Investigation into the circumstances surrounding the death of a male prisoner whilst in the custody of HMP Stafford in April 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is a report into the death of a man at HMP Stafford on 28 April 2010. The man died from natural causes. A post mortem showed that he died from coronary artery atheroma (this is also known as sudden cardiac death, a lack of blood supply to the heart due to blocked arteries causing the heart to stop.)

I offer my sincere condolences to the man's family and friends for their loss. One of my Family Liaison Officers contacted the man's wife to inform her about the investigation and to provide her with an opportunity to raise any issues about the care the man received in custody.

The investigation was carried out by an Investigator from my office. Both he and I would like to thank the Governor, and his staff particularly the Prisons Family Liaison Officer, for their co-operation during the course of our enquiries.

I also thank South Staffordshire Primary Care Trust (PCT) for appointing a doctor from the PCT to review the man's clinical care.

As the man died from natural causes, the findings of the clinical review play an essential part in my report. The review shows that the man received good care whilst in custody that was equitable to that which he could have expected in the community and his death could neither have been predicted nor prevented.

I make no recommendations but do commend the Prisons Family Liaison Officer for the efforts made in the family liaison.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **October 2010**

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SUMMARY

The man was remanded to HMP Blakenhurst on 17 October 2005. He underwent a healthscreen assessment with a nurse where he said he had a history of depression and was a smoker.

The man was subsequently convicted of sex offences and sentenced to seven years imprisonment on 9 November 2005. He was transferred to HMP Stafford on 3 January 2006. He stayed in a shared cell in the vulnerable persons wing. The man had regular contact with healthcare staff for monitoring his medication and dental treatment.

On 28 April 2010, at approximately 7.50am, the man's cellmate used the cell bell and told staff that the man had been sick and had chest pains. Healthcare staff responded, but the man quickly became unconscious. An emergency ambulance was called and commenced cardio pulmonary resuscitation was started. Healthcare staff continued with resuscitation until the paramedics arrived and took over the attempts to resuscitate the man but he was pronounced dead at 8.55am.

The man's nominated next of kin was recorded as his partner. However Stafford established that this person had died. Stafford was able to obtain the details of other family members and they were visited to break the news of his death. At this meeting Stafford were given the contact details of the man's second wife. Following contact by phone, arrangements were made for her to visit the prison.

I am satisfied that the care and attention the man received at Stafford was equitable to that he could have expected to receive in the community and his death could neither have been predicted or prevented. I make no recommendations but commend the good work of the Family Liaison Officer.

THE INVESTIGATION PROCESS

1. The investigation was opened on 27 April 2010 when my investigator issued notices announcing the investigation to staff and prisoners. One prisoner came forward as a result.

2. The Investigator visited HMP Stafford on 11 May. During his visit he was also given copies of all documentation relating to the man. My investigator returned on 29 June and interviewed four members of staff and one prisoner.

3. South Staffordshire Primary Care Trust asked a Doctor from the local PCT to review the man's clinical care. The Investigator and the Clinical Reviewer jointly discussed aspects of the man's treatment with healthcare staff at Stafford. I am grateful to the Clinical Reviewer for her timely report.

4. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

5. The Family Liaison Officer from my office contacted the man's wife to inform her about the investigation and to invite her to ask any questions or raise any concerns about the care the man received in prison. The man's wife said she had been shocked by the suddenness of the man's death. She did not wish to raise any specific concerns at this stage, however, asked to receive a copy of this report when available. The man's wife will have an opportunity to comment on the findings, should she wish to do so. I hope this report answers any questions she may have and helps the man's family better understand the events leading to his death.

HMP STAFFORD

6. HMP Stafford was built on its present site in 1794. It currently has capacity to hold 741 prisoners across seven wings. The man lived in a cell on E wing which, together with F wing, form an area of the prison known as the Crescent. The Crescent is designated as accommodation for vulnerable prisoners (those who are separated from the majority of prisoners because of factors such as the type of offence committed).

