Investigation into the circumstances surrounding death of a man at HMP Wakefield in January 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is the report of an investigation into the circumstances of the death of a man, a prisoner at HMP Wakefield, in January 2010. The man's death was sudden and unexpected. He had been diagnosed with a number of medical conditions which were unrelated to his death from heart disease.

I would like to offer my sincere condolences to the man's wife and family and to all those affected by his passing. Prisoners and staff to whom my investigator spoke, who knew the man well, were all saddened by his death.

One of my colleagues conducted the investigation. Ms A, Registered General Nurse (RGN), Practice Nurse Facilitator, conducted an independent review of the man's medical care on behalf of an NHS District Primary Care Trust (PCT). I am grateful to Ms A for her valuable contribution.

I would also like to thank the Governor of Wakefield and her staff for their cooperation. I am grateful to the Head of Healthcare, who liaised with my office and I appreciate the assistance of prisoners and staff on the man's wing who provided valuable information.

I make six recommendations. The man had a chronic back condition following an injury at work some years before he went into prison. The clinical reviewer judged that, while his routine care was adequate, the management of his back condition fell short of comparable care in the community. I endorse her recommendations regarding prescribing medication at Wakefield and delays in access to necessary medical aids, as well as a further recommendation regarding record keeping. I have previously made recommendations regarding the standard of record keeping at Wakefield and am disappointed to repeat it here.

Whilst I recognise that the man's wife was satisfied with the support she received from the prison after her husband died, I consider that the choice of family liaison officer was inappropriate. I acknowledge that the individual concerned undertook on the role while on annual leave and in the absence of anyone else being available. However, he previously responded to the man's wife's complaints about her husband's medication and there could have been a conflict of interest. I therefore make a recommendation regarding alternative family liaison officers. My final recommendation is about the need for privacy screens when officers are dealing with potentially distressing events. I am pleased to note the tremendous efforts of three officers, namely Officer C, Officer E and Officer D who tried to save the man's life and recommend that the Governor writes to commend them.

The National Offender Management Service have accepted three of my recommendations and their response is documented on page 22 of my report.

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

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SUMMARY

The man was remanded into custody at HMP Manchester in June 2006 and transferred to HMP Wakefield in December 2006. He was found collapsed in his cell in January 2010. A post mortem examination discovered that he died from ischaemic heart disease.

In the early 1990's, the man sustained an industrial injury. He crushed three discs in his back and endured a chronic and painful back condition from that point. While in the community, the man benefited from effective pain management. However, the investigation has found that pain management for his chronic back condition by the healthcare department at Wakefield fell short of the standards expected.

In May 2008, the man's solicitor wrote to the prison on his behalf. He asked for regular reviews of the man's medication and for the prison to ensure that the man was not left in pain.

Following this, the man's wife wrote three letters of complaint to the Governor during 2009. She said that her husband was not receiving the medication that he needed and was entitled to. Given his disability and back condition, she was also concerned at the distance he had to walk to his workplace.

The prison responded to her complaints appropriately on two occasions confirming that a referral had been made to a physiotherapist and a change in the man's work place had been requested. The healthcare department's response to the third complaint letter, dated 22 May 2009, was less than satisfactory as it did not specifically address the issues raised. The clinical review highlights concerns regarding the man's difficulties with his medication and poor record keeping. The former Chief Inspector of Prisons raised similar concerns about pharmacy services in her inspection report in December 2008. I consider that the length of time it took for the prison to resolve the man's medication, change his place of work and provide a back brace is unacceptable.

The man had been suffering from chest pains for two to three weeks before his death. He told his wife about this, but did not share his concerns with discipline or healthcare staff. Prisoners who knew him were aware and urged him to go to healthcare. He did so reluctantly, but did not tell them he was suffering from chest pain, but said that he had a chest infection.

On 22 January, at 6.15pm, prison staff were making their evening checks when they found the man unresponsive on his bed in his cell. Despite every effort by wing officers and healthcare staff to resuscitate him, the man could not be revived.

The prison did not have a family liaison officer who was available. The Head of Healthcare agreed to undertake the task, despite being on annual leave. A few hours after the death, he travelled to the home of the man's wife, accompanied by a police officer to break the news of her husband's death.

The clinical reviewer has judged that, overall, the man's routine care was adequate. However, the management of the pain resulting from his chronic back condition fell short of the standard expected and was not equal to what he would have received in the community. I make six recommendations. They include addressing poor record keeping and an urgent review of the prescribing services, together with an audit of prescribing by nurse prescribers. A further recommendation asks that the prison ensure that there are minimal delays to prisoners receiving medical aids/equipment. I also consider there is a need for the prison to establish a working duty rota of trained family liaison officers. Screens should be provided on each wing to ensure the privacy of officers carrying out life saving actions. They will preserve the dignity of the prisoner involved and reduce the risk of distressing events being witnessed by other prisoners.

