Investigation into the circumstances surrounding the death of a man at hospital in July 2011, whilst in custody at HMP Stafford

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is a report into the death of a man at hospital on 26 July 2011 whilst in the custody of HMP Stafford. He was 67 years old and a post mortem showed that he died from necrotising fasciitis (a soft tissue bacterial infection), secondary to acute appendicitis.

I offer my sincere condolences to the man's family and friends for their loss. One of our 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 he received in custody.

The investigation was carried out by an investigator. I am grateful to the Acting Deputy Governor of Stafford and his staff for their co-operation with the investigation. I also wish to thank the local PCT for a clinical reviewer to review the man's clinical care. I apologise that the report is slightly late.

As the man died at an outside hospital, the findings of the clinical review play an essential part in this report. The review found that he received a standard of care whilst in custody that was equitable to that which he could have expected in the community. The investigation also confirmed that security arrangements applied to him when he visited hospital were proportionate and that the prison was appropriately supportive to his wife after his death. As a result, I make no recommendations myself but will draw those made by the clinical review concerning matters outside my remit to the Department for Health.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2012**

CONTENTS

SUMMARY

1. The man was convicted of serious offences and sentenced to nine years imprisonment on 8 August 2008 and was sent to HMP Hewell. He was a life long smoker had a history of emphysema (long term progressive lung disease) and was prescribed inhalers. He also walked with the aid of a stick.

2. On 14 November, the man was transferred to HMP Stafford. Whilst at Stafford he was monitored regularly by healthcare staff. He was also offered smoking cessation advice but he declined. He occupied a ground floor cell to assist his mobility.

3. The man had a cervical spine operation on 13 August 2009. He remained in hospital for five days before being discharged back to Stafford. He saw prison doctors and nurses regularly and recovered well from the operation.

4. A prison doctor referred the man to an orthopaedic consultant for an assessment for hip replacement surgery on 8 November 2010, as he experienced severe pain in his hip and his mobility had greatly reduced. He saw the orthopaedic consultant on 26 January 2011 and the assessment made was that he required a right hip replacement.

5. On 30 June, the man had the hip replacement surgery and was discharged back to Stafford on the 3 July. For the next two weeks healthcare staff and uniformed staff monitored his progress both day and night and his mobility greatly improved.

6. The man complained of severe stomach pain on 22 July, and the prison doctor referred him to the hospital for further assessment. He was returned to prison later that same day with the advice to take laxatives and eat a high fibre diet.

7. One morning a few days later, at approximately 8.10am, the man was found in his cell in a collapsed state. An emergency ambulance was called and he was taken to hospital. By 1.30pm a hospital consultant told prison staff that he was in a critical condition and unlikely to survive. The prison contacted his wife to tell her the situation and advised her to get to the hospital as soon as possible. He died later that afternoon at 4.40pm.

8. In the days that followed, the prison family liaison officer maintained contact with the man's wife and offered support and financial assistance towards the funeral expenses.

9. We are satisfied that the care and attention the man received at Stafford was equitable to what he could have expected to receive in the community. We make no recommendations, but draw the attention of the recommendations made by the clinical review to matters outside my remit to the Department for Health.

THE INVESTIGATION PROCESS

10. The investigation was opened on 27 July 2011 when the investigator issued notices announcing the investigation to staff and prisoners.

11. The investigator visited HMP Stafford on 29 July. During his visit he was given copies of all documentation relating to the man. He returned on 25 and 30 August and interviewed four members of staff. Written feedback was given to the Governor on 31 August.

12. The local Primary Care Trust asked appointed a lead clinical reviewer to review the man's clinical care. The investigator and the lead clinical reviewer jointly discussed aspects of his treatment and jointly interviewed staff at Stafford. We are grateful to the clinical reviewer and her colleagues for their considered report. However, the late receipt of the clinical review has prevented the prompt issue of this report.

13. 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. The Coroner provided the investigator with a copy of the post mortem which showed that the cause of his death was necrotising fasciitis (soft tissue bacterial infection), secondary to acute appendicitis (sudden inflammation of the appendix).

