Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Holme House, in hospital in June 2008

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

This is the report of an investigation into the death of a man who died in June 2008 in hospital whilst a prisoner at HMP Holme House. The man had transferred from Holme House to the hospital two days earlier after being unwell for several days. He was 54 years old.

A post mortem was held at the request of HM Coroner for Teesside. It found that the man died from meningitis. I extend my sincere condolences to his family and friends.

This investigation was undertaken by one of my investigators. In addition, a review of his healthcare was commissioned from North Tees and Hartlepool Foundation Trust. I am grateful to a doctor who carried out the review. I would also like to thank the Governor of Holme House and his staff for their help and assistance. I am particularly grateful to the prison's liaison officer.

Prisoners and staff on B wing of houseblock six, where the man lived, were concerned that he was becoming increasingly unwell before he was admitted to hospital. It is clear from the investigation that wing staff made every effort to contact staff in the healthcare centre, relaying their concerns for the man.

I am concerned about the timeliness and standard of care given to the man by the healthcare centre. I make one recommendation to the Chief Executive of North Tees Primary Care Trust: that his treatment by healthcare staff is subject to a root cause analysis and that the performance of relevant staff is audited. I note three examples of good practice for the attention of the Governor.

The draft report was circulated, with advance disclosure, to the Prison Service, North Tees PCT and the Department of Health. A response was received to the recommendation, which was included in that report.

In this final version of my report, the man's family have commented on the pain their brother suffered before he was admitted to hospital.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2009**

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SUMMARY

The man was received into HMP Holme House in December 2007. He had been recalled to prison for failing to comply with licence conditions. A first reception health screen conducted by a nurse raised no health issues other than he had a runny nose and red hands. He was located on B wing and became the wing cleaner.

A few days later, the man saw a nurse for advice on stopping smoking, and asked the doctor for a referral to the gym as he wanted to lose some weight. It is noted in the man's medical record that he received a regular prescription for Gaviscon (an indigestion remedy) and some ointment for a fungal foot infection.

On 29 May 2008, the man was seen by a nurse in the healthcare centre. He was flushed, with a cough and a temperature of 40 degrees (normal temperature is 37 degrees). A referral was made for the man to see the doctor the following day. He was advised to take paracetamol and plenty of fluids.

The next day, a B wing officer requested that a wheelchair from healthcare be provided for the man to get to the healthcare centre for his appointment with the doctor. It was the officer's opinion that the man was too unwell to walk to the healthcare centre. Healthcare staff declined to fetch the man in a wheelchair. In the afternoon, the officer went to the healthcare centre as the man was still too ill to go and the doctor had not yet visited him in his cell. Later, he was examined in his cell by the doctor and a nurse. The doctor prescribed pain relief.

On 1 June, the man made a great effort to go to the healthcare centre and was examined by a nurse. He was feeling dizzy, had been vomiting and complained of lower back pain. His hands were very red, although his temperature was now normal. The nurse thought the man looked in pain and was hot and clammy to touch. She spoke to the doctor who in turn prescribed an injection to help stop the man's sickness. He was told to contact healthcare if the problems persisted.

Around 6.00am on 2 June, the prisoner in the cell next door was woken by groaning and moaning from the man's cell. This was also heard by another prisoner. The prisoners alerted night duty staff, and Operational Support Grade (OSG) opened the hatch in the cell door. The man was seen pacing around his cell and did not respond to the OSG's questions. The OSG phoned healthcare, who advised that the man should take paracetamol and they would come and visit him.

The man was becoming increasingly agitated and continued groaning. The OSG spoke to the man again, but could not get him to respond. An officer then reported for duty on the wing and went to the man's cell. Following a conversation with two prisoners, he called the Night Orderly Officer (NOO) to come to the cell for immediate help. The NOO arrived with another officer and a nurse.

When the man's cell was opened, it became very apparent that he was unwell. He was pacing the room, agitated, disorientated and seemingly delirious. The nurse was unable to take any clinical observations from the man, as they could not calm him down. A nurse telephoned the on call doctor who advised that the man be taken to hospital, and an ambulance was called. The paramedics found the man still

disoriented, and taking his blood pressure, pulse and temperature proved to be difficult. At 8.00am, he was transferred from Holme House to hospital. He was not restrained but was accompanied by two officers.

