Investigation into the death of a man, who died in hospital on 20 May 2005 whilst a prisoner at HMP Kirkham

Report by the Prisons and Probation Ombudsman for England and Wales

August 2006

This report concerns the death from apparent natural causes of a man in hospital in the early hours of 20 May 2005. He was aged 50, was a prisoner at HMP Kirkham.

The man suffered from liver disease. He had been taken from Kirkham to a medical centre on 30 April after complaining of abdominal discomfort and reduced urine output. From there he was admitted to hospital where he remained until his death.

During his time in hospital, the man had fluid drained from around the liver and underwent emergency surgery for an incarcerated umbilical hernia. On 10 May, his condition was reported to have deteriorated and on 11 May he was transferred to the Intensive Care Unit. Unfortunately, the man's condition continued to deteriorate. The post mortem report concluded that he died from pneumonia secondary to cirrhosis of the liver.

I would like to extend my condolences to the man's family for their loss. During this investigation, the family raised a number of concerns that I hope this report addresses.

I thank the duty governor and the other staff members at Kirkham who assisted my investigators. I am also grateful to Fylde Primary Care Trust for their review of the man's clinical care.

Four recommendations are made in this report. I have also identified three examples of good practice.

This version of my report, published on my website, has been amended to remove the names of the deceased and the names of staff and prisoners who were involved in my inverstigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2006**

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Summary

The man was born on 31 January 1955. He had a history of drug and alcohol use and had serious liver problems for which he was undergoing clinical investigation in the community.

On 4 April 2005, his was sentenced to nine months imprisonment for possession of a ‘firearm’, which was in fact a CS gas canister and an attempt to convey these items into prison. He was received into HMP Preston, where he underwent a detoxification programme. When this was complete, he transferred to Kirkham prison on 22 April.

The man’s health gave cause for concern whilst at Kirkham. He was given medication for pain relief, but continued to be unwell. On 30 April 2005, he attended the prison healthcare centre complaining of abdominal discomfort. The nurse who examined him considered it necessary to refer him to a local medical centre and he was admitted there some hours later.

From the medical centre, the man was transferred to hospital where, over several days, he was treated for liver problems. He underwent emergency surgery for an incarcerated umbilical hernia on 9 May. Subsequently, the man’s condition deteriorated and he was admitted to Intensive Care on 11 May. He died there on 20 May, with his family around him.

The post mortem report concluded that the man died from pneumonia and cirrhosis of the liver. A clinical review carried out by Fylde Primary Care Trust concluded that, although the surgery for hernia was not expected or planned, it was necessary and appropriate. It also indicated that the man’s particular health issues significantly affected the outcome of what would normally have been a routine operation.

I judge that he received healthcare that was comparable to that which he could have expected if he was living at home. However, I raise a question about the medication with which the man was issued for pain relief and a recommendation is made to provide additional safeguards in this area. I have made three other recommendations and identified three examples of good practice.

The Investigation

The investigation was opened on 2 June when one of my investigators contacted the appointed prison liaison officer, a governor, to arrange to an initial visit to Kirkham on 27 June.

One of my Family Liaison Officers made contact with the man's partner to establish what concerns she wished the investigator to follow up on her behalf. The man's partner was concerned about how quickly her partner's health had deteriorated in hospital between 9 and 10 May. She was also concerned that he was not able to keep a hospital appointment for a biopsy. She also said that, until she phoned at 9.45pm on 30 April, she had not been informed by the prison that he partner had been taken to hospital earlier that day.

My investigator visited Kirkham on 27 June to familiarise herself with the prison, particularly the houseblock where the man resided. She returned on 13 July and spoke with members of the healthcare centre staff. She also examined prison records and documentation and spoke with relevant staff.

An independent clinical review of the man's healthcare was carried out by Fylde Primary Care Trust.

In January 2006, after submitting a draft report, one of the investigators stopped working for my office. This investigation was subsequently passed to the second investigator to complete.

In order to complete the report and answer a number of outstanding questions, my colleague spoke with healthcare staff who were involved in the man's care. She also contacted the Clinical Reviewer - Fylde NHS PCT, the Prison Duty Governor, and the Coroners office.

The Man

The man was born on 31 January 1955. He had a history of drug and alcohol use dating back to his youth, and had appeared before the courts on numerous occasions mainly concerning offences relating to his dependency on drugs. The man had held several jobs. However, his drug use, and later his health problems, diminished his ability to hold down a job and before his conviction he had been unemployed for a number of years.