I am pleased to commend the efforts of officers who tried to save the man's life and persevered until the paramedics arrived.

INVESTIGATION PROCESS

1. The man died in January 2010. This office was notified of his death later on the day of his death. 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 investigator to make themselves known. The investigator, my colleague, reviewed copies of the man's core record, clinical record, and other records relevant to his time in custody and his death.

2. The investigator 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 coroner's officer told my colleague that the man died of ischaemic heart disease.

3. My colleague visited Wakefield on 9 March. She toured the wing and met Principal Officer A, the principal officer (PO) on C wing where the man was located at the time of his death. She spoke with prisoners and staff on the wing who knew the man.

4. A clinical review of the man's clinical care was commissioned from an NHS District Primary Care Trust and undertaken by Ms A, practice nurse facilitator. Ms A focussed on the clinical care the man received at Wakefield. Her review appears as an annex to this report.

5. One of my family liaison officers contacted the man's wife, as his next of kin, to advise her about my investigation and give her the opportunity to raise any questions or concerns to be considered as part of this. The man's wife had a number of concerns regarding the care her husband received at Wakefield. These included:

    - Poor pain management for the man's chronic back condition.
    - Lengthy waits to see a doctor and receive medication.
    - The prison had sent a response to her complaint about her husband's care that contradicted what her husband had told her.
    - The man's disability was not taken into account when allocating him to work in the prison workshop. The workshop location was a long walk from the man's cell and he had to cope with several flights of stairs to get there and back from his cell.
    - Why her husband had received no medication during his first few weeks in custody.

6. The man's wife suggested to my family liaison officer that the investigator speak with Prisoners A and B, prisoners and friends of the man, in the course of the investigation. My colleague did so and was most grateful to the man's wife and Prisoners A and B for their assistance.

7. The man's wife spoke positively about the help and support she had received from the prison following her husband's death. She confirmed that his property had been returned and the prison had paid the funeral

costs. I hope this report addresses the concerns she has about the care her husband received at Wakefield and provides her with a better understanding of the events leading to his death.

HMP WAKEFIELD

11. HMP Wakefield is part of the high security estate. On average, the prison holds 740 men including a small number of remand prisoners and category A and B prisoners[1]. It is a main centre for life sentenced prisoners with a focus on serious sex offenders.

12. There are four main residential wings A, B, C, and D. B wing has a small unit for remand prisoners and four cells adapted for prisoners with mobility difficulties. Lifts had been installed on the wing and the man would have been able to take advantage of this if he had wished to. A close supervision centre (CSC), managed by the Head of Healthcare, houses eight prisoners who pose exceptional risks.

12. The Independent Monitoring Board (IMB)[2] report for the period May 2008 to April 2009, acknowledged the improvement in healthcare resources following investment by the Primary Care Trust. Prisoners who used healthcare services were observed to be well cared for. The IMB raised concerns about inadequate support for prisoners with severe mental health problems and suitability of accommodation for the ageing prison population. At the time of their report, Wakefield held around 100 prisoners over the age of 60 years and 116 disabled prisoners. There were approximately 240 prisoners in the 40 to 50 years age group who were serving long sentences and who would increase the ageing population. The IMB praised the effectiveness of the nurse-led Primary Care Centre. Prisoners such as the man used the first contact services for rapid assessment and management of acute and chronic conditions.

13. In her report following an announced inspection in December 2008, the former Chief Inspector of Prisons described Wakefield as having built upon improvements made over the past five years. Wakefield was assessed as a prison performing reasonably well overall, although the former Chief Inspector acknowledged there was more to be done.

14. The inspection highlighted a number of problems with pharmacy services and medication management. This was an issue for the man while he was at Wakefield and the subject of complaints to the Governor by his wife. The investigator, my colleague and the clinical reviewer, Ms A, have considered these matters later in this report.

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[1] 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.

[2] All prisons in England and Wales have an Independent Monitoring Board (IMB). The IMB is staffed by volunteers from the local community. The IMB have access to every area of the prison, including attending meetings, adjudications and segregation reviews, answering prisoners' queries and investigating complaints. The IMB is required to publish an annual report.

15. There have been a number of deaths at Wakefield since 2004, when my office took over responsibility for conducting investigations into all deaths in prison custody. Although recommendations have been previously made about record keeping, there are no similarities between the man's death and those of previous prisoners.