On arrival at hospital, the man was admitted to the intensive care unit and placed on a life support machine. His family was visited by the prison's family liaison officer. They were not at home so a letter was left for them to contact the hospital and the prison.

The man's sister arrived at the hospital later that evening. On 2 June 2008, the man's life support machine was turned off with the agreement of his family. The post mortem report found that he had died of meningitis.

THE INVESTIGATION PROCESS

1. On 9 June 2008, a letter was sent to the Chief Executive of Stockton on Tees Teaching Primary Care Trust (PCT), requesting a clinical review into the man's medical care whilst at Holme House.

2. My investigator visited Holme House and met with a Governor on 26 June 2008. Notices of the Ombudsman's Investigation and Terms of Reference were sent in advance. Three prisoners responded to the notice of investigation and my investigator visited two of those prisoners on B wing of houseblock six. The third prisoner was not on the wing during the investigator's visit. Whilst on the wing, my investigator spoke to an officer and a Senior Officer (SO).

3. My investigator had received a letter from another prisoner's solicitor indicating that he wished to speak to her. The prisoner had been released from Holme House before the investigator's visit. She wrote to the prisoner at his home address and confirmed this by telephone to the solicitor. At the time of the circulation of this report the prisoner had not responded to my investigator.

4. No members of the Independent Monitoring Board (IMB) or the Prison Officers' Association (POA) requested to see my investigator. The IMB and POA have previous experience of the procedures for a death in custody investigation.

5. My investigator wrote to the Chief Executive of the PCT on 2 July. She asked for a clinical reviewer to be appointed who would be independent of the PCT, following concerns raised by prison staff about the man's medical care. Despite telephone calls and email messages throughout July and August, my investigator was unable to make contact with the PCT to find out who would be conducting the review.

6. On 14 July, my investigator visited HMP Kirklevington Grange to interview a friend of the man's from Holme House. Later that day, she went to Holme House and interviewed three officers. The following day, my investigator interviewed one officer and three friends of the man on houseblock six. On 8 and 9 September, my investigator and one of my assistant ombudsmen interviewed healthcare staff and an operational support grade at Holme House.

7. My assistant ombudsman wrote to the Chief Executive of the PCT asking for progress on the clinical review on 18 September. My investigator was contacted on 23 September by the Assistant Director Integrated Governance. An independent clinical reviewer had been identified and the man's medical notes were being forwarded him. The lateness of the clinical review caused a delay in my completing this report, but I am very grateful to the clinical reviewer, a doctor, for his review.

8. On 25 September, my investigator and one of my family liaison officers visited the man's sister at her home address. Other family members were present.

9. The man's sister was concerned about rumours circulating within her hometown that her brother had not received appropriate healthcare prior to being admitted to

hospital. My colleagues told the man's sister of the investigation process and reassured her that the investigation would take into consideration the important issue she had raised.

HMP HOLME HOUSE

10. Holme House is a category B prison for unconvicted, convicted and sentenced male adults. It opened in May 1992. The prison primarily serves the communities of the Tees Valley, South West Durham, East Durham and North Yorkshire. It has a total of six residential units, known as houseblocks one to six. It has an operational capacity (maximum crowded capacity) of 994.

11. Houseblock six is used for sentenced prisoners. In common with other establishments, Holme House runs a personal officer scheme. Officers are responsible for the prisoners in a specified number of cells and cover in each other's absence.

12. North Tees Primary Care Trust are the providers of healthcare services at Holme House. There is an in patient unit with 28 beds and 24 hour nursing care. An out of hours doctor's service is covered by the prison doctor with help from an emergency out of hours doctor service.

13. HM Chief Inspector of Prisons, Ms Anne Owers, conducted an announced inspection of Holme House in April 2005. Following the inspection, Ms Owers said of Holme House:

> "Staff – prisoner relationships appeared to be good and were reported as such in the survey. There was no evidence of disrespectful treatment of prisoners, although there were some instances of staff dealing with prisoners in a superficial manner or without regard to their individual needs. The healthcare department provided a good range of clinical services, although in our survey prisoner perceptions of the quality of healthcare were below the benchmark. There had been problems in the recruitment of GPs but this was being addressed. Inpatient care was provided in decent, clean surroundings but there was limited opportunity for patients to associate. The mental health in-reach service provided a good service to prisoners in the houseblocks."