7. Healthcare is provided by the South Staffordshire Primary Care Trust, who employ a healthcare manager, nurses and support staff. There is no inpatient healthcare facility at Stafford and no nursing presence in the prison overnight.

8. Stafford was last inspected by HM Chief Inspector of Prisons in June 2009. The Chief Inspector found that Stafford was performing "reasonably well" in all areas. She also found that the "provision of health services had improved", there was good access to primary care, and health services staff were aware of the needs of older prisoners.

9. In their annual report for the period ending April 2009, the Independent Monitoring Board (a body of local people who independently monitor and report on the prison) made the following comments regarding healthcare provision:

> "The Healthcare Unit became fully staffed against its profile during the year and was able to meet the needs of the additional 60 prisoners who arrived during the period January – March 2009. The rising population of elderly prisoners in the prison has highlighted the fact that healthcare staffing needs to be reviewed to ensure that the most effective skills mix is in place.
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> "All prisoners are medically examined by the healthcare team upon arrival in the prison or within a two hour period."
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> "This year has seen a continuation of a variety of campaigns including smoking cessation, diabetes care, hepatitis B vaccination programme, chlamydia screening for under 25s, dental health and healthy eating."

10. This is the eighth death of a prisoner at Stafford since the Ombudsman began investigating all deaths in custody in England and Wales in April 2004. Five of the previous seven deaths were due to natural causes. A report on one of these deaths in 2008, regarding the death of a man who died after collapsing in his cell, commended the response of staff.

KEY FINDINGS

11. The man was remanded to custody in October 2005, and subsequently convicted of sex offences and sentenced to seven years imprisonment on in November 2005. The man had a history of depression and was a smoker.

12. When the man was remanded in custody, he was sent to HMP Blakenhurst. On arrival there he had a First Reception Health Screen conducted by a nurse. (The health screens are conducted to obtain a brief confidential medical and psychiatric history from the prisoner to ensure that he receives the appropriate medical treatment and medication as required.) The man told the nurse that he he smoked cigarettes daily and had no intention of attemping to give up. He said that he had never used illicit drugs in the past.

13. Between 18 October and 9 November 2005 the man saw nurses on three separate occasions with no concerns recorded. The man was convicted and sentenced to seven years in custody in November at a local Crown Court.

14. Eight days later the man saw an unidentified prison doctor as he complained of being depressed and experienced heartburn after having food. The doctor prescribed fluoxetine (antidepressant) and omeprazole (for treatment of gastric conditions).

15. On 3 January 2006, the man transferred to HMP Stafford where he saw a nurse who recorded the medication he had taken whilst at Blakenhurst. The man told the nurse that he felt fine since taking the fluoxetine. A cell sharing risk assessment (to identify any risk of harm a prisoner may pose to another if located in a shared cell) was completed which assessed the man as suitable to share a cell and he was allocated a shared cell on E wing.

16. From February 2006 to June 2009, the man saw prison doctors (unidentifiable due to hand written records with no printed names), on 13 separate occasions to review his medication. During this time the man complained that he felt depressed and had sleeping difficulties. His prescription for fluoxetine was changed to mirtazapine (for treatment of depression). The doctors maintained the man's prescription of omeprazole as tests confirmed the requirement for ongoing medication. The man was also given smoking cessation advice, which he declined.

17. On 18 July 2009, the man saw a Nurse as he complained of toothache. The nurse prescribed ibuprofen for the pain and referred the man to the dentist. The man saw the dentist on 8 October who put in place a treatment regime for an abscess, ibuprofen for pain relief and further dental work that included tooth extraction.

18. A prison doctor saw the man on 29 October and conducted a mental health review. The doctor recorded that the man's depression was well controlled and that the prescribed mirtazapine was to continue.

19. Two weeks later a nurse who was part of the mental health team, saw the man for a further mental health review. The nurse recorded that the man was in good spirits. He told the Nurse that his mood varied which he gauged as seven or eight out of ten (ten being the happiest). He also told the nurse that he had no problems sleeping, went to the gym once a week and enjoyed the company of his cellmate. He declined any further intervention from the mental health team and said that he was aware that he could contact a member of the team at any time if he felt he needed support in the future. The nurse's assessment was that there was no evidence of thought disorder or distress and discharged him from mental health interventions.

