthcare at Preston should remind all staff of the importance of completing form 213 Report of Injury to Inmate in all instances when a patient sustains an injury.

The Head of Healthcare at Preston should review the process of assessment following a fall by a patient to ensure that vital sign observations are routinely taken to help identify any possible underlying conditions.

51. The clinical reviewer concludes that there is evidence of good record keeping by most healthcare staff at Preston. However, he draws attention to various examples where the record is not clear about what medication was given to the man and when and where the drug administration card has not been completed. We make the following recommendations:

The Head of Healthcare at Preston should ensure that nursing staff who administer medication enter the correct information on the drug administration chart.

The Head of Healthcare at Preston should remind staff that all assessments, reviews or contact with a patient should be entered in the clinical notes.

Escort/bedwatch 29 - 31 May

52. Guidance to prison staff about escorts and bedwatches in outside hospital is contained in the National Security Framework (NSF). The NSF provides that a risk assessment to decide the level of escort and restraint required must take place before a prisoner is moved to hospital. The risk assessment must take into account the prisoner's medical condition, the prisoner's security category, the nature of offence, the risk to the public and hospital staff, the prisoner's motivation to escape and the physical security of the hospital. The normal arrangement for prisoners on escort is two officers. Restraints must be used unless there are medical objections and up to the point of medical consultation, when they should be removed. They are normally reapplied as soon as the consultation is complete. Management checks take place daily and a requirement of these is to review the level of escort and restraint.

53. The NSF also includes guidance on the level of escort and restraint appropriate for seriously or terminally ill prisoners. The relevant section says:

> "Such circumstances require delicate handling to ensure that not only is the balance between security and the clinical needs of the individual met, but also that the legal test of balance in the decisions reached are also met and supported by fully completed risk assessment documentation. Under such circumstances individual risk assessments will also require a more frequent level of review … "

54. The man, as a category C prisoner, was taken to hospital with an escort of two officers. During the escort he was handcuffed to one of the officers. This is standard practice when escorting a category C prisoner to outside hospital. In line with Preston's local policy, once he was admitted to the ward the handcuffs were replaced with an escort chain. This was removed immediately he began coughing up blood on 31 May to allow nursing staff to begin treating him.

55. He was a frail and elderly man with severely limited mobility. He was only able to walk using a zimmer frame and had fallen on several occasions in his cell in Preston. On 29 May, Wymott were informed that his chances of

survival were only 50-50. As a result the Head of Wymott Prison began trying to find out who was his next of kin. The original bedwatch risk assessment also refers to him as "terminally ill". From the accounts of escorting staff at hospital, he was mostly asleep, not interested in eating or drinking and did not leave his bed. In the circumstances we consider that an escort of two officers was more than sufficient to ensure public safety and the safety of him. We have not seen any evidence that a reduction in the level of escort or restraint was considered under the provisions of the NSF at the daily management checks on 30 or 31 May.

56. In the light of his severe lack of mobility and very poor health we consider that, especially once it was established that he had only a 50-50 chance of surviving, there was scope to consider removal of the escort chain and even a reduction in the level of escort to a single officer. The balance between public safety and dignity for the individual can be a difficult one to strike. Despite the nature of his offences we consider that his risk to the public and his risk of escape was significantly diminished.

I recommend that the Governors of Wymott and Preston ensure that the local instructions to staff reviewing escorts and restraint for seriously or terminally ill prisoners on bedwatch comply with the guidance in the NSF and that relevant staff are aware of these.

Family liaison

57. The Head of Wymott Prison began the process of identifying the man's next of kin on 29 May when he learned that he was suspected of having pneumonia and was given a "50-50" chance of surviving. He was asked whether he wanted anyone to be told that he was in hospital and he said he did not. He had not had any contact with his family during his time in Wymott or Preston and in fact it transpired that he did not have up to date contact details for his next of kin. After he died all reasonable attempts were made to contact the next of kin that evening. The next day, when the correct contact details were obtained, Wymott rang his brother.

58. We consider that every effort was made to contact his next of kin in a timely manner. Wymott complied with the guidance in Prison Service Order 2710 Follow up to deaths in custody, maintaining contact with the family, returning property and offering to assist with funeral expenses.

CONCLUSION

59. He was an elderly man who was chronically ill for the last several months of his life. He received appropriate medical treatment and care while at Wymott and Preston. His final illness came upon him quite suddenly and he was taken to hospital in a timely manner. We consider that there was scope to reduce the level of restraint and escort at hospital during his last two days and we make a recommendation about this. I make four recommendations about administrative practices in the in-patient unit at Preston.

RECOMMENDATIONS

The following recommendation is a local recommendation and is directed to the Governors of Wymott and Preston:

1. I recommend that the Governors of Wymott and Preston ensure that the local instructions to staff reviewing escorts and restraint for seriously or terminally ill prisoners on bedwatch comply with the guidance in the NSF and that relevant staff are aware of these.

   This recommendation was accepted at draft report stage and the prison commented:
   "Managers have been reminded of the Guidance regarding the use of restraints for seriously and/or terminally ill patients."

The following recommendations are local recommendations and are directed to the Head of Healthcare at Preston.

1. The Head of Healthcare at Preston should remind all staff of the importance of completing form 213 Report of Injury to Inmate in all instances when a patient sustains an injury.

   This recommendation was accepted at draft report stage.

2. The Head of Healthcare at Preston should review the process of assessment following a fall by a patient to ensure that vital sign observations are routinely taken to help identify any possible underlying conditions.

3. The Head of Healthcare at Preston should ensure that nursing staff who administer medication enter the correct information on the drug administration chart.

   This recommendation was accepted at draft report stage and the prison commented:
   "All staff to receive an update on medical records and documentation. Staff informed by the Head of Healthcare of the importance of adhering to the NMC guidance for the safe administration and recording of medicines."

4. The Head of Healthcare at Preston should remind staff that all assessments, reviews or contact with a patient should be entered in the clinical notes.

   This recommendation was accepted at draft report stage and the prison commented:
   "All assessments and reviews now documented on systm1 notes and care plans and assessments are now all electronic with no paper information being stored."