His family described him as a caring person who lived for his close knit family. He is survived by his daughter aged 26 and son aged 16 who deeply feel his loss. The man had struggled for much of his life with addiction. He was hoping that his detoxification while in custody would have enabled him to turn his back on Heroin. He leaves a huge gap in the family and he was will be greatly missed”.

The man had serious liver problems and was undergoing clinical investigations for these. A probation report dated 31 March 2005 stated that he told his probation officer that he had been frightened by recent symptoms and was trying to cut down on his drinking as a result. He was also seeking help for his drug dependency.

On 4 April 2005, the man was sentenced to nine months imprisonment for possession of a firearm, namely a CS gas canister, and an attempt to convey this and other items into prison. He was received into HMP Preston on 4 April and transferred to HMP Kirkham on 22 April.

The man had been in Kirkham only a short time before his admission to hospital on 30 April. However, he had a good friend in the prison and had maintained regular contact with his partner and his family, who were supportive. The man received regular visits whilst in prison and latterly whilst in hospital.

HMP Kirkham

HMP Kirkham is a category D training prison for adult men. Accommodation is provided in single-storey houseblocks; workshops and a sports centre are provided on site.

Kirkham provides accommodation for approximately 590 prisoners. Facilities enable a daytime, evening and weekend education programme to be delivered. Prisoners are employed in the prison's workshops, farm, garden and works departments, and there are opportunities for some prisoners to gain paid employment, community work and college placements in the local community.

Healthcare is provided by qualified nurses between the hours of 7.30am and 5.30pm Monday to Friday, 9am – 3pm Saturdays and 10am – 4pm Sundays and Bank Holidays. There is no inpatient facility. Prisoners are referred to a medical centre if they have a medical problem which requires a doctor's opinion or to Accident and Emergency at the local hospital in case of emergency. Prisoners generally attend healthcare for medical problems, but in case of emergency the nurse visits them in their residential blocks.

Events leading up to 30 April 2005

The man was sentenced to nine months imprisonment on 4 April 2005 at Preston Crown Court. He was received into HMP Preston the same day and his healthcare needs were assessed. It was noted that he had cirrhosis of the liver and that he had a hospital medical appointment arranged by his own GP for 25 April. The man was already being prescribed methadone for his drug dependence and was noted to have concerns about the detoxification programme along with his liver problems.

He was seen again by healthcare staff on 5 April. A drug assessment was carried out and a reduction programme recommended. It was also noted that, because the man knew the date and time of his appointment for a liver biopsy, his appointment would be rearranged for security reasons.

On 15 April, the man was noted to be on the transfer list for Kirkham prison. However, he was unable to transfer at that time as his opiate reduction programme had not been completed. It was recorded that this was explained to the man who accepted the explanation. It was arranged that he would be transferred when his programme was complete.

No further entries were made in his medical record during his time in Preston. However, his medication administration record chart indicates that he was given paracetamol on 19 April, presumably for pain relief.

On 22 April, the man was transferred to Kirkham. A health check was carried out on reception which noted 'alcoholic liver disease'. It was also recorded that he had an outstanding appointment, but that he did not know when this was.

A Sports Centre Action Plan dated 25 April 2005 states that the man discussed his hernia with a Physical Education Officer (PEO). He had been told that he was not to attend the gym until he had seen the doctor and been given the okay. A copy of the 'Sports Centre Weights Room Induction Competence Sheet' shows that the man demonstrated a safe technique when using gym equipment. This was assessed using 1kg weights and was considered safe taking into account the man's medical history.

On 25 April, he saw healthcare staff and requested a referral due to an umbilical hernia and chronic liver disease. He said that he had undergone two unsuccessful biopsies in the past. On 26 April, healthcare staff telephoned the man's consultant, and were told that she did not want to see him again. Healthcare staff requested a letter confirming this. A letter dated 4 May was subsequently received. It stated that The man had been listed for liver biopsy, but that the consultant had cancelled the appointment as she did not feel that it would add any further information. Her only question at that time was whether it was safe to treat his Hepatitis C. She noted that the man had a further appointment at her liver clinic on 3 August 2005.

