Investigation into the death in custody of a man in May 2004 at a local hospital whilst a serving prisoner at HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

December 2005

This is the report of an investigation into the circumstances surrounding the death of a man in 2004.

The man passed away whilst in custody of HMP Maidstone. He died at a nearby hospital following an emergency admission. The cause of death was a ruptured myocardial infarction. He died aged 74 years.

The investigation was opened by one of my colleagues. An independent review of the man's medical care in prison was carried out by another colleague, al RN ONC, and she has completed the report. I make a number of recommendations on the issues of records and record keeping, medication, health promotion, professional accountability and the delay in transferring the man to hospital. I also identify three examples of good practice.

I would like to extend my sincere condolences to those touched by this death. I must also thank the management and staff at HMP Maidstone for their assistance and co-operation during the course of this investigation.

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

Stephen Shaw CBE **December 2005**
Prisons and Probation Ombudsman

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Summary

At the time of his death, this man was 74 years old . He was serving a seven year sentence for sexual offences committed in the 1970s and 1980s. Since his initial reception into custody at HMP Woodhill in July 1998, it had been noted on several occasions that the man was suffering from raised blood pressure and low mood.

The man was transferred from Woodhill to Littlehey on 13 October 1998. On 7 June 2000, the man was seen by a doctor who noted in the continuous medical record that he had had an accident in 1972. It appears that the man told the doctor that his testosterone level was low. It was noted that during the accident, which involved a JCB, he had sustained crush injuries to his pelvis and his testes were damaged. The doctor noted: No sexual drive/ability following accident, unable to achieve an erection or ejaculation. The man therefore claimed that he could not have committed the sex crimes of which he was accused. He was due in court the following month. The doctor agreed to investigate the impotence of which the man complained. A hormone screen was carried out on 9 June 2000. The result showed a normal testosterone level with a raised oestradiol level. This appears to indicate that hormone levels were not the cause of the impotence about which he complained.

On 10 June, the medical record lists blood results showing that the man's potassium level was high (6.7). He was started on Frusemide (a diuretic) for a week with a view to repeating the blood test.

The man was transferred to Bristol on 17 January 2002 and to back Littlehey on 30 January 2002. He was released from custody on 14 March 2003 having reached his non-parole release date. In July 2003, he suffered a stroke and was admitted to Luton and Dunstable Hospital where he remained until December 2003.

On discharge from hospital, the man failed to attend a probation meeting and to stay in the accommodation arranged for him by the Probation Service. He was re-called into custody at Woodhill on 17 December 2003.

On 4 February 2004, he was transferred from Woodhill to Lewes. It was noted that he did not know what medication he was on. On 20 May 2004, the man was transferred to Maidstone. A reception screen was performed in the Healthcare Centre, but his blood pressure was not documented. On 21 May 2004, he was seen by the medical officer and a past medical history was taken and documented. His blood pressure was noted not to have been taken recently, and was recorded at that time as 150/100. The man's stroke prevention (aspirin) and hypertensive medication was re-started.

On 4 May 2004, a letter was written by a, Consultant Physician Cardiology department, following an apparent referral by the doctor at Woodhill. The letter stated that the man had cancelled his appointment as he had moved elsewhere in the system. On 20 May, the man was received at HMP Maidstone.

On 27 May 2004, he complained of chest pain and pains along his left hand side. He attended healthcare and was sent back to the wing. It is unclear (due to lack of documentation in the records) what treatment, if any he received.

On 28 May 2004, the man collapsed in his cell. The wing staff contacted healthcare who told them this had happened before and to contact them again in the morning if he was no better.

He collapsed again in his cell on 31 May 2004. An emergency ambulance was called and CPR commenced. Unfortunately, staff were unable to resuscitate him and he was pronounced dead at 12.45pm in a nearby hospital..

The post mortem report states the cause of death was a ruptured myocardial infarction.

I have identified a range of learning points for healthcare staff. In particular, I was struck by the poor level of record keeping. The report also makes a recommendation relating to the actions of one of the Maidstone nurses.