14. The most recent report by the prison's Independent Monitoring Board (IMB) was issued in 2005. The presented a generally favourable view of all areas of the prison. The following comment was made of healthcare:

> "There are concerns by nursing staff due to the rapid turnover of staff. The perception is that qualified staff appointments within the prison are merely as a stop-gap or stepping stone jobs. The unit has benefited from inclusion in the roster of two officers easing safety and security issues."

Most of the concerns raised by the IMB have since been addressed.

15. This is the sixth death from natural causes at Holme House that my office had investigated since taking over responsibility for all death in custody investigations in 2004. My previous investigations have not raised issues relevant to this one.

KEY FINDINGS

16. On 26 December 2007, the man was received into Holme House. A first reception health screen document was completed. The man did not report any health issues to the nurse, other than a runny nose and red hands. The man's medical notes do not give the name of the nurse completing the screening document. A secondary health assessment was completed and the man was referred to the doctor about his red hands.

17. On the following two days, the man's medical notes show a heading of 'out patients' but no further information is recorded. On 2 January 2008, the medical notes record that a doctor prescribed Fixodent (an oral adhesive for false teeth). No other information was noted. The next day, the man saw a nurse for advice and support to stop smoking. Later, he was examined by the doctor who noted the man's blood pressure reading of 125/77 (within the normal range of 130/80). He was not short of breath and did not have any chest pain. The man's weight was noted as 81 kilograms and he asked the doctor to refer him to the gym to help him lose weight.

18. On 12 January, the man was seen by a nurse. She recorded his smoking habits and prescribed nicotine patches. On 15 February, it was noted that a doctor prescribed Gaviscon (an indigestion remedy). There was no information recorded as to why Gaviscon was prescribed. Four days later, the man saw a nurse on houseblock six. The nurse noted that the man had blistering and itching to his left foot and would discuss this with the doctor. Later that day, the doctor prescribed Mycil (an anti-fungal ointment.)

19. The doctor prescribed Gaviscon and Mycil for the man again on 20 March. A similar prescription was issued by the doctor on 17 April. On 8 May, it was recorded that another prescription for Gaviscon was documented by the doctor. These entries on his medical record were for repeat prescriptions and the man did not see the doctor.

20. On 29 May, a nurse examined the man. He was breathless and coughing up white and green phlegm. His temperature was 40 degrees and he was flushed with a blood pressure reading of 158/85. The nurse said at interview that his temperature was high and he had a fever. The nurse told my investigators:

> " He did complain about a bit of lower back pain, which again I've not recorded in the notes but I remember that. And we did sort of allude to, I did, you know any rashes or sickness. There was no vomiting; it was a case of somebody with a high temperature feeling unwell. The man was referred to the doctor and advised to take plenty of fluid and paracetamol. I was concerned but I felt quite comfortable him going back overnight, I was quite comfortable with that decision."

21. The nurse spoke to a senior colleague about the man's symptoms, and made her aware of his condition. She also recorded on the electronic recording system that

the man should see the doctor the following day. There is no indication from the man's medical notes that he was seen again that day.

22. On 30 May, an officer made an entry in the man's personal file. The officer noted that he had made contact with healthcare staff to remind them that the man had an appointment with the doctor that morning. The officer told the healthcare staff that the man would need a wheelchair and assistance to attend his appointment as he was very unwell. The member of healthcare who spoke to the officer told him that a wheelchair could not be provided and the man should attend the healthcare centre. The officer continued the entry and noted that he had contacted healthcare again in the afternoon to find out what was happening as the man had not yet seen the doctor. He was told that, unless the man walked down to healthcare for his appointment, he would not be seen by the doctor. The officer was told that it was the doctor's decision. The officer completed his entry by adding that most of the day the man had been immobile in his cell.

23. A short while later, the officer went to the healthcare centre himself, as healthcare staff had still not arrived to see the man. He insisted that a member of healthcare staff should go to see the man in his cell.

24. At 3.10pm, the man was examined by the doctor in his cell. The doctor noted in the man's medical record, "says he is poorly and suffering from back pain, it is not his chest. Non multum, could very well have come to OP [out patients]." At interview, the doctor told my investigators:

> "The man was lying on his bed. He was in pain; I wouldn't say he was in excessive pain because he was lying quite still and relaxed. I asked him about his pain and I asked particularly about his chest because the day before a nurse had noted that she thought he had a chest infection. She said that he said that he felt ill, 'poorly' is the word that they use in this area [the doctor's reference to 'they' is a term referring to prisoners], and he was suffering from back pain but it was not his chest infection."