On 27 April, he was issued with 16 paracetamol tablets and 12 ibuprofen tablets for pain relief. During interview, the pharmacy technician in the healthcare centre confirmed that this was routinely issued to all patients as a two-day supply. She also confirmed that, prior to issuing medication, the pharmacist will ask the patient if

they are allergic to any medication. She relies on patient reporting and information on allergies noted in red on the front of the patient record for information, rather than information received from the reception health screen. The pharmacy technician agreed that paracetamol would not usually be prescribed for patients with liver disease. It is impossible to establish the quantity (if any) of the medication that the man took during the next couple of days, as during cell clearance following his death it was noted that 'a quantity' of medication was found. However, it is unlikely that the medication would have had a particularly detrimental effect on the man's clinical condition.

On Friday 29 April, at 10am, he attended the healthcare centre complaining of loin pain. The nurse who attended to him noted that he could not take paracetamol and therefore gave him ibuprofen. Unfortunately, the attending nurse has since left the prison and it is impossible to establish from where this information was gained. At 4pm the same day, the man returned to healthcare complaining of back pain and an increase in abdominal swelling. Ascites (a collection of fluid in the abdominal cavity) was noted. He was given advice regarding his diet – namely, to reduce his salt intake and to limit his daily fluid intake to 1500mls. An appointment was made for him to see the doctor after the Bank Holiday weekend. He was also advised to return to healthcare if his condition worsened in the meantime.

The man did return to healthcare the following day at 1pm, complaining that the distension of his abdomen was getting worse. His medical record noted that he was unable to provide a specimen of urine. The nurse who examined him confirmed during an interview that on examining the man, he was concerned that the renal system might have become compromised. He considered this to be an emergency situation and therefore made a referral to the medical centre. The nurse also confirmed that the man was not complaining of problems with the hernia at that time, and that he noted no problems with the hernia other than it being pushed out by the ascites.

The man was taken to the medical centre at 3pm that day. From there he was moved to hospital for investigations/assessment. The prison did not notify his partner of this move. At 9.45pm that evening, the man's partner telephoned to enquire how her partner was and was told he was in hospital and would be staying there overnight. She was given the details to enable her to contact the ward directly.

Events from 30 April 2005 to 20 May 2005

After assessment at the medical centre, the man was admitted to a hospital medical assessment unit.

The prison held a Release on Temporary Licence (ROTL) board on 30 April at 2pm. A decision was made to release the man from prison custody during his stay in hospital. This meant that prison staff were not required to accompany him and handcuffs were not used.

The man was moved onto ward 14 for further investigations and assessment at 12pm on 1 May. Prison staff informed the man's partner of this move and passed on the direct telephone number for the ward.

The prison maintained regular contact with the hospital and information received about his condition was recorded in his prison records.

An entry in the man's prison medical record on 6 May indicates that an ascites drain had been inserted and one litre of fluid drained. The record also states that he was possibly to be scheduled for a liver biopsy. On 8 May, it was noted that the ascites drain had been removed. An entry on 9 May states that he had moved wards following surgery for 'encarcerated' [incarcerated] para umbilical hernia. He was reported to be in a little pain but otherwise settled.

An officer visited the man in hospital on 10 May. He was unable to give the man his 'allowance' (money allocated for use whilst in custody) and was concerned by his condition. The man was heavily sedated and unable to speak to the officer. The ward sister had described him as 'poorly'. The officer contacted prison healthcare staff who contacted the hospital to be told that he was very poorly. Prison staff were also informed that the man's partner had visited the previous day. One of the man's partners concerns was how quickly her partner's health deteriorated between 9 and 10 May. The documentation suggests that these concerns were also shared by the officer.

On 11 May, prison healthcare staff made several telephone calls to the hospital. They were informed that the man had been moved to the Intensive Care Unit and had been put on a ventilator. His family had been informed and were due to see him shortly.

The man remained seriously ill. On 12 May, he had a CT Scan of his brain which revealed no abnormalities. Due to the apparent seriousness of his condition, a staff nurse, in the prison, made sure that the hospital was aware of the procedure to follow if the man died. A governor was also informed of how ill the man was.

On 16 May, he was reported to be deteriorating. On 18 May, prison healthcare staff reported that hospital nursing staff were concerned about giving information over the telephone. A password system was therefore set up which healthcare staff and the prison communications department were made aware of. This ensured timely and appropriate communication between the prison and hospital.

