Investigation into the circumstances surrounding the death of a man at HMP Wakefield in May 2009

Report by the Prisons and Probation Ombudsman for England and Wales

November 2010

This is a report of an investigation into the circumstances of the death of a man at a local Hospital, on 8 May 2009. The man was a prisoner at HMP Wakefield .

The man collapsed in his cell on the morning of 8 May 2009. Although his health was poor, his death was sudden and unexpected. The post mortem confirmed that the cause of death was pancreatitis. I would like to offer my sincere condolences to the man's family, friends and to all those who knew him. I apologise for the delay in issuing the report and any additional distress this may have caused.

Two of my colleagues conducted the investigation. An independent review of the man's medical care was undertaken by the Practice Nurse Facilitator and a Doctor from Wakefield District Primary Care Trust. I am grateful to them for their valuable contribution.

I also wish to thank the former Governor and her staff for their cooperation. Particular thanks go to a Senior Officer whose help and assistance was invaluable when the investigators visited the prison and to the Reverend who provided a good standard of liaison.

The investigation has shown that prison healthcare staff responded each time the man reported abdominal pain and referred him to hospital appropriately. When he collapsed in his cell, he was taken back to hospital and died a few hours later.

I am satisfied that there is no evidence that the man's death could have been prevented. However, improvements should be made to clinical procedures such as record keeping, communication, clinical decision-making and the handling of information from external hospitals. I make three recommendations and a fourth regarding the payment of funeral expenses.

The National Offender Management Service has accepted three of my recommendations and partially accepted a fourth. Their response is documented on page 16 of this report.

Jane Webb
Acting Prisons and Probation Ombudsman **November 2010**

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SUMMARY

The man was sentenced to ten years imprisonment at a local Crown Court in August 2004. He served a short period at Leeds prison at the beginning of his sentence before transferring to HMP Wakefield in December 2004.

On reception to prison, the man underwent routine health screening. This showed that he had a longstanding respiratory condition which required occasional hospital treatment. He had been diagnosed with a number of other, less serious, ailments which were managed by the prison healthcare department.

In April 2009, the man reported abdominal pain to the medical staff at the prison. His discomfort was recorded with increasing regularity. On 25 April, he was admitted to hospital where he was found to have a swollen stomach, increased respiratory rate and raised pulse. He returned to the prison two days later and was considered fit enough to return to his cell.

The man was in regular contact with healthcare staff during the period leading up to his death. On 28 April, he told staff he was feeling better, however it was also noted that he had lost a lot of weight.

On 5 May, the man was examined by a prison doctor who thought he might have a bowel obstruction. The doctor arranged for the man to be taken to hospital as a matter of urgency. Following treatment for abdominal discomfort and constipation, he returned to HMP Wakefield. Two days later, the prison arranged for the man to go to hospital for a review. No change was noted in his condition and the man returned to the prison. Later that day, the man complained to prison staff of breathlessness and, after taking respiratory medication, he improved.

At 9.37am on 8 May, the man collapsed in his cell and was immediately assisted by wing staff nearby. Medical staff arrived quickly and an ambulance was called. There was also some concern that the man might have injured his head as he fell.

The prison medical staff helpfully printed out the man's full medical history for ambulance staff to take with them to the hospital as well as handing over the man's medication, hearing aid and glasses. This was good practice.

The man had emergency surgery at the local hospital. Later that day, the hospital advised a principal officer (PO) that the man was extremely ill and might not survive. At 11.00pm the hospital telephoned to say that he had died.

The investigation finds that the man received appropriate care at Wakefield. Staff responded to his medical needs and referred him to outside hospital appropriately. However, the clinical review reveals some shortcomings in clinical procedures and I have made relevant recommendations as well as the prison's failure to contribute to the man's funeral expenses.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 9 May 2009. Terms of Reference and notices were issued to staff and prisoners at Wakefield telling them that an investigation would be taking place, and inviting those who wished to see the investigators to make themselves known. The investigators requested copies of the man's prison records including medical records, wing sheets, security information, hospital bed watch logs and the family liaison log.

2. The investigators also contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. The post mortem report was received on 16 October. The post mortem records that the man died of:

   1(a) Intra Abdominal Haemorrhage
   (b) ruptured spleen associated with Acute on Chronic Relapse in Pancreatitis

3. The coroner has requested a copy of my report upon completion and I am happy to comply.

4. The investigators visited Wakefield on 30 June and 1 July 2009. They met a Chaplain and a member of the Independent Monitoring Board (IMB) and three prisoners who were friends of the man. The investigators visited D wing where the man had been located and met informally with staff and prisoners.