25. The doctor prescribed Diclofenac (a non-steroidal anti-inflammatory drug) and Baclofen (a muscle relaxant). There is no record of a blood pressure reading, temperature, or pulse reading being taken during this examination.

26. The following day, the doctor again repeated a prescription for Gaviscon without seeing the man. The following day a nurse saw the man in healthcare. The nurse noted in the man's medical record that he was complaining of lower back pain, which had worsened overnight. He was unable to sleep and the pain was the same whether he was lying or standing. The man felt dizzy when walking and had vomited four times that morning.

27. The nurse examined him and noted he looked in pain, was hot and clammy to touch. His temperature was 36.4 degrees and blood pressure 135/97 (higher than the normal range). Both the man's hands were red, and he told the nurse he had had a similar problem about five years earlier when the symptoms had subsided after about four weeks. The nurse discussed the man's symptoms with the doctor. The doctor prescribed a 10mg injection of Metoclopromide (a drug

used for upset stomach and vomiting) which the nurse administered. The man was advised to drink plenty of fluids, try to eat a light lunch and not take any painkillers unless he had eaten something. The man was also told to contact healthcare if the problems persisted.

28. A friend of the man's assisted him with getting his meals from the servery, drinks to keep his fluid intake up, and sat with him. On 1 June, another friend of the man's saw him on the landing. In interview, he described the man as being in great pain and looking grey. The man was complaining of severe back pain and could hardly stand up. The friend passed on some Deep Heat (a cream medication to soothe back pain) to another prisoner to rub on the man's back. The man, who occupied a single cell, told his adjoining cell mate that if he was unable to get out of bed that night he would bang the wall for him to ring his cell bell. This friend's cell was next to the man's.

29. About 6.20am on 2 June, the man's friend was woken by sounds coming from the man's cell. He could hear the man groaning and banging in his cell. Another prisoner was also woken by the man's shouting and banging from his cell. He called out of his window to the prisoner next to the man's cell, and told him to ring his bell to alert staff. The prisoner rang his bell and night duty Operational Support Grade (OSG) responded. The prisoner told the OSG that the man had been very unwell and needed a nurse. The prisoner could still hear the man moaning and groaning.

30. The OSG looked at the man through the hatch on his cell door, and saw that he was lying face down on the bed. The OSG asked the man what was wrong but he did not answer. In interview, the OSG said the man then got off the bed and wandered around his cell, but did not respond to her questions and seemed disoriented.

31. The OSG went to the wing office and telephoned the healthcare centre. She explained what she had seen and that the man seemed to be disoriented. The nurse advised the OSG to tell the man to take the paracetamol that he had been prescribed. Whilst returning to the man's cell she attended a cell bell in the cell next to the man. The prisoner told the OSG that the man was smashing his cell. The OSG then opened the hatch on the man's cell door and he was standing by the door. She told him to take the paracetamol.

32. An officer who had just reported for duty on the wing, came to the man's cell and asked the OSG what was the matter. The officer knew the man well and recalled him from his previous custodial sentence. The OSG told the officer that the man was not responding and seemed disoriented in his cell. The officer then spoke to the prisoner in the cell next to the man. The prisoner told the officer that the man had been unwell all weekend and had been moaning for some time. The officer asked the prisoner if the man had taken anything (a reference to any illicit drugs). The prisoner said that the man would never do anything like that in prison.

33. The officer then went to the man's cell, but he too was unable to get the man to respond to his voice. The OSG told the officer that she had spoken to the Night Orderly Officer (NOO). The NOO had told the OSG that the

man had a bad back and the nurse would come and see him at unlock time (unlock is when prisoners are released from their cell to start their daily routine).

34. The officer went to see another prisoner and spoke to him through the hatch of his cell door. This prisoner told the officer that the man needed help and he had been sick all weekend. The officer went to the wing office, rang the NOO and told him to come to the man's cell and open the door, as he needed help immediately.

35. At about 6.45am, the NOO, a night duty officer, the officer, and a nurse went to the man's cell. On opening the cell they found the man pacing, unable to communicate and uncooperative. At interview, the officer told my investigator:

> "When we first went into the cell the heat was unbelievable it was like the tropics which was very unusual, his windows were shut and they were steamed up and dripping with condensation, so I opened the windows and tried to get some kind of reaction from the man, so I sat him down on the bed and he wouldn't settle he got back up pacing the cell."