Investigation Process

All the indications were that this man’s death was from natural causes. In these circumstances, I judge that it may be sufficient for a clinical review to be carried out by an independent health care professional rather than a full investigation. My approach in cases of apparent natural causes deaths has been to conduct an initial review to determine if a full investigation is justified. In this man’s case, I decided that the circumstances did not require a full investigation.

One of my investigators along with a Family Liaison Officer, visited Maidstone and met with Head of Security, Head of Healthcare, a Senior Officer and two prisoners..

Access to the man’s prison records, including his medical records was provided to the investigation.

A nurse employed by my office, conducted a review of the health and social care this man received whilst in custody.

The family liaison officer contacted a friend of the man, who had known him for 25 years.

Events leading up to the death

On 17 December 2003, the man was re-called to HMP Woodhill having had his licence revoked due to non-attendance at a probation appointment and failing to stay in the accommodation arranged for him.

A letter from Probation stated that the man had been in hospital from 20 July 2003 until 12 December 2003, having suffered a stroke. He was said to wear incontinence pads and use a walking stick. He was also partially deaf. A psycho-geriatric assessment in August said he was 'OK,' but a friend of his said that his conversation had become rambling and disjointed.

On the First Reception Health Screen at Woodhill, no weight or vital signs were recorded. The man was noted to be incontinent of urine, weak due to his stroke and had poor personal hygiene. He was referred to the doctor. It appears that the man did not tell the reception nurse that he was on any medication. The additional information sheet completed by the doctor queries whether he had an enlarged prostate as he had been incontinent for four months. Age was noted as 63 years old, when in fact he was 73 years old. The continuous Medical Record requests daily monitoring of the man's blood pressure. It also states that he had been incontinent for four years, as opposed to four months as mentioned above. The documented plan was: 1) Psychiatric assessment, 2) In-reach team, 3) GP to be contacted for medical information. It appears that the GP notes were never requested.

On 18 December, a note was made to obtain the man's medical records from Luton and Dunstable Hospital. Below knee medical stockings were requested. It appears that the notes were never requested from Luton and Dunstable Hospital.

On 19 December, it was noted that the man had left his medication in his car. It was suggested that the prison get in touch with the probation officer so that the medication could be fetched. His BP was 210/110 and he was re-commenced on Atenalol and started on Ditropan. It is not clear when he had last taken it. He was moved to ordinary location. Dementia was queried, although it was not thought to be a problem when assessed by 'old age psychiatrist'.

By 19 January, the man's BP had come down to 181/105 and his pulse to 81. However, it was noted that he had not received his Atenalol or medical stockings. There appears to be no drug prescription chart for this period, and it is impossible to say whether or not he did ever received his medication. It is possible that he had not received any since he returned to custody on 17 December. Bearing in mind his reluctance to take the medication whilst in custody, it is possible that he had not taken any since his discharge from hospital on 12 December. The man's weight was 111kg. He had been experiencing difficulty in swallowing for the past 3-4 weeks and he had a cough. A chest x-ray was requested which was performed the next day. The medical records on 5 February noted the result showed an enlarged heart. There is no documentation regarding any required plan of action or recommendations.

A psychiatric assessment appears to have been carried out around 28 January. Although the copy is largely illegible, the impression seems to be that the man was not suffering from dementia. A review in a few weeks time was recommended.

The Probation Centre faxed a doctor at Woodhill on 26 January. It is interesting to note the last paragraph of the faxed note, which reads that the man was so intent on proving his innocence that dealing with life in the community took second place.

There were no further entries regarding the man's medication from 19 January until 4 February when he was transferred to Lewes. He was said then to be on Atenalol, Aspirin and Oxybutanin, which he declined to take. The man was noted not to know his medication but he continued to hold 'in-possession' drugs. His BP was noted to be 170/100.