5. A Practice Nurse Facilitator and a Doctor from Wakefield District Primary Care Trust (PCT), conducted a clinical review of the man's medical care. Mid Yorkshire Hospitals NHS Trust also undertook a death in custody review of the man's care in hospital.

6. One of the Ombudsman's Family Liaison Officers sent a letter of introduction to the man's family advising them of the investigation and inviting them to raise any concerns. The family have not responded but they will be given the opportunity to comment on the draft report before it is finalised.

HMP WAKEFIELD

6. HMP Wakefield is a high security prison for 752 adult male long term prisoners. The prison holds men in security categories A and B and is the main centre for life sentenced prisoners, with a focus on sex offenders. (Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels: A, B, C and D. Category A prisoners are those whose escape would be highly dangerous to the public, the police or to the security of the state. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.)

7. In the most recent Ministry of Justice quarterly ratings for prison performance, Wakefield prison was assessed as a good performing prison. All the cells have integral sanitation and the prison healthcare centre is separate from the main residential areas. Nursing care is available 24 hours a day, seven days a week.

8. All prisons in England and Wales have an Independent Monitoring Board (IMB), which is made up of local volunteers. All members of the Board have full access to the prison and prisoners. Each IMB is required to publish an annual report. IMB members deal with a range of issues, including prisoner complaints, prison regime, standard of healthcare and security issues.

9. The Independent Monitoring Board at Wakefield published their most recent report in April 2008. The report noted the improvement in healthcare resources following investment by the Primary Care Trust. In particular, the appointment of a new Head of Function and healthcare manager had resulted in better services and an increase in morale amongst staff. The IMB report also comments on the intention to appoint a full time pharmacist and they hope that this appointment will address the issue of medicine management at the prison.

10. The prison is subject to inspection by HM Inspectorate of Prisons. Following the last inspection in December 2008, HM Chief Inspector of Prisons, described Wakefield as having improved considerably over the last five years. She made a number of recommendations regarding healthcare provision some of which are relevant to the man's care and these points are addressed later in this report.

11. A follow up inspection in May 2009, concluded that Wakefield was a generally safe prison. However, a number of areas were identified for improvement. These included the personal officer scheme, prisoner /staff relationships, and the opportunity for retired prisoners and sexual offenders, such as the man, to opt out of structured programmes, designed to address and reduce their risk of reoffending.

12. The prison was said to have benefited from recent PCT investment and the HM Chief Inspector of Prisons commented on the excellent working relationships between the prison health centre and Wakefield PCT. She also noted some poor examples of record keeping within healthcare delivery. Record keeping is also an issue in this investigation.

13. There have been a number of deaths in at Wakefield since 2004, when this office took over responsibility for conducting investigations into all deaths in prison custody. Although recommendations have been made previously about record keeping and other issues which feature in this report, I am satisfied that there are no links between the man's death and those of previous prisoners.

KEY FINDINGS

14. The man appeared at a local Crown Court in June 2004 and was sentenced to ten years imprisonment. After serving the first of his sentence at HMP Leeds, he transferred to HMP Wakefield in October 2004.

15. The man had been diagnosed with a number of health problems before he went into prison. These included chronic obstructive pulmonary disease (COPD), a respiratory condition, hypertension (high blood pressure), chronic ear infections and dermatitis (inflammation of the skin). He was treated by medical staff at both Leeds and Wakefield prisons. The man's health problems were mostly managed by the Wakefield prison healthcare team, although there were a number of referrals to outside hospitals.

16. On the morning of 18 April 2009, the man told wing officers that he had abdominal pain. He was referred to the healthcare department where a nurse assessed him. She noted that the man's abdomen was tender and bloated and that he was out of breath. The nurse wrote in her notes, "...nebuliser given" and "Plan: to contact out of hours GP service". (A nebuliser is a machine through which medication is given as a mist, to be inhaled into the lungs)

17. Later that morning, the nurse updated her notes:

> "Reassessed the man at 10.45 hrs not in his cell, walking around the wing, not in any obvious distress, not short of breath…tells me his abdominal pain is not as bad … Discussed with GP and agreed for nursing staff to assess the man and if condition worsens to contact GP services again."

The entry concludes with "the man informed and happy with this".