Throughout his time in hospital and previously whilst in prison, the man's family visited him regularly and when he had moved to intensive care, they ensured that a family member was with him at all times.

The man remained very ill. At 1.10am on 20 May the prison was informed that he had died at 12.50am that morning, with his family at his bedside.

Events after the man's death

At 1.14am on 20 May, the duty governor was informed of the man's death and went to the hospital. Incident logs completed by the Night Orderly Officer and duty governor record the various contacts made.

The duty governor was appointed family liaison officer and contacted the family at 9.30am that morning to make arrangements for visits. The man's partner declined a home visit, but arranged to visit the prison later that day. The chaplain was also informed and asked to contact the family to offer support. Following a further telephone call, the family rearranged to meet the family liaison officer and the chaplain at the hospital.

At 11.00am, the duty governor was contacted by the Coroner's Office requesting confirmation of the man's status as a serving prisoner. During this conversation, the duty governor was informed that the man's sister had raised concerns regarding him being made to lift weights at the prison gym, despite having a hernia.
At 11.15am, the duty governor entered notes having interviewed the Physical Education Officer (PEO) and reviewed written documentation regarding these concerns. As noted above, a Sports Centre Action Plan dated 25 April 2005 states that the man discussed his hernia with the PEO and that he had been told that he was not to attend the gym until he had seen the doctor and been given the all-clear. A copy of the 'Sports Centre Weights Room Induction Competence Sheet' shows that the man demonstrated a safe technique when using gym equipment. The assessment includes lifting weights of approximately 1kg, which the PESO confirmed would be less than a 'bag of shopping'. Completion of the induction competence was not contra-indicated by the man's reported medical condition. The medical grading given by healthcare to him during their initial healthcare assessment was 1B. This does not prohibit prisoners from lifting weights but does stop them from taking part in contact sports. The PE department staff carry out their own assessment based on healthcare's grading. The grading is entered by healthcare staff on the reception health screen form and communicated to the PE department.

At 11.50am, the duty governor spoke to all the prisoners on the man's former billet, E4, and informed them of his death. All were offered support but only one prisoner, who knew, the man was at work in the kitchen. The duty governor visited the prisoner in the kitchen to tell him of his friend's death. The prisoner was offered support and time off work, but he declined both. Staff were briefed to offer support if needed later.

At 3pm, the duty governor and chaplain went to the hospital in the expectation of meeting with the man's family. In the event, the family had been refused permission by the Coroner to view his body and had understandably decided not to attend. The family were offered a home visit, which they chose to decline.

On 26 May, confirmation was received of the post mortem findings and the release of the man's body for the funeral. The duty governor personally delivered the man's belongings to his partner at her home.

Incident sheets and other documentation specifically relating to a death in custody were completed, dated and signed where appropriate. Notices to prisoners and staff

were displayed informing them of the man’s death and advising on who to contact for support if required. A Critical Incident Debrief was held for prison staff. This was also extended to members of the hospital staff.

Key Findings and Conclusions

The man had a known, serious medical condition that had existed for some time prior to coming into custody. The evidence from my investigation indicates that the healthcare he received whilst in prison was comparable to that which he could have expected to receive if he was living at home. He had access to prison healthcare quickly when feeling unwell, and was referred promptly and appropriately to secondary care when his condition gave cause for concern.

The man was issued with paracetamol and ibuprofen tablets for pain relief. He kept these in his possession. This was confirmed by prison healthcare staff as being common practice unless there is specific evidence of allergies noted on the patient's file or reported by the patient. This investigation did not find any evidence to suggest that paracetamol was specifically contra-indicated in his case, although it is common for patients with liver disease not to be prescribed this drug and the prison healthcare pharmacist confirmed this to be the case. It should also be noted that there was no evidence to confirm whether the man had, in fact, taken any of the medication issued to him. The cell clearance report states that 'a quantity of medication' was found. It is therefore impossible to say how many tablets (if any) the man had actually taken.

The presence of liver disease was clearly noted on the man's initial health screening documentation both at Preston and Kirkham, although it appears that these documents are not routinely seen by the pharmacist at Kirkham prior to dispensing medication. 'Liver disease' was not documented in the appropriate section on the front of the drug chart. Reviewing the procedure for thorough documentation on drug charts regarding medical conditions, and access to such documentation by the pharmacist, may provide some additional safeguards.