On 5 February, his BP was 190/125. It was recommended that he had his BP taken in out-patients. The frequency was not noted. The man was noted to be very low in mood, but not suicidal. He was referred to the In Reach Mental Health team. He said he wanted another stroke so that he could die.

On 11 February, the man complained of palpitations. His BP was 189/114, pulse 77. Blood oxygen saturation levels were noted to be 97%. He requested to see a doctor the next day.

A doctor saw him on 12 February. It was noted that he had had a stroke in late 2003 and was on Aspirin and Atenalol, used a stick, and suffered from hypertension. The note also said that his BP was very, very high in the past. The note continued: low in mood, incontinent, non-specific upper back and shoulder aches, BP 170/120 - suggested weekly checks, chest was clear. The man was reported as saying he felt there was not much point to life. This was largely related to his probation conditions having been broken and his return to prison (which he termed 'an injustice'). It was documented that he had no active suicidal intent. A blood test was recommended to check U & Es, cholesterol and glucose.

On 17 February, a Mental Health In Reach risk assessment concluded that the man was a medium risk of suicide, low risk of violence and neglect. Assessment confirmed that he was unable to manage his existing physical health problems. The assessment stated that the man was 'frightened to take medication, feels it would muddle his head'. The notes stated that he did not want to see a psychiatrist, although he appeared low and depressed. He had very low self esteem, and had lost his partner and house. He said he did not commit the offences as charged, and believed he was pressurised to admit the offences.

On 19 February 2004, the medical record noted his BP as 150/98 and that he had not been taking his medication. It said that he was 'waiting for bloods' but it is unclear as to whether these were ever taken and there are no results entered or filed in the medical record. It was suggested that his BP was taken once a month.

The Mental Health In-Reach Client Contact on 26 February 2004 stated: Brighter in presentation today, said he had talked to his solicitor and he believes he will be discharged from prison. No evidence of mental illness. The mna knew how to

contact the In Reach Team if he needed to, but felt he needed no intervention at that time.

The Mental Health In Reach Client Contact on 15 March 2004 showed that the man was still low, but this was due to his physical ailments. He talked at length about the injustice of his prison sentence.

The medical record on 23 March 2004, stated that his BP was 170/120 – he had apparently forgotten his pills. A partly illegible entry mentions '…story of fall - ?use redirection'.

On 29 March, the Mental Health In Reach Client Contact showed that the man's mood level appears to be low. He was tearful and wished to see a psychiatrist.

On 8 April 2004 the man experienced shooting pains up his right hand side, and worsening dysphagia - difficulty swallowing. A referral was made to Ear, Nose and Throat due to a 3-month history of worsening dysphagia. (he was only able to swallow pea sized lumps). He was also experiencing nausea and retching when he tried to eat. No dysphagia was noted with fluids.

It appears from the Mental Health In Reach Client Contact sheet on 12 April that an appointment was booked for the man to see a psychiatrist.

On 15 April, the medical records show that the previous day the man had suffered with a burning pain on the right side of his chest. It appears that it was queried as to whether a referral had been made to gastroenterology. An entry alongside this query indicates that the writer thought a referral had been made on 8 April. However this referral was, I believe, to ENT, not gastroenterology. The prescription of Aspirin was stopped. It appears that the man never received an appointment with the ENT consultant.

On 20 April, an unsigned one page entry in the medical record appears to be made by a psychiatrist who concluded that the man was not psychotic, clinically depressed, distressed or ruminative. The man was prescribed Hydroxyzine for two weeks, but it is unclear as to whether he ever received the medication. The drug chart dated 27 April does not have this medication on it. There are no further notes in the medical record until 20 May.

The man was transferred from Lewes to Maidstone prison on 20 May 2004. The Reception screen form was fairly well completed by a nurse. However, his blood pressure was not checked, his medication not noted and there was no record of his recent dysphagia. It was also documented that he had no concerns regarding his mental health and that there were no external agencies concerns. This indicates that the man's medical record had not been read at this stage. He was located flat due to his mobility problems.