14. A member of our Family Liaison Team and the investigator visited the man's wife on 26 August to inform her about the investigation and to invite her to ask any questions or raise any concerns about the care he received in prison. She said she had been shocked by the suddenness of his death. A number of questions were asked during the course of the meeting to which the investigator was able to provide answers and information. She asked to receive a copy of this report. She will have the opportunity to comment on the findings should she wish to do so. We hope this report answers any questions she may have and helps her better understand the events leading to her husband's death.

HMP STAFFORD

15. 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).

16. Healthcare is provided by the local PCT, 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.

17. 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. It was 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.

18. In their annual report for the period ending April 2011, the Independent Monitoring Board (a body of local unpaid volunteers appointed by the Secretary of State for Justice, who independently monitor and report on the prison) made the following comments regarding healthcare provision:

> "Healthcare is provided by the local PCT. It is understood that provision is likely to transfer to a new Partnership Trust and monitoring of services will need to be maximised to ensure that there is no lessening of current service levels to prisoners.
>
> "There is no in-patient facility at HMP Stafford and provision of bedwatches in local hospitals has continued to impact on financial resources and the prison's operations when officers are assigned to watch duty.
>
> "HMP Stafford has a significant population of elderly prisoners. Resources and skill base of staff have been identified to help deliver appropriate health programmes. The Social Care Project is operating successfully and is now available to all prisoners aged 50 years and over who receive a comprehensive health check.
>
> "The Board is pleased to report the continuation of a variety of campaigns to promote sexual health, smoking cessation, diabetes care (increasing in number), dental health, vaccinations and healthy eating."

19. 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. There are no similarities between the man's death and the other natural cause deaths.

KEY EVENTS

20. The man was born in August 1943, was married, and prior to entering custody he lived in Warwickshire. He was a life long smoker, had a history of emphysema and used a walking stick. On 8 August 2008, he was convicted of sex offences at Crown court and sentenced to 9 years in custody and sent to HMP Hewell.

21. On arrival at Hewell, the man had a First Reception Health Screen conducted by a nurse. (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.) He told the nurse that this was his first time in prison. He said he smoked and had no intention of attemping to give up. He said that he had never used illicit drugs. The nurse recorded that he had a history of emphysema, also known as chronic obstructive pulmonary disease (COPD) (a progressive condition which causes irreversible damage to the lungs and produces symptoms such as wheeze, breathlessness and increased sputum production making the patient at increased risk of chest infections), had been prescibed salbutamol and becotide inhalers (steroid inhalers that reduce swelling in the lungs) by his community doctor, had no previous mental health problems, had no thoughts of harming himself and that he used a walking stick.

22. Two days later, the man saw a prison doctor (unidentifiable due to hand written records with no printed names) who confirmed that he had emphysema and the prescribed medication should continue. The doctor also recorded that he complained of pins and needles in his hands and feet and pain in his lower back. The doctor prescribed paracetamol and gave him advice on his posture.

23. In the weeks that followed, the man saw prison doctors (again unidentifiable due to hand written records with no printed names) on three further occasions, the last being on 8 October, when the doctor prescribed a seven day course of amoxicillin (antibiotic) for a chest infection.

24. On 14 November, the man was transferred to HMP Stafford where he had an initial healthscreen conducted by a nurse, who recorded the medication he had taken whilst at Hewell. The nurse also recorded his blood pressure as 113/82 (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) He was also offered smoking cessation advice but he declined. The nurse recommended that he should occupy a ground floor cell and, if sharing, use the bottom bunk to assist with his mobility.

25. The man saw Prison Doctor A on 22 December after he complained of neck pain and experienced pins and needles in his hands and feet. The doctor examined him and diagnosed that he had sciatica (lower back and leg pain caused by irritation of the sciatic nerve) and the possibility of cervical spondylosis (abnormal wear of the cartiledge and bones of the neck). Because

of this, the doctor referred him to an orthopaedic consultant (specialist in bone, muscle and joint surgery) for an assessment.

26. On 30 January 2009, the man attended an orthopaedic appointment at hospital and saw the orthopaedic nursing specialist