KEY FINDINGS

16. The man was born in 1949. He was married and lived with his wife before his imprisonment. Records show that it was his intention to return to the family home upon his release.

17. The records also show that the man left school without any qualifications. He held a number of jobs throughout his working life. They included factory work, a carpet fitter and an assistant shop manager. While working as a gas appliance fitter he sustained a serious injury to his back in which three discs were crushed. He had been unable to work since that time. The man was registered disabled.

18. The man was sentenced to ten years imprisonment in July 2006, and sent to HMP Manchester. He continued to deny his offences throughout his sentence and appealed against his conviction and sentence. His appeal was unsuccessful. Despite this, he chose not to attend meetings with prison and probation staff to discuss the work he needed to complete to reduce his risk of re-offending and increase his chances of being released early on parole licence.

19. Upon his arrival at Manchester, the man was given the opportunity to make a telephone call to his family to let them know where he was. The man's wife's telephone was turned off and she could not be contacted. Meanwhile the man was located on the induction wing to learn about the prison and the prison regime. An entry in the prisoner personal record document on 28 July, shows that the man had already been selected for transfer to HMP Wakefield. However, this did not happen until December 2006.

20. A first health assessment was undertaken in which the man said he did not wish to see a doctor. The man was assessed as suitable to be located on a wing, go to work and share a cell. The question about whether he had any concerns about his physical health was unanswered. No medical information was received from an external source, but the man said he saw his doctor around four months before but could not remember why. He confirmed that he was receiving prescribed medication, temazepan[3], cocodamol[4] and diclofenac[5] . There is no evidence that the member of healthcare staff who completed the form considered whether the man might need medication or physically examined him. The screening form asking for a medical history was not completed.

21. The man was interviewed by wing staff when he arrived on the induction unit later that day. He told them he was taking painkillers and sleeping tablets. No other issues were identified. The wing sheet noted that the man had disability requirements but that he had not been allocated suitable accommodation at that time.

[3] Temazepam is sedative used to treat insomnia.
[4] Cocodamol is used for pain relief.
[5] Diclofenac is used as a treatment for anti-inflammatory relief.

22. An entry in the man's prison wing sheet on 28 July, shows that the chaplaincy at Manchester contacted his wife that day and told her he was in prison. The man's wife was very distressed at the news.

23. Throughout the early part of his sentence at Manchester, it was recorded in the man's wing sheet that he had settled well into the prison, obeyed the rules and regulations and went to work. He was noted to be clean and tidy, and polite to staff.

24. The man transferred to Wakefield on 15 December 2006. He was interviewed by prison staff the same day and neither the man nor the staff had any concerns. An entry in the clinical record dated the same day shows that the man was seen by a member of the healthcare staff in reception. It is impossible to determine which member of staff saw the man as entries, although dated, are not timed and the signatures are illegible. The entry recorded that the man had a chronic back problem and was taking diclofenac and paracetamol and using Deep Heat cream. He appeared happy to be at Wakefield.

25. The man was seen at a First Contact clinic[6] on 12 February 2007. His attendance was recorded by a handwritten entry on a contact sheet in his clinical record. He was allocated to work in the textiles workshop and asked to be put on the afternoon shift as he found it difficult to move about in the morning. Healthcare staff agreed and said they would ring C wing, where the man was located, to confirm that this was appropriate.

26. There is evidence of the man's attendance at four subsequent First Contact clinics on 16 April, 20 April, 4 May, 25 June and 2 August 2007, where he was seen by nursing staff. His chronic back problem was noted. The man's ongoing difficulty getting medication for pain management are apparent on each occasion and he had been advised to report sick. The investigator noted that there are no corresponding entries in the computerised clinical record. I address the matter of the importance of good record keeping in the Issues section of this report.

27. The man's wing history sheet required two detailed entries from his personal officer[7] per month. An entry by his personal officer for 8 March said that while not necessarily isolating himself from other prisoners, the man was a private man who preferred his own company.

28. At the First Contact clinic on 20 April, the man told Nurse A, a registered general nurse, that he used a lower back brace at home. However, the prison security department would not allow it to be sent in as parts of it were made of metal. Only a back brace made entirely of fabric was permitted. Nurse A planned to speak to the prison doctor to arrange for a

[6] First Contact clinic is run by nursing staff for prisoners with chronic conditions/health needs.
[7] A personal officer is allocated to each prisoner and is a personal point of contact in case of difficulties.

referral to the Surgical Appliances Department at Pinderfields Hospital if the prison could not provide a back brace.