18. The following morning, a different nurse reviewed the man and noted, "…shortness of breath, looked cyanosed (a blue tinge to the skin), sounds chesty". She advised him to use his nebuliser. A couple of minutes later, the nurse spoke with a doctor at NHS Direct who advised her to send the man to hospital. (NHS direct provides health advice and support.)

19. The man left the prison at 11.40am and arrived at the Accident and Emergency a local hospital at noon. The clinical reviewer commented that there are no medical records relating to the man's time at the hospital.

20. A Prisoner Escort Record (PER) is completed by staff escorting prisoners outside the prison. It provides a chronological record of the escort, including details of meals served, the times the journey started and also serves as a communication tool about the risks a prisoner poses either to himself or others. It is recorded in the PER relevant to the man's time at the hospital that he underwent two electrocardiogram (ECG) tests. (This is a process to check for underlying heart conditions.) The PER also shows that the man had an x-ray and then returned to Wakefield prison.

21. On 21 April, the man again complained of abdominal pain to the duty nurse. He was given prednisolone, (an anti-inflammatory drug) and referred to the doctor. The man also told the duty nurse that he did not know what the doctor at the local hospital had said about his examination. The note closes with “to see gp mane”, meaning that he should see the prison doctor in the morning.

22. When he was seen again on 23 April, the man told the duty nurse on that day, he had continuing pain which had spread across his abdomen. He said that he had not eaten since Sunday (19 April), but he had taken fluids. The man confirmed that he was passing urine, but had poor bowel movement. The duty nurse referred the man to the prison doctor.

23. The doctor assessed the man at around midday on the same day. According to the medical record, she diagnosed a chest infection and prescribed medication. The doctor reviewed the man the next day and recorded that he appeared a lot better and was to be monitored by nursing staff. She also left advice as to how staff should manage the man over the coming weekend. In interview, the prison doctor said that she did not physically examine by touch the man’s abdomen.

24. On 25 April, the man reported to a nurse that he felt worse and he refused to take his prescribed medication due to the pain he was experiencing. In line with the prison doctor’s instructions should the man deteriorate, the nurse arranged for him to go to hospital. The man left the prison later that afternoon and was taken to hospital.

25. The man was treated for Chronic obstructive pulmonary disease (COPD) and returned to the prison two days later on 27 April. His discharge information form, signed by a doctor from the hospital, recorded that the man should take nine different medications. (A subsequent discharge letter dated 30 April, gives a brief history of the man’s treatment by Mid Yorkshire NHS Trust and states that he was admitted with COPD related shortness of breath. The letter makes no mention of treatment for abdominal pain but clarifies the recommended course of drug treatments.)

26. The nurse that initially assessed the man on the 18 April reviewed the man on 28 April and recorded that he appeared to have lost a lot of weight. He was given the medication supplied by the hospital and booked in to see the prison doctor as only one week’s supply was provided.

27. On 5 May, the nurse that had reviewed him on the 19 April noted in the clinical record that the prison doctor had seen the man that morning and thought that he might have a bowel obstruction. There is no entry by the prison doctor about the man’s symptoms. He was taken to the Accident and Emergency Department of the local hospital, where he was diagnosed as constipated. Later that day, a letter from the hospital was faxed to the prison. It referred to upper abdominal discomfort and suggests treatment for constipation.

28. Two days later, a different prison doctor examined the man in his cell as he still had severe abdominal pain. The doctor summarised recent events concerning the man’s treatment in the medical record and wrote “give PCM now and review

at 2pm." The clinical reviewer commented that it is not clear what "PCM" means. In the afternoon, the prison doctor that initially assessed the man said that he should not be given anything to eat but only have drinks.

29. At 9.55pm that evening, the nurse that had been on duty on the 21 April was called to see the man by wing staff. The man had stomach pain and difficulty breathing. He told the nurse that he had not been taking his medication. She assisted the man to use his inhaler, take Movicol (laxative) and other medication. The nurse noted an improvement after he had taken them.

30. The next day (8 May) at 9.37am, a officer saw the man collapse in his cell. He said that the man hit his head on the sink in the cell as he fell. The officer called medical staff to the man's cell specifying a "code blue". (This is the radio code used at Wakefield to indicate a medical emergency involving breathing problems.) A Principal Officer (PO) attended with the nurse that initially reviewed the man on the 19 April. The nurse was unable to obtain a blood pressure reading as the man was curled up in a foetal position, holding his abdomen. The nurse noted that the man was cold to the touch, though not pale. She also saw that he was breathless and considered this might have been due to the pain, a head injury or his existing condition. An emergency ambulance was called and he was taken back to the local hospital. The nurse commented in interview that the ambulance seemed to take a long time to arrive and she had to check with the PO that it had been called.