The man was seen by the doctor at Maidstone on 21 May and, although it is difficult to read the entry, it appears that he mentioned his Road Traffic Accident in 1973 and the fact that he was impotent. The doctor noted 'save this history and question how he could commit a sexual offence'.

On 27 May, the entry in the medical record noted that the man had a stroke in December 2003, was not on Aspirin and had no recent BP. The man appears to have told the doctor that he was not on Aspirin because he was not keen on tablets and did not ask for any. Aspirin was restarted as was his Atenalol. These were prescribed that day, but according to the drug chart they do not appear to have been dispensed by pharmacy. He was also complaining of aching pains in his elbow, shoulder and left arm. He said it felt like rheumatism. He was unable to recall his first CVA in 1999. It was noted that he had poor memory. He was to be reviewed the following week.

On 27 May 2004, another prisoner helped take the man to Healthcare as he was complaining of chest pain and pains along his left-hand side. He was sent back to the wing. When the prisoner checked how he was later, the man said he did not get on too badly.

On 28 May, the same prisoner reported seeing the man pulling himself from the floor onto his bed, having collapsed in his cell. The prisoner informed the landing desk officer and then overheard the officers saying, 'Healthcare said to lie down and we'll see how you are on Monday morning'. He did not see the man again and received a note under his door on Monday to say that the man had died.

When he collapsed on 28 May, he told the attending officers that this had happened before just before he had his stroke. The officers contacted Healthcare and a nurse told them that it had happened the day before and to check on him that day. There are no notes in the records to indicate this, or to say what treatment the man received the previous day. It appears that this information was not communicated back to the man. The nurse apparently left a note for the nurse who was on the next day she was Head of Healthcare, saying that there was a possibility that the man would come up to see the doctor, but if he was okay he would not. The head of healthcare stated in her interview that it was a busy day and she heard nothing from the wing, so assumed that the man had not asked to see the doctor. The first nurse did not document this episode in the man's records. The first nurse stated that because Maidstone does not have any in-patient facilities, they rely on the wing staff to alert Healthcare if there are any changes in a prisoner's condition.

The first nurse also stated during her interview that 'we try and assume that people are taking their medication, we monitor if it has been picked up properly and every now and again cells are searched to see if there is excessive medication in there and then it is brought to our attention'. She added that they were in the process of making the wing where the man was located into a disabled wing by putting showers in. She said that they have got several disabled people on the wing and that they did not always get the right facilities for them.

On 31 May, the man was seen by another prisoner to be in pain and clutching his chest. The man collapsed in his cell at 11.50am. Staff were called. They administered CPR and immediately requested an emergency ambulance. Cyanosis was present around his lips and extremities, but a carotid pulse was present. Respiratory effort was poor and irregular. An airway was inserted and the man was ventilated with a bag, mask and oxygen. At 11.55am there was no pulse or

respiratory effort. Full CPR was commenced and continued until the arrival of the ambulance service who took over care between 11.55am and 12.00 noon. (There is a five-minute discrepancy in the times given by various staff). At approximately 11.55am the man was placed on stretcher but the wheels locked and he could not be transferred to the ambulance. A second ambulance was called and arrived at 12.20pm. They left the prison at 12.30pm, but the man died in the nearby hospital at 12.45pm.

The duty medical officer was advised. A&E were notified by phone of all relevant medical information in advance of the man’s transfer.

The prison response following the death

The report on events following the death, written by the Head of Security and PSU, is clear and appears thorough.

The chaplain attended the wing and a hot debrief was conducted for the staff involved.

A sensitive note was given to the prisoners on Mr Ashcroft's wing informing them of his death and offering support. This is an example of good practice.

The man only recorded a friend in regular contact with him and paid for his funeral. An enquiry was made through my Family Liaison Officer regarding the man's belongings. The Head of Security replied that the friend was not classed as the man's Next of Kin, and therefore the property would go into storage. The Treasury Solicitors would decide the position regarding the possessions as they were in effect his estate.