29. The security department was unable to give permission for the brace. Doctor A, one of the prison doctors, wrote to the Surgical Appliances Department on 10 May, asking them to assess the man for a fabric back brace. The matter was still not resolved in September when the residence governor sent a memorandum to healthcare asking for a formal medical decision. This was because the security department required the brace to be medically prescribed before allowing the man to have it. The residence governor confirmed that he had the brace as the man's wife had posted it directly to him. Doctor A replied to the residence governor on 12 September, that she had referred the man to the Hospital on 10 May, but had not had a response. In the circumstances, she asked if the residence governor could issue the brace to the man as he needed it to help ease his low back pain. The clinical record shows that the man was in possession of the brace when he visited the prison doctor on 24 October. The clinical reviewer has considered the matter of the delay in the man receiving the back brace.

30. In June, the man was given permission to visit his dying sister in Hospice. His good behaviour towards hospice and prison staff was recorded. On 15 July, a member of the chaplaincy team broke the news to the man that his sister had died.

31. The clinical record shows that throughout 2007 and 2008, the man continued to visit the healthcare department regularly for medical reviews and repeat prescriptions for diclofenac, ibuprofen gel, paracetamol and medication for an ongoing skin condition. However, on 27 May 2008, following a visit to the man at the prison, the man's solicitor wrote a complaint letter to the Governor. The solicitor said that the man had three crushed discs, sciatical nerve damage and mobility problems and was registered disabled. The man had told his solicitor that he had been prescribed paracetamol, ibuprofen gel and 75mg of Dicoflex (a brand of diclofenac) and was still in considerable pain. He said that he did not have an appointment with a doctor until 30 May. The solicitor asked that the man's medication be reviewed regularly to ensure that the man was not "left in pain".

32. The Governor of Wakefield replied to the man's solicitors on 11 June, saying that she would ensure that the man's medication was regularly reviewed. There followed an exchange of correspondence between the man's solicitor and the prison about the man's medical care. Through his solicitor, the man complained that he expected to see a doctor on 30 May, but saw a nurse who arranged for his next three month's supply of medication to be made available. When he went to collect his medication on 8 June, he was told that it was not there. The man put in an application to see a doctor but saw a nurse again on 17 June.

33. The clinical record supports the man's version of events. Nurse B, a prescribing nurse, reviewed him on 30 May and prescribed diclofenac, ibuprofen gel and medication for his skin complaint. On 17 June, The man told Nurse B that he received the paracetamol for the first week but was told that no more was available. Nurse B planned to discuss this with the pharmacy department. The next entry in the clinical record, dated 26 August, shows that the man saw Doctor B, a prison doctor, and asked for a repeat prescription.

34. The man's wife wrote to the Governor early in 2009, to complain that her husband continued to have problems with his medication. The man's medication in the community had been effective and she asked if the prison could contact the man's community doctor and obtain his medical records. She was also concerned about the distance he had to walk and the number of stairs he had to use to get from his cell to work. The Head of Healthcare replied that the problem arose because two similar items had been prescribed and, as a precaution, the pharmacist would not give them to the man. A referral had been made to a physiotherapist and a change in the man's workplace was being actively pursued. (A note in the clinical record shows that the man had the physiotherapy assessment on 18 May.)

35. On 8 April, the man's wife wrote to the prison again, to say that her husband was still not receiving the right medication, there were items missing and there had been no change in his work location. The prison responded again saying that the man had now received six month's medication; a change of labour form had been submitted and a referral made to a physiotherapist. A copy of the man's wife's letter would be sent to each of the labour board, disability team and the physiotherapist.

36. The man's wife wrote a third letter of complaint on 22 May, saying that her husband was again without his medication and that Doctor A had not renewed his prescription despite being asked to do so on 9 May. (There is no entry in the clinical record to say that the man saw the doctor on this date.) The man had apparently been told to report as sick until he saw the doctor but told his wife that he did not want to do this as "he likes to keep going". The response from the then Head of Healthcare on 29 May, was that the prison had ensured that his medicines were administered on time and that all patients have to see a doctor for a review throughout the year. The response did not acknowledge or address the specific issue of the man not receiving his medication. The clinical review highlights concerns regarding the man's difficulties with his medication and poor record keeping by healthcare staff.