The complaint/diagnosis section of the prescription chart, as well as the 'allergy' section, should be completed and checked by personnel prior to prescribing/issuing medication.

The man was scheduled to have a liver biopsy at the time he was in custody in Kirkham. However, documentary evidence on file shows his consultant cancelled the biopsy due to an already confirmed diagnosis of cirrhosis of the liver. The man did have an appointment to attend the Liver Clinic on 3 August.

A clinical review into the care the man received whist in prison and hospital was conducted by Fylde Primary Care Trust. Whilst in hospital, he had surgery for a hernia, which was not expected or planned, but which the clinical reviewer felt was both appropriate and necessary. The review concluded that the outcome of the man's hospital admission was not as would normally be expected. However, in his case, there were factors relating to his current medical conditions and the need for powerful pain relief that made his case more complicated. Although we did not have access to the hospital clinical records, it is understood from the clinical reviewer that large quantities of Morphine (approximately 80mg) were administered to the man post operatively due to the pain he was suffering. It is apparently documented that Naloxone was given in an attempt to reverse the effects of the Morphine. This will have been a very difficult judgement call for the hospital medical staff to have made. As he was unwell due to the cirrhosis of his liver, required emergency surgery due to

the incarcerated umbilical hernia, and had a history of drug abuse, the dose of pain relieving medication required may have been above average.

There was no toxicology report at the time of post mortem. I am unable, therefore, to comment whether the medication administered to the man whilst in hospital contributed to the deterioration in his condition. However, it is of concern that the quantity of morphine given to him was such that a drug (Naloxone) to reverse the effects was required.

A copy of this report will be shared with the hospital requesting that they carry out an internal investigation into the medication administered to the man post-operatively.

There is evidence that, during the man's time in hospital, prison healthcare staff maintained good and effective contact between the hospital and the prison. However, the man's partner was concerned that she was not informed about his admission to hospital and was told only when she contacted the prison herself that evening to enquire how he was. Kirkham's systems for maintaining contact with families are generally effective and there is a clear policy for notifying the next of kin where prisoners are admitted to hospital where there are issues of a serious or life threatening nature. Due to the number of prisoner's who are referred to hospital, often returning the same day, contact is not made with the next of kin until they are admitted. At the time of the man's admission his condition was not considered life threatening, and therefore the reason that his partner was not contacted at the time of his admission. The prison were informed of the man's admission to hospital, by the escorting officer's at about 9.30pm on 30 April 2005, shortly before the man's partner contacted the prison and before the Night Orderly Officer had a chance to make contact with her.

The Governor should arrange to explain to the man's partner the local policy for notifying the next of kin in emergency situations and the reasons for not immediately notifying the next of kin for routine hospital appointments.

The action taken by prison staff following the man's death was appropriate and in line with Prison Service policy. Incident reports were appropriately completed, dated and signed and the procedures for informing the necessary parties were followed. The prison family liaison officer personally visited the man's partner to deliver his belongings. Support was offered to the family, fellow prisoners and staff. Staff from the hospital were invited to the prison post-incident debrief which I note as an example of good practice.

The cell clearance was carried out by two officers, in line with prison policy. However, due to the fact that the medication found was not identified, nor counted, it is impossible to establish whether the man had taken any or all of the Paracetamol and Ibuprofen issued three days prior to his admission to outside hospital.

The exact quantity and type of medication found during cell clearances should be documented and healthcare informed.

Recommendations

1. **The complaint/diagnosis section of the prescription chart, as well as the 'allergy' section, should be completed and checked by personnel prior to prescribing/issuing medication.**

2. **A copy of this report will be shared with the hospital requesting that they carry out an internal investigation into the medication administered to the man post-operatively.**

3. **The Governor should arrange to explain to the man's partner the local policy for notifying the next of kin in emergency situations and the reasons for not immediately notifying the next of kin for routine hospital appointments.**

4. **The exact quantity and type of medication found during cell clearances should be documented and healthcare informed.**

Good Practice

5. **The 'significant events/problems' front sheet attached to the healthcare notes is a useful way for healthcare staff to obtain information quickly. This helps facilitate a high standard and continuity of care.**

6. **I commend the quality of communication between the prison and the hospital, in particular the use of a password before passing on confidential medical information.**

7. **I commend the inclusion of the hospital staff in the prison's post-incident debrief procedure.**