36. The officers were unable to make the man remain still and so could not measure his pulse or blood pressure whilst he was so disoriented. The officer said that they managed to get the blood pressure cuff onto the man's arm but he ripped it off, was still moaning and trying to move around the cell. He would not respond to any questions or commands. At one stage, the man leant over the toilet in the cell and tried to get water. The officer had to steer the man away from doing this.

37. The nurse noted that the man was hot and clammy. During interview, the nurse told my investigators that the man was obviously distressed and agitated and she was unable to examine him. The nurse said:

> "He was really disorientated, he was stumbling around the cell, he had no idea who we were. One of the day officers had come on, that apparently knew him quite well because I understand the man had a little job on that houseblock. So he was quite well known and he knew all the officers as well and it was obvious that he didn't recognise the officer that had come on that morning. I just couldn't pinpoint anything that, usually you can go in and you think it could be this and I just looked at him and I thought I've got no idea what this could be. So I'd taken the emergency bag with me so I thought well I'll do his blood pressure and his pulse and I'll look in his eyes and go through the usual scenario that we go through seeing a patient. But he was so distressed and disorientated, I don't know what the man thought we were going to do to him, but he didn't want us to touch him. He was pulling away and he was getting really, really distressed and agitated. So we put a mattress on the floor, I think I'd asked someone, I said can you get hold of a nurse in the hospital [healthcare unit], ask her to ring the doctor, I need somebody."

38. The nurse in healthcare made telephone contact with the doctor. The doctor advised that the man should go to outside hospital. The nurse contacted the

hospital bed manager, and was advised that the man should be taken by ambulance to the hospital's Accident and Emergency Department.

39. After the mattress had been placed on the cell floor, the staff waited outside the cell until the paramedics arrived, keeping a close watch on the man who was still moving around the cell, incoherent and agitated. When the paramedics arrived they too were unable to examine the man, despite many attempts to calm him. The paramedics requested an evac chair (a chair with belts attached, which is easy to lift and manoeuvre). They thought a stretcher was inappropriate given the man's distressed demeanour. A chair was brought from healthcare and the man was taken to the ambulance.

40. A risk assessment was completed, and at 8.00am the man was escorted to hospital by two officers. He was not restrained and was admitted to the hospital's intensive care unit. It was noted on the man's bedwatch notes at 12.55pm that his condition was deteriorating. The escort officers requested that the man's family be contacted to attend the hospital as he had been placed on a life support machine.

41. Several attempts to contact the man's sister were made by telephone by the duty family liaison officer. At 3.15pm, the family liaison officer and a governor went to her home. There was no one in so they left a letter asking the man's sister to contact the hospital as soon as possible, and left the family liaison officer's contact details. Later, the man's sister returned home and went immediately to the hospital where she stayed at his bedside.

42. At 2.00pm on 4 June, with the agreement of the man's sister, his life support system was switched off. He died at 2.05pm. His sister was at his bedside.

43. The following day, the family liaison officer visited the man's sister with another family liaison officer, who would take over the role of liaison officer. On 9 June, this officer supported the man's sister at the opening of his inquest.

44. On 12 June, the man's sister, niece and a family friend visited their brother's cell on B wing and met some of his friends. A wing collection by his friends had been organised for a floral tribute for the man's funeral service. The man's sister thanked his friends for their kindness. They later visited the chapel, and met the chaplain and lit a candle in memory of their brother.

45. The next day, the family liaison officer, a governor, and the chaplain attended the man's funeral. The prison offered financial support towards the funeral expenses.

ISSUES

Clinical Issues

46. A review of the man's medical care was commissioned with Stockton on Tees Teaching PCT. A doctor was asked to carry out this review. The doctor's report recorded the interventions by healthcare staff in response to the man's symptoms and the actions taken.

Healthcare provision prior to 29 May

47. The doctor has judged that the man received adequate attention for his minor illnesses of indigestion and a fungal foot infection. He was also seen for health promotion with smoking cessation advice and weight loss.