37. The investigator spoke with Prisoner A, the man's friend. Prisoner A confirmed that the man told him that he had received stronger medication in the community. He was aware that the man suffered from chronic back pain because of an industrial injury. The man's clinical record says that the accident happened around 1993/1994 when he was moving an unstable 45 gallon barrel. He fell, but managed to avoid the barrel falling

on top of him. Prisoner A said that the man first worked in the trimming and packing workshop at the prison. This involved carrying boxes which caused him pain. The man moved to a second workshop which was more suitable work and also nearer to his cell. Prisoner A told my colleague that the prison had offered the man a wheelchair, but he refused. He also said that the man told him that he had a history of a heart or angina problem in his 20's.

38. My investigator spoke with Principal Officer A, a principal officer in the wing where the man was located. Principal Officer A said that the man was located on the ground floor of the wing because of his mobility problems, but the wing had a lift to the upper floors. Principal Officer A was aware that the man could manoeuvre himself up and down the stairs without using the lift.

39. Prisoner B, a prisoner and the man's friend, was aware of the man's difficulties getting his medication. The man expressed his view to him that his medication had been changed because of costs.

40. The man continued to visit the healthcare department regularly for physiotherapy and to renew his medication. He last visited healthcare on 12 November where a review was undertaken by Doctor C, a prison doctor.

41. The man's wing record gives consistently good reports of his behaviour and attitude to staff and others throughout his sentence. However, while compliant with the prison rules and regulations, the investigator noted that the man did not discuss his pain management difficulties with wing staff. They were unaware of his problems with medication.

21 January 2010

42. Head of Healthcare and Wakefield liaison for this investigation told the investigator that telephone calls made by prisoners were recorded. He had listened to a recording of a telephone conversation between the man and his wife made on 21 January. (Although my investigator was given a CD copy, the recording could not be accessed.) Apparently, the man told his wife that he had been suffering from pains in his chest and legs for two to three weeks. However, there is no evidence that he shared these concerns with either healthcare or discipline staff. Head of Healthcare said that the man made a similar call the night before he died, telling his wife that he felt very ill with pains in his chest and arms but again, did not share this with prison or healthcare staff.

43. Prisoner A told the investigator that the man had a cold two weeks before he died and had complained of pain and tightness in his chest. He was urged to see a doctor as another prisoner had suggested that he might have a chest infection. Prisoner A recalled that the man had gone to the healthcare centre and told them that he thought he had a chest infection but did not tell them he had chest pain. Prisoner A thought that if the man

had told them he was suffering from chest pain and not a chest infection, it would have been dealt with as a matter of urgency. There is no evidence in the clinical record that the man went to healthcare complaining of a chest infection.

22 January

44. On the morning of Friday 22 January, Prisoner A remembers the man leaning against his cell door complaining of chest pain. He told him to go to the doctor. He offered to get him water and the man went to lie on his bed. By lunchtime, when Prisoner A returned from work, the man was looking better, but did not want his lunch. Prisoner A told him that he would see him tonight and would get him some water. He arrived at the man's cell at around 4.50pm. The man offered his dinner to Prisoner A as he did not want it. Prisoner A thought that he did not seem too bad as he had asked for some hot water. Prisoner C, another prisoner who knew the man, said that he spoke with him that afternoon. He told him he did not feel well and so Prisoner C advised him to go to healthcare. The man replied that it was a waste of time as they would not do anything.

45. Officer A, a prison officer, knew the man well. She described him as a person who liked to have a laugh and a joke. She said that staff did not know he was unwell and she thought that he did not want to burden them with the knowledge. He never complained to officers about anything and she described him as a model prisoner.

46. Officer A said that most of the wing staff left at 5.00pm, leaving herself and Officer B, another officer, on duty. She said there was paperwork and checks to do before the night staff arrived at around 8.00pm. Before going off duty, she and Officer B made a full roll check (physical count) of the prisoners at around 6.00pm, which was earlier than usual. Officer B checked one side of the wing while Officer A checked the other. They started on the top floor of the wing, opening cell observation panels and speaking to prisoners as most were awake. She said that they worked their way down to the ground floor and she checked the cells on the left side of the landing and Officer B checked those on the right. The man's cell was on Officer B's side. Officer A said she was standing outside the kitchen as there were no cells on that side, when Officer B reached the man's cell at around 6.15pm.

47. Officer B looked through the observation panel and saw that the man was lying in an awkward position on the bed. He said he shouted and kicked the door to get a response. Officer B could not see the man's face, but he noticed that his shins and the lower part of his arm were purple.

48. Officer B called Officer A over as he was concerned and both officers looked through the panel. She said that the man knew her better than Officer B and, if she called to him, she was confident he would answer her. She thought that he could have been sleeping but she could not see his face. His arm was curled up and one leg was off the bed. She noticed

that the bottom part of his arm was mottled and his fingernails were white. There was no response to her bang on the door. They opened the door and went into the cell. Officer B saw that the man's face was grey in colour. Officer A thought he had passed away. Neither officer was recently trained in first aid or resuscitation techniques.