A Forensic Pathologist, carried out the post mortem on 2 June 2004 and confirmed the cause of death to be as a result of a ruptured myocardial infarction.

Findings and Conclusions

The man was transferred between prisons on several occasions, although there are no notes to indicate the reasons for the transfers. I believe the number of times he was transferred did not facilitate the standard or continuity of care he could have expected to receive.

The First Health Screen at Woodhill failed to note the man's BP and medication. It appears to have been two days before he received his anti-hypertensive medication and, despite the recorded history of stroke and the note by the doctor to check his BP daily, this was not done on the first day. Thereafter his BP was not taken and recorded on a regular basis. There was gross inconsistency in the recommended frequency of BP checks (e.g. 17 December 2003 - daily, 12 February 2004 - weekly checks, 19 February - monthly checks).

Despite the man stating several times that he did not want to take his medication, there appears to have been no attempt to explain to him the importance of taking his medicines as prescribed. There is conflicting information as to the reasons the man gave for not taking his medication. At one point he said that he wanted to have another stroke and die; at another, that he was 'frightened to take medication, as he felt it would muddle his head'. Either way the man appears to have been in need of counselling in order to discuss these issues and ensure that he took his medication in future.

The man was not observed by staff while taking his medication and therefore it was very easy for him not to. He continued to hold in-possession medication, despite staff being aware that he was not taking it.

The man had been prescribed Atenalol since his first admission into custody in 1998. It appears not to have controlled his blood pressure adequately, yet no changes or additions were made to the prescription in order to find a more effective antihypertensive treatment.

The chest x-ray recommended on 19 January 2004 was organised and performed very quickly. The result was documented in the medical record on 5 February, however no action was recommended apart from BP checks in outpatients - frequency not noted.

On 4 May, a letter regarding a referral was received from the Cardiology Unit. There is no mention of a cardiology referral in the medical record. It does not appear that Lewes was contacted by Woodhill to discuss the letter that had been received and alternative arrangements made for the man to see a cardiologist at a local hospital.

There appears to be no documentation regarding an appointment following the ENT referral in April 2004.

The Mental Health In Reach team saw the man on a regular basis approximately twice a month between February and May 2004 and thorough notes were entered in the medical record. There is no documentation to suggest that this support was to continue on his transfer from Lewes to Maidstone.

The man appears to have mentioned several times that he felt low in mood due to the 'injustice' of his conviction. Although he had a hormone level test in June 2000 which showed a normal testosterone but raised Oestradiol level, no action was taken. The results do not appear to have been discussed with the man.

There is an undated request to the kitchen for a soft diet. This was due to the man's dysphagia. However, despite several entries regarding his weight, the fact that he was obese and his hypertension, I can see no evidence of any advice or help given with an appropriate diet (e.g. reduced salt, calorie controlled or low fat). The man did appear to lose weight (111kg on 19 January to 102kg at time of death). This appears to have been due to him being unable to tolerate a solid diet, as opposed to any effort made by staff to help him lose weight. The health benefits of weight control and gentle exercise do not appear to have been discussed with him.

On each transfer, a reception health screen was carried out and this is good practice. However, the information collected was often either inadequate or not acted upon - for example, the man's consistently high BP.

Having been photocopied, some of the reports and entries in the medical record were illegible. I believe this may possibly be due to the entry being made in blue ink.

There is no documentation by nurses in the medical record regarding the man's condition on 27 or 28 May 2004. This was despite the fact that he attended healthcare on 27 May, complaining of chest pain and pains along his left hand side, and they were informed that he had collapsed in his cell on 28 May.

The entry in the medical record on 27 May by the doctor states: complaining of aching pain in elbow, shoulder and left arm. This entry, along with the man's complaints of chest pain and pain along his left hand side and his on-going hypertension should, in my opinion, have indicated to the nurse that an ECG should have been performed in order to rule out any cardiac involvement.