31. Every prisoner who is taken to hospital from prison is subject to security assessments which address such issues as preventing escape and the protection of the public. The risk assessments involve decisions about whether or restraints not should be used and, if so, the level of restraint required. The man was assessed as a high risk to the public and it was considered that his medical condition would not restrict his ability to escape unaided. The hospital was regarded as an insecure location. The man was therefore restrained by an escort chain (a long chain with a handcuff at each end) on the way to hospital, with an order to use handcuffs when medical staff indicated that they would not hinder recovery or treatment.

32. The PO told the investigators that a full printout of the man's medication went with paramedics to assist treatment. The medical records confirm that his medication and a print out of his medical history were given to the ambulance crew. His glasses and hearing aid were also sent which was good practice.

33. Prison staff tried to contact the man's nominated next of kin, his sister, at her home. She was not at home at the time of the call but other family members managed to contact her and told her about the man's circumstances. She was able to visit the hospital and the prison chaplain subsequently explained to her what had happened in the prison. Prison staff also spoke to one of the man's daughters to update her on his condition.

34. The man underwent emergency surgery later the same day and suffered a sustained prolonged heart attack in the operating theatre. The PO contacted the

hospital at 2.22pm. He was told that the man was on a life support machine and might not survive.

35. A nurse received a telephone call from the local hospital at 11.00pm informing her that the man had died. The prison contacted the family and the family liaison log confirms that the man's sister was at his bedside when he died.

36. The prison's family liaison officer maintained regular contact with the man's family. A lunch and memorial service were subsequently held in the prison, which were attended by members of the family who were also given the opportunity to meet the Governor and look around the cell. An entry in the family liaison log confirms that the prison did not contribute to the man's funeral costs as he had a large amount of money in his bank account.

ISSUES

Clinical care

37. The Practice Nurse Facilitator and a Doctor carried out a clinical review of the medical treatment the man received at Wakefield prison on behalf of West Yorkshire Primary Care Trust. They reviewed all necessary records and the Practice Nurse Facilitator conducted interviews jointly with the investigators.

38. The reviewers found that the routine care given to the man by healthcare staff during his stay in prison appears to have been of a good or reasonable standard and he was appropriately referred to the local hospital on three occasions.

39. The Practice Nurse Facilitator commented on the lack of evidence that the prison doctor physically examined the man during the late stages of his illness. While this would, perhaps, not have changed the outcome in this case, it might be critical in future cases.

Record keeping

40. Nursing entries within the medical records and computer held records show consistently poor record keeping. There are entries where the meaning is ambiguous and open to differing interpretation by subsequent readers. Some entries are unsigned, or have illegible signatures so the author is unknown.

41. Within the computer records, the name of the person making the entry is recorded but the role or designation of that person is not. The author of many entries remains unidentifiable and could have been made by any member of staff with access to the system. The clinical reviewer comments that there is at least one entry made in the name of a nurse who was adamant it was not her, but was unsure who could have made the entry using her personal identifiable log on. There are also multiple blank entries, just a name and time but no text. Again it is unclear who has made the entry and for what purpose.

Information sharing by healthcare staff

42. The clinical reviewer also comments on the prison's use of handover, observation and communications books relating to healthcare matters. In particular, it is unclear as to which book should be used for recording specific information. Nursing staff appeared to rely on verbal requests or the assumption that prisoners would be reviewed as a matter of course, if they had been seen frequently during the day. I endorse the clinical reviewer's recommendation that the three books currently in use are replaced by one book.

    The Head of Healthcare should ensure that one handover book is used to communicate information to healthcare staff when starting and finishing duty.

Medical assessment on 7 May

43. The clinical reviewer considers that on 7 May when the man was suffering from severe abdominal pain which did not improve with simple treatment, the prison doctor would have been justified in arranging a further review at the hospital. Also, the records of this consultation do not really describe the doctor's clinical reasoning, the range of possible diagnoses and management options or any attempt to involve the patient in decisions about his management.

    The Head of Healthcare should ensure that the clinical decision-making by healthcare professionals is recorded and clearly explained within prisoners' clinical records. Entries should also include whether or not the prisoner is involved in decisions about the management of their care.