49. They relocked the cell and Officer A went to summon assistance while Officer B remained outside. She ran up to the second floor to the wing office where Principal Officer B was located in his role as Oscar 1[8]. While running to the office, she used her radio to call for nursing assistance. She said that there was a code blue [9]on 'C' wing. She told Principal Officer B that a prisoner was not responding. He locked the wing office doors and ran down to 'C' wing with Officer A.

50. They reached the cell and Principal Officer B used his radio to call for an ambulance through the prison control room. The Incident report records Principal Officer B requesting the ambulance at 6.15pm. While he was doing this, two officers from 'A' wing, Officer C, who was trained in first aid and Officer D, responded to Officer A's call for medical assistance over the radio net. Officer B unlocked the cell and went in with Officers C, D and A.

51. In his statement, Officer B said Officers C and D immediately took charge. Officers A and B said that because of the small cell, Officers C and D moved the man off the bed outside to the corridor. Officer A said she and Officer C felt for a pulse but could not find one.

52. Officer C started chest compressions for cardiac pulmonary resuscitation (CPR). Officer D held the man's head and also tried to find a pulse at the man's wrist and throat but was unsuccessful. Officer E, an officer trained in first aid who worked on 'B' wing, also went to the cell. In his statement, Officer E said that, similarly, he had heard the code blue call for healthcare staff to attend 'C' wing. He reported to Principal Officer B and told him he was trained in first aid.

53. Officer E said that Officer C looked tired and he took over CPR from him. Officer C then gave breaths to The man. The officers exchanged places when one tired.

54. Nurse C was Hotel 5[10] at the time the man was found collapsed in his cell. It was at 6.14pm and she was in the healthcare centre inpatients unit in the prison at the time. Upon hearing the call for medical assistance, she stopped at the healthcare primary care centre to collect the emergency response medical bag and the defibrillator.[11]

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[8] Oscar 1 is the officer in charge of the operational running of the prison.

[9] The prison uses colour codes to describe the type of medical emergency: red indicates a blood related incident and blue means not breathing.

[10] Hotel 5 is the emergency radio call sign for the nominated healthcare worker who has to respond to medical emergencies in the prison.

[11] A defibrillator is an electronic device which sends an electric shock to the heart to restore the normal heart rhythm. Defibrillation is performed to correct life-threatening fibrillations of the heart, which could result in cardiac arrest.

55. Nurse C said she arrived at the man's cell at 6.20pm. She saw that he was lying on the floor outside his cell, unconscious and very blue. Officers C and E were carrying out CPR. She was told that an ambulance had been called.

56. Officers C and E continued with CPR. Principal Officer B asked for the man's shirt to be removed so Nurse C could attach the defibrillator pads to his chest. The defibrillator advised that CPR should continue and both officers confirmed to Nurse C that they were happy to do so. There was fluid in the man's mouth and throat and she and Officer E turned the man on his side to try to clear his airway. Despite this, both officers continued with CPR. The paramedics arrived at 6.24pm, when the defibrillator was making a second check of the man's heart. After receiving an update of the situation, they took over the man's care. Despite the efforts by prison staff, the paramedics pronounced the man's death at 6.45pm.

After The man's death

58. No family liaison officers were available at the prison. The investigator was told that there was a shortage of staff who were willing to undertake the role. Although he was on annual leave, the Head of Healthcare, assumed responsibility for contacting the family. He told the investigator that he was accompanied by a police officer to break the news to the man's wife and arrived at her home at quarter past midnight. He spent around two hours and waited until other family members arrived to support her.

59. Although the man's wife has questions about her husband's care, she spoke positively to my family liaison officer about the support she had received from the prison following his death. She confirmed that the prison returned the man's property and paid for the cost of his funeral.

60. A Hot Debrief[12] was held on 22 January. Staff present at the man's cell were given the opportunity to share how they felt with colleagues. They were offered support from the Staff Care and Welfare Team or the Employee Support Services. They reviewed how the situation was managed and the lessons that had been learned. Staff identified that more first aid trained staff were needed. They also suggested there may have been some delay collecting the emergency treatment bag from healthcare. Events showed that screens would have been advantageous as CPR had to be carried out on the landing because of lack of space in the cell.

[12]The purpose of the "Hot" debrief is to acknowledge what happened, acknowledge the role of the staff involved, normalise the situation and ensure that immediate needs of the staff have been met.