A statement from an officer regarding the man's collapse on 28 May says that, following the collapse he said he was okay. The officer noticed that his trousers were wet and that he might have urinated. I believe that, if the nurse had attended when contacted by the wing staff, the man would have been more likely to have received the care that he required and deserved.

It is unclear whether the wing officers have received first aid training within the standard timeframe. However, from their interview notes, it appears that they may not feel completely confident in their knowledge and ability.

It is also unclear what type of emergency treatment was administered initially when the man collapsed on 31 May. The entry in the medical record by a RMN states that staff were administering 'CPR' when he arrived at the man's cell. This implies that cardiac massage was being performed, along with ventilation. However the RMN having made an assessment of the man's condition, states that a carotid pulse and some respiration was present. The man's treatment at that stage was correct in that he was ventilated using an airway, bag, mask and oxygen. At 11.55am, no pulse or

respiratory effort was present and full CPR was commenced until the ambulance arrived. Again this is the correct and appropriate treatment.

The stretcher wheels locked and another ambulance had to be called, causing a delay in transferring the man to hospital of approximately 35 minutes.

During the Coroner’s inquest, the Senior Medical Officer from Maidstone prison stated that the man’s symptoms were consistent with a cardiac arrest and that an appointment had been made for him to attend the nearby hospital, which was due the week after he died. This is not documented in the medical record and I can find no record of a referral.

Recommendations

Records and record keeping

1. I recommend that healthcare professionals at Woodhill, Lewes and Maidstone are reminded:

    i. Of the importance of First Reception Health Screen procedures. This includes thorough completion of the First Reception Health Screen form and obtaining medical records from the GP and hospitals if required.

    ii. The importance of legible, accurate and thorough documentation, particularly in relation to record keeping. Documentation should be made in black ink, dated and name signed and printed, along with designation. All events and health complaints affecting the patient should be entered in the medical record.

    iii. That tests carried out should be noted in the medical record, along with the result and any action required and by whom.

    iv. That when referrals are made, these should be clearly entered in the medical record. A copy of the referral letter should be filed. Referrals should be followed up if required, by nursing staff, to ensure that the patient receives an appointment within an acceptable timeframe.

    v. That observation charts should be used to ensure regular monitoring of patients with an on-going history of hypertension.

    vi. That the use of Nursing Care Plans should be considered. This would facilitate the provision of a total care package which addresses each problem and ensures continuity of a high standard of nursing care.

    vii. That patients should be observed taking their prescribed medication, if there is any question regarding whether or not they are taking it. This applies to elderly or forgetful patients as well as those who have indicated that they'd prefer not to take it. It should also be considered as to whether in-possession medication is appropriate in these cases and an appropriate risk assessment undertaken.

    viii. That care should be taken to ensure that all prescribed medication is written up in the drug chart and dispensed as soon as possible by Pharmacy. Medication should be reviewed on a regular basis to monitor effectiveness.

    ix. That patients complaining of continual low mood should receive on-going counselling from the general/psychiatric nursing staff as well as the specialist professionals to whom they are referred.

x. That patients who are considered to be 'obese', overweight or suffering from a condition which diet can affect, should receive advice and guidance. Referral to a dietician should be made if indicated.

2. I recommend that the PCT in partnership with the HMP Maidstone, commission an investigation into the clinical care afforded by the first nurse In light of sections 1.3 and 1.4 of the NMC Code of Professional Conduct.

3. I recommend that the Prison Service considers whether all frontline prison officers, as well as healthcare staff, should receive annual update in CPR training. This is in line with the UK Resuscitation Council's recommendation for healthcare staff.

4. I recommend that a copy of this report be sent to the attending ambulance service in order that they may investigate the incident of the stretcher trolley wheels locking which caused the approximate 35 minute delay in transferring the man to hospital.

Identified good practice

The documentation in the medical record and the actions taken by the RMN on 31 May were accurate and appropriate.

The note issued to prisoners following the death of the man was sensitive and offered support if required.

The counselling offered by the Mental Health In Reach Team appeared to be thorough and appropriate.