Handling of discharge information from outside hospital

44. Wakefield District PCT also commissioned a review into the care the man received between 19 April and 8 May while in hospital. The review concluded that hospital staff followed local policy and procedures in ensuring that summaries and recommendations were shared with the prison. However the prison doctor, was clear that the discharge information from the hospital, which accompanied the prisoner upon his return to the prison, was not immediately received by healthcare. The investigators spoke with healthcare staff who contradicted this. They said that the information was available in healthcare as it had been sent with the prisoner and was then passed by the reception department to the healthcare unit.

    The Head of Healthcare should ensure that all members of the healthcare team, including the doctors, are aware of how information is handled when prisoners return to prison from hospital and how their healthcare needs are assessed.

Provision of medical information to ambulance staff

45. When it became clear that the man would have to be taken to hospital, following his collapse on 8 May, prison staff printed out his full medical history. They gave the document to the ambulance crew, together with all his medication, to assist hospital staff who would treat him. The prison staff also ensured that the man's hearing aid and glasses went with him. I commend as good practice staff taking the trouble to assist hospital staff by printing out the man's full medical history and for sending his medication, hearing aid and glasses.

Family liaison

49. The family liaison log is very detailed and comprehensive. I am pleased to see that the prison's family liaison officer had regular contact with family members and responded to their wishes. However, the prison decided not to offer a contribution to the man's funeral as he had what they considered to be a large amount of money. Supplementary guidance to Prison Service Order (PSO) 2710 advises that prisons should offer to pay reasonable funeral expenses.

Disregarding the PSO because the deceased had the means to pay for the funeral is not within the spirit of the PSO and I consider that the Governor should make a payment retrospectively.

The Governor should retrospectively offer a contribution towards the man's funeral expenses and ensure that staff adhere to the instructions in PSO 2710.

CONCLUSION

50. The man was elderly and had a number of health problems when he went into prison in August 2004. He died in hospital on 8 May 2009 from chronic pancreatitis. After reporting abdominal discomfort to prison healthcare staff in April 2009, he was seen regularly by both nursing staff and prison doctors. In addition, staff referred him three times to outside hospitals. On 8 May, the man collapsed in his cell and was taken by emergency ambulance to the local hospital where he died after emergency surgery.

51. The clinical review found that the man's routine care in prison appears to have been of a reasonable or good standard. However, the quality of medical records completed before 2007 is poor and those after 2007 are adequate at best. The communication of important information, both at the handover between healthcare staff as they are beginning and ending duty, and the discharge letter from the hospital regarding returning prisoners is also a concern. The inadequacies in record keeping might lead to vital information being lost and, while not critical to the man's care, it might prove to be so in future. I concur with the clinical reviewers' views and endorse their recommendations on these issues. My recommendations aside, I conclude that the care the man received at Wakefield was equal to that which he would have received in the community.

RECOMMENDATIONS

1. **The Head of Healthcare should ensure that healthcare staff maintain clinical records in accordance with the standards set down by the Nursing and Midwifery Council of England and Wales.**

   Accepted. All healthcare staff as part of the SPDR process 2009/2010 were issued with Record Keeping standards from the Nursing and Midwifery Council. Further training will be delivered to staff in Quarter 1 of 2010/11.

   Funding for electronic training on SystmOne has been agreed and training will be offered to staff on a monthly basis which will include record maintenance.

2. **The Head of Healthcare should ensure that one handover book is used to communicate information to healthcare staff when starting and finishing duty.**

   Partially Accepted. An operational and clinical handover book are currently in use within Healthcare. Two separate books are needed in order that confidentiality codes of practice are not breeched. Handover sheets are also used at the beginning/end of shifts for staff within the Primary Care Centre.

3. **The Head of Healthcare should ensure all members of the healthcare team, including doctors, are aware of how information is handled when prisoners return to prison from hospital and how healthcare needs are assessed.**

   Accepted. A Local Notice to Staff will be issued to all Healthcare Staff reinforcing the procedure for prisoners when they are returned to the prison. A protocol will be developed for Reception and Healthcare to ensure all clinical information is passed to Healthcare when a prisoner returns from outside hospital.

4. **The Governor should retrospectively offer a contribution towards the man's funeral expenses and ensure that staff adhere to the instructions in PSO 2710.**

   Accepted. A retrospective offer of £2000.00 will be made to the family of the man. A full apology will also be issued as a result of this oversight.