ISSUES

Clinical care

61. Ms A, RGN at an NHS District Primary Care Trust (PCT) reviewed the man's clinical care. Her review is based on prison medical records and liaison with the investigator, my colleague. Ms A identified issues regarding the management of the man's chronic back condition. Specifically, prescribed medication that was not available, together with the absence of entries in the clinical record relating to their prescription and poor record keeping.

62. Nevertheless Ms A concludes that, overall, the routine medical care given to t\he man at Wakefield was appropriate. However, there was no multidisciplinary approach in the management of his chronic back condition and no management plans or an identified clinician responsible for supervising or co-ordinating his care. Ms A assesses that "there were occasions when his pain management was less than acceptable". She highlights significant concerns regarding the confusing systems in place for recording and prescribing medication. Ms A makes three recommendations regarding these issues which I endorse.

63. The clinical review acknowledges that the man was offered annual medical reviews, but refused routine blood screening tests. Ms A advises that the man did not appear to have any symptoms or signs that could have prevented his collapse.

Prescribing medication

66. The former Chief Inspector of Prisons found that prescriptions for in-possession and administered medications were written on standard prescription forms:

> "… charts were not correctly completed to indicate which medications were to be administered and which were daily or weekly in possession and they were not correctly annotated by nurses to indicate whether medication had been administered/collected or the patient failed to attend. Prescriptions were often written up for three months supply and did not include a diagnosis. Prescribers did not always record prescribed items on system one[13]."

The clinical reviewer found similar instances of poor recording in the man's clinical record. In her clinical review, Ms A said there were "significant concerns regarding the confusing systems in place for recording and prescribing medication". She also noted that the First Contact sheet information was not recorded in the clinical record. Accurate record keeping is not optional and records should be kept

[13] System One is the computerised healthcare recording system

according to the Nursing and Midwifery Council's standards. Ms A makes a recommendation regarding an urgent review of the systems and processes for prescribing medication, with which I concur.

The Head of Healthcare should undertake an urgent review of the systems and processes in place for prescribing current and repeat medication, including recording in the clinical record.

The Head of Healthcare must remind healthcare staff that accurate and timely record keeping is essential in accordance with the standards of the Nursing and Midwifery Council.

Nurse prescribers

67. Ms A also found apparent discrepancies between the medication prescribed on the prescription sheets and the information documented in the clinical record. She has made a recommendation in this regard which I endorse.

The Head of Healthcare should ensure that an audit of prescribing by nurse prescribers is undertaken in order to establish the appropriateness of prescribed medication, against the needs identified in the clinical record.

Family liaison

68. The Head of Healthcare, Segregation Unit and Close Supervision Unit, was on annual leave when he was contacted by the prison and asked to undertake the role of family liaison officer. He told my investigator that this was in the absence of any other liaison officer being available and as he had been trained. It is commendable that he agreed to carry out the role in these circumstances to assist the prison.

69. However, in doing so, I consider that the prison, albeit unknowingly, placed Head of Healthcare in a difficult position. There are copies of letters within the clinical record showing that Head of Healthcare responded to complaints from the man's wife about his medical care. She has also raised a number of issues around the man's medical care with my office. I judge that, in this instance, given the nature of previous concerns and correspondence, there was a conflict of interest regarding Head of Healthcare's role as family liaison officer and as Head of Healthcare. As this did not impact adversely on the communication between Head of Healthcare and the man's family, I make no formal recommendation on this specific point. However, I consider that given the nature of the population at Wakefield prison and the consequent regularity with which deaths or other serious matters occur, it is essential that sufficient trained family liaison officers are available.

The Governor should ensure that there is a permanent rota of staff trained in the role of family liaison officer available to undertake the position in the event of future deaths at the prison.

Medical aids

69. The man used a back brace support before he went into prison. He asked for a brace in April 2007, which he did not receive until six months later in October 2007. The matter was not resolved until the residence governor intervened by writing to the healthcare department asking for a formal medical decision regarding the brace, so the security department could consider it. I believe that this was an unacceptable and unnecessary delay caused through poor communication between the security and healthcare departments. The clinical reviewer has considered the matter of the unacceptable delay, again I endorse her recommendation.

    The Governor and Head of Healthcare should review internal communication systems to minimise delays in prisoners receiving medical aids/equipment. Items not held in the healthcare department should be obtained and made available to the prisoner as soon as possible.

Response when the man collapsed

70. I am pleased to make commendations regarding the efforts of Officer C, Officer D and Officer E in responding to the emergency call, taking command of the situation and attempting to save the man's life. Sadly, they were unsuccessful. However, comments made to my investigator by prisoners, and staff who were present at the man's cell and the officers' statements show that their efforts were over and above that required of them.