20. On 24 November, the man saw the dentist and had further dentistry work. A prison doctor, reviewed the man's medication on 28 January 2010, and made no alterations. One month later a different prison doctor, again reviewed the man's prescribed medication and made no changes.

21. The nurse he had previously seen about his toothache saw the man on 1 March as he complained of dry skin, and the nurse prescribed aqueous cream (for treatment of dry skin) to be applied two to three times a day. The same nurse saw the man three weeks later and prescribed some more aqueous cream.

22. On 31 March, the dentist saw the man for additional dentistry treatment. The prison doctor that had previously reviewed his medication reviewed the man's prescribed medication on 21 April. The doctor repeated the prescription of mirtazapine, omeprazole and ibuprofen.

23. Another nurse saw the man on 23 April as he complained of dry skin, and the nurse prescribed additional aqueous cream. The man did not raise any other concerns with the nurse.

Events of 28 April

24. At approximately 7.50am on 28 April, the man's cellmate rang the cell bell for assistance (each cell has an alarm button that prisoners use in an emergency when the cell door is locked). An officer responded to the alarm and on arrival at the cell was told by the man's cell mate that the man was being sick and had chest pain. The officer could see through the observation hatch that the man was unwell and called for medical assistance.

25. The nurse that originally saw the man for his toothache and the nurse that saw him in April about his dry skin were already on E wing and went straight to the man's cell with the emergency treatment bag. The nurses noted that the man appeared to be having a fit and immediately requested an emergency ambulance. The man was lying on the bottom bunk with his arms stretched out. The nurses moved the man on to the floor and checked for signs of life but no pulse could be found. The officer that responded to the cell bell moved the man's cell mate to another cell.

26. Both the nurses immediately commenced cardiopulmonary resuscitation (CPR) and seconds later another nurse, along with the nurse that had previously

conducted the man's mental health review and arrived with the automatic external defibrillator (AED) (a portable electronic device that diagnoses rythmns after cardiac arrest). It was attached to the man and it advised to deliver an electric shock. A shock was delivered and the AED advised to continue with CPR. The nursing team continued with the CPR as directed by the AED until the paramedics arrived at approximately 8.15am and took over the CPR.

27. At 8.55am the prison doctor that had carried out two reviews of the man's medication arrived at the cell and was told by the paramedics that the man was showing no signs of life. The doctor certified that the man had died.

28. Later that morning a debrief was held with staff involved in the incident at which the Governor was present. Support was made available to all staff. In addition the Governor arranged for an open door policy on the wing that afternoon so that prisoners were unrestricted, with the chaplaincy being available so that support could be given. Particular consideration was given to the support and needs of the man's cell mate and his relocation to another cell.

29. Later that day the prison's family liaison officer, attempted to contact the man's nominated contact, his partner. (PSO [Prison Service Order] 0500 (Reception) makes it clear that "Staff must ask prisoners for the name, address and telephone number of their next of kin and accurately record the information." PSO 2710 (Follow-up to deaths in custody) instructs prisons to "Arrange notification to the next of kin and any other person reasonably nominated by the prisoner." The prison will therefore only contact the nominated next of kin, and will often not have details or knowledge of anyone else.)

30. The prison's family liaison officer established that the man's partner had died, and due to the nature of the man's offences, contact with other family members had to be directed through the victim support unit. Eventually the prison's family liaison officer was given the details of one of the man's sons and his first wife, and arrangements were made to visit them.

31. At the visit the prison's family liaison officer was given the contact details of the man's second wife. The prison's family liaison officer contacted her by phone and explained the reasons for the delay in making contact. Arrangements were made for the man's second wife to visit Stafford on 4 May. At this visit the prison's family liaison officer explained to her that the prison would provide financial assistance towards the costs of funeral expenses. As the man's second wife did not know the Stafford area the prison's family liaison officer took her to see her husband's body at the mortuary.