Response by healthcare to the man's early signs of illness

48. On 29 May, the man was assessed by a nurse. Although he had a high temperature of 40 degrees there were no other significant symptoms. A chest infection was considered to be the cause of his illness and a follow up appointment was made for the man to see the doctor the following day. The doctor has noted that the man could have had his temperature re-taken a few hours later, or healthcare staff could have asked wing discipline staff to report to them on how the man was feeling.

49. In interview, the prison doctor said she examined the man in his cell on the afternoon of 30 May. The man was lying on his bed, seemed unwell, and told her he was poorly. He had some mobility in his legs and was able to talk to her about his symptoms. The prison doctor prescribed a muscle relaxant medication to help with his back pain, and painkillers. It was the prison doctor's opinion that he man could have walked to the healthcare centre for his appointment.

50. The doctor notes in his review that there were no detailed records made in the medical record of the man's physical state following the consultation. There was no mention of any possible infection or any reference to the symptoms noted by the nurse the day before.

51. The prison doctor's examination of the man included his back, with a physical test to eliminate sciatic nerve pain (of which there was none). The test is also used to decide if back and neck pain is associated with meningitis. The man's chest was also examined and described as clear in his notes.

52. With regard to the man's visit to the healthcare centre on 1 June, the doctor has found that the healthcare team of the nurse and the prison doctor could have could have formed the opinion that, as he was able to attend healthcare centre that day, he was getting better. His temperature was recorded as normal, although he was hot and clammy and both his hands were noted as red. The doctor considers that the man's temperature reading is likely to have been an error. The vomiting was thought to have been caused by the medication Diclofenac (prescribed the previous day). The doctor comments that this was not

an unreasonable view as the man had also been prescribed Gaviscon for his stomach acid. However, the assumptions were incorrect and, furthermore, the man was only seen in passing and was not formally assessed by the doctor.

The man's admission to hospital

53. On the morning of 2 June, the man was so unwell that he was unaware of his conduct. The man had previously asked his friend in the cell next door to ring his cell bell if he banged on the wall to indicate he needed help during the night. It would seem that the man was unable to do so due to his delirious state. The prisoner was awoken by noises coming from the man's cell and further calls from another prisoner. The prisoner rang his cell bell and the OSG responded.

54. In interview, the OSG recalled that after answering the prisoner's cell bell and after observing the man she rang healthcare and spoke to a nurse. The OSG did not mention ringing the NOO but did remember speaking to a nurse who told her to tell the man to take the paracetamol prescribed the previous day.

55. The OSG was trying to convey this to the man through the hatch of his cell door when an officer reported for early morning duty on B wing. The officer went to the man's cell and spoke to the OSG. The officer then spoke to the prisoner in the cell next to the man, to ask if he knew if the man had taken any illicit medication. The prisoner told the officer that the man had been unwell all weekend and would never take any non-prescribed medication. The officer also spoke to another prisoner who confirmed how ill the man had been. The officer made contact with the NOO asking him to attend the man's cell immediately with a nurse.

56. When the officers entered the man's cell it became apparent from the man's demeanour that he was very ill. Despite attempts to calm him the man was disoriented and acting out of character.

57. Healthcare staff contacted the on call doctor who advised that the man be admitted to hospital. An ambulance was called and the man was transferred to hospital at 8.00am.

58. Self-evidently, there was a considerable gap between prison staff first being alerted to the man's condition at 6.20am to his transfer from Holme House by ambulance at 8.00am. However, because of the man's behaviour, which we now know to have been caused by his medical condition, certain medical procedures took longer than normal. The doctor judges that his admission to hospital was dealt with as quickly as possible given his conduct that morning.

59. The doctor has also found that the man's admission to hospital was dealt with as an emergency and his clinical signs and symptoms were appropriate for an emergency admission.