    The Governor should write to Officer C, Officer E and Officer D commending them for their tremendous efforts in trying to save the life of The man.

71. The hot debrief meeting held on 22 January with staff identified, among other issues, a need for screens on the wings. CPR had to be carried out on the landing due insufficient space to do this effectively in the cell. The man was found in the evening after prisoners had been locked in their cells and the observation panels on the cell doors may have been closed. However, it is possible that future events may occur during the day and, unavoidably, in full view of prisoners. Screens on the wings would assist staff give dignity to the prisoner and help to reduce the risk of other prisoners witnessing such events.

    The Governor should provide privacy screens for each wing, to be used by medical and discipline staff involved in medical emergencies. These will also reduce the risk of prisoners witnessing distressing events and will give dignity to the prisoner.

CONCLUSION

71. The man had served over three years of his sentence when he died from ischaemic heart disease in January 2010. Although he had a longstanding chronic back condition following an industrial accident, he had not shown any signs or symptoms of heart disease and his death was sudden and unexpected.

72. Prisoners who knew the man well said that he had chest pain for a few weeks before his death and they advised him to go to the healthcare centre. However, he told healthcare staff that he had a chest infection and said nothing about chest pain.

73. The clinical reviewer is satisfied that, overall, the man's routine care was appropriate. However, there were occasions when pain management for his chronic back condition fell short of the standards expected. The investigation has found that this supports the man's wife's concerns around her husband's medication. The method of recording and prescribing medication is inadequate and needs to be reviewed.

RECOMMENDATIONS AND COMMENDATION

1. **The Head of Healthcare should undertake an urgent review of the systems and processes in place for prescribing current and repeat medication, including recording in the clinical record.**

   Accepted. Medicines Management Process mapping exercise to be undertaken Aug 2010 to address clinical issues relating to medication prescribing/dispensing/administration. Paracetamol Protocol completed.
   Systm 1 training undertaken.
   Auto consultation added to Systm 1.
   Prescription Chart audit completed – action plan ongoing.
   In-Possession Policy refreshed Aug 2010 – undergoing ratification.

2. **The Head of Healthcare must remind healthcare staff that accurate and timely record keeping is essential in accordance with the standards of the Nursing and Midwifery Council.**

   Accepted. With effect from April 2010 resources were made available to deliver SystmOne training one day per week; this will be ongoing throughout 2010. As part of the staff appraisal system all staff have been issued with Record Keeping standards in accordance with the Nursing and Midwifery Council. Record keeping audit completed for 2010 – action plan written.
   Training session on record keeping and professional accountability planned for Sept. 2010.

3. **The Head of Healthcare should ensure that an audit of prescribing by nurse prescribers is undertaken in order to establish the appropriateness of prescribed medication, against the needs identified in the clinical record.**

   Accepted. Audit of Nurse Prescribers currently being undertaken – self audit process followed by NHSWD and continuous in practice.

4. **The Governor should ensure that there is a permanent rota of staff trained in the role of family liaison officer available to undertake the position in the event of future deaths at the prison.**

   Partially Accepted. At the time of the DIC, there was a Family Liaison Rota in place, and there still is one in place. Unfortunately, the On Call FLO was not contactable at the time, therefore an alternative FLO had to be deployed.

   The Head of Healthcare does not feel there was any conflict of interest with regard to the letters he sent to the man's wife. The family themselves never raised any issues or concerns regarding these letters during the Head of Healthcare's visits to their home.

5. **The Governor and Head of Healthcare should review internal communication systems to minimise delays in prisoners receiving medical aids/equipment. Items not held in the healthcare department should be obtained and made available to the prisoner as soon as possible.**

   Partially Accepted. Due to the high security nature of the prison there will be a delay in the prison receiving the equipment due to it having to be checked and x-rayed. This is reviewed on a case-by-case basis but the prisoner will be kept informed should there be any further delays in them receiving it.

6. **The Governor should provide privacy screens for each wing, to be used by medical and discipline staff involved in medical emergencies. These will also reduce the risk of prisoners witnessing distressing events and will give dignity to the prisoner.**

   Partially Accepted. We recognise the need to ensure the deceased is afforded Dignity and Decency in death. However, we would access the method of delivering this on a case by case basis.

   We will look to source an appropriate method of ensuring the Dignity and Decency following a DIC, and develop a local protocol with or Dedicated Search team, who manage the scene immediately following such an incident.

Commendation

The Governor should write to Officer C, Officer E and Officer D commending them for their tremendous efforts in trying to save the life of the man.