32. In the days that followed the prison's family liaison officer also had phone calls from some of the man's other children who asked about the circumstances of his death.

33. The prison's family liaison officer liaised with the funeral directors on the man's second wife's behalf and also with the man's solicitors to obtain the advice regarding his estate.

ISSUES

Clinical Care

34. The clinical reviewer and I are satisfied that the care the man received was equitable to what he could have expected in the community. The clinical review makes the following comments regarding the man's clinical care:

> "There is no evidence that the man complained of chest pains or cardiac related symptoms prior to the morning of his death. He saw healthcare staff regularly in relation to his other medical problems. Blood pressure measurements when done were normal. Symptoms such as chest pains, breathlessness or palpitations may have alerted healthcare staff to investigate these and undertake specific cardiac investigations but this was not the case.
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> "Assessment of cardiac risk factors indicates that the man's cardiac risk was low
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> "It can sometimes be difficult to distinguish between chest pains due to cardiac disease and chest pains due to gastro-oesophageal disease and this is well recognised in primary care. Dyspepsia may include symptoms of heartburn, chest discomfort, upper abdominal pain or discomfort and bloating.
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> "The man had a positive H Pylori test – this is an infection in the stomach that predisposes to inflammation. The man remained on Omeprazole throughout his period in HMP Stafford. The evidence indicates that the man had a valid diagnosis of 'dyspepsia' or gastro-oesophageal disease.
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> "The man had no symptoms or signs prior to his death to indicate cardiac disease and the post mortem result confirmed only mild atheroma."

Emergency response

35. A fellow prisoner raised the alarm with staff at approximately 7.50am and within minutes, the request had been made for an emergency ambulance, CPR had started and a defibrillator was being used. The staff in attendance continued CPR, as directed by the defibrillator, until the paramedics arrived at the man's side and took over the attempt to resuscitate him.

36. The staff who responded to the man's need for emergency assistance acted with great speed and professionalism. The clinical reviewer makes the following comment:

> "Resuscitation commenced correctly immediately at the point of collapse and a shock administered by a defibrillator within 2 minutes of collapse. This would have given the best opportunity of success in resuscitation, although in this case it was sadly unsuccessful."

37. I believe the Governor should recognise the professionalism displayed by the staff who were directly involved in the swift emergency assistance provided to the man.

Family Liaison

38. Stafford appropriately followed the guidance given in PSO 2710, "Follow up to death in custody". As the man's nominated next of kin had have died, Stafford had to sensitively approach other members of his family via the victims support unit. Not withstanding this Stafford still was able to provide a prompt face to face visit to break the news to the man's family.

39. Extra work was also undertaken by the prison's family liaison officer in contacting the man's second wife, assisting in the arrangements of his funeral and handling all external communications. The prison's family liaison officer maintained contact with the family to inform them of the date of the funeral and to obtain permission from the man's solicitors to release his property to his rightful next of kin.

    I commend the work carried out by the prison's family liaison officer in following the best practice in PSO 2710 and undertaking additional work on the man's behalf.

CONCLUSION

40. During his time at Stafford, the man had well documented regular interventions with doctors and other healthcare staff. I am satisfied that the care that the man received at Stafford was equitable to that expected in the community and that his death could neither be predicted or prevented.

41. Following the man's death Stafford appropriately followed the guidance given in PSO 2710, "Follow up to death in custody". I also commend the extra work done by the Prisons Family Liaison Officer.

At the consultation stage of the report the man's wife and son were concerned that it took 15 minutes for the paramedics to arrive and attend to the man. They questioned whether systems are in place to allow emergency crews quick and easy access to the prison in the event of an emergency. It is understandable that the man's family want reassurance that valuable time was not lost when responding to the man following his collapse. I am satisfied however that there was no delay in the paramedics getting from the prison gate to the man's side.

RECOMMENDATIONS

1. I commend the work carried out by the Prisons Family Liaison Officer in following the best practice in PSO 2710 and undertaking additional work on the man's behalf.