Overall judgment on the man's clinical care

60. The doctor comes to the following conclusions about the man's clinical care between 29 May and 2 June 2008:

> "In my opinion, there was a series of wrong assumptions made based on the available clinical evidence. A greater index of suspicion may have led to a more detailed examination and then the original diagnosis of simple back pain challenged. Unfortunately, a more thorough follow up examination did not happen.
>
> "As regards the performance of individual healthcare professionals. In my opinion, at best there were insufficient clinical details recorded and further regular follow up appointments arranged. However, it may be the case that this presentation of bacterial meningitis was unusual; and that is why it was not suspected by anyone involved in the man's care. At worst, the man was left for the majority of the weekend without proper follow up and the clear deterioration of his physical state went unnoticed. When he was seen in healthcare on the 1 June, he was clinically worse and timely suspicion then of something else going on was possible, with the available evidence. Unfortunately, the opportunity was missed and only when the events of the 2 June unfolded with his delirium and further clinical deterioration, did the healthcare department suspect more sinister pathology and arrange an emergency admission."
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> "This case should be a learning point for the healthcare department and in my opinion must be included in the next significant event meeting at HMP Holme House healthcare department. Once completed, and following further discussions with the PCT, individuals will require further scrutiny of their performance in order to learn from any shortcomings."
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> **The Chief Executive of North Tees and Hartlepool Foundation Trust, in conjunction with the Governor, should conduct a root cause analysis into the death of the man and include a performance standard of all healthcare staff involved in his medical care.**

Family concerns

61. Following the man's death, his family felt well supported by the prison staff and were offered help and assistance for which they were grateful. Several weeks after their brother's death, certain rumours circulated his home town that he had not received appropriate healthcare and that he should have been sent into hospital earlier.

62. Whilst the family were still appreciative of the support from Holme House, they were concerned about the standard of healthcare their brother had received. They had heard that he had been unwell for several weeks prior to his admission to hospital with 'flu type' symptoms. The question that remained for his family is whether he could have been diagnosed and treated earlier, and if he would have survived.

63. The man did not report any symptoms to healthcare staff until 29 May, four days before he was admitted to hospital. I am unable to comment on any other symptoms the man may have had before that time as there are no indications in his medical notes or personal file.

64. In his clinical review, the doctor says a diagnosis of meningitis is often made in community general practice after the patient has been admitted to hospital following tests. The man's case was no different and the presentation of his bacterial meningitis was unusual. Nevertheless, an earlier diagnosis might have helped the man.

65. The clinical review raises issues in relation to the actions of healthcare staff which are endorsed in my recommendation.

Good practice on the part of the prison's Family Liaison Officers

66. The family liaison officers offered sensitive assistance to the man's family. They visited them at the man's sister's home and accompanied her to the opening of his inquest. The man's family were very appreciative of their continued support and in helping with arrangements following their brother's death.

67. A written log of events was documented by the family liaison officers. It provided a comprehensive and detailed account of all their interventions with the man's family. It was concise and clear, giving dates and times of when the officers saw and spoke to the man's family. My investigator noted that it was the most informative family log she had seen during any such investigation.

I commend the good practice of the family liaison officers.

Support for the man from B Wing

68. Following the man's death, a display of notices from my office initiated responses from both officers and prisoners. At interview it became apparent that an officer had raised his concerns over the man's welfare with healthcare staff. Other B wing staff also told my investigator of their worries concerning the man and the assistance they gave to ensure he was as comfortable as possible. A friend of the man's, told my investigator that he thought the officers had been 'spot on' in caring for the man.

69. The prisoner in the adjoining cell to the man looked after him for several days before he was admitted to hospital. This prisoner helped the man with his personal care, fetched his meals and made him drinks. He also sat with the man, keeping him company whilst he was unwell in bed. Other friends on the wing visited the man whilst he was unwell and offered their support.

70. The man was a trusted and reliable prisoner on B wing. He assisted wing staff as a wing cleaner and was held in high esteem by staff. All three officers my investigator spoke to on B wing praised the man for his behaviour and approach.

I commend the staff and prisoners of B wing for their support of the man during his illness.

I commend the prisoner in the next cell to the man for the assistance and care shown to the man whilst he was unwell and ask that his personal file be endorsed to that effect.

RECOMMENDATIONS

The Chief Executive of North Tees Primary Care Trust

The Chief Executive of North Tees and Hartlepool Foundation Trust, in conjunction with the Governor, should conduct a root cause analysis into the death of the man and include a performance standard of all healthcare staff involved in his medical care.

Accepted – "North Tees and Hartlepool Foundation Trust, in conjunction with the Governor will carry out a root cause analysis into the death of the man. However, not all the health concerns are purely the responsibility of North Tees and Hartlepool Foundation Trust. (i.e. the doctors are employed by a separate organisation."

GOOD PRACTICE

1. I commend the good practice of the family liaison officers.

2. I commend the staff and prisoners of B wing for their support of the man during his illness.

3. I commend the prisoner in the next cell to the man for the assistance and care shown to the man whilst he was unwell and ask that his personal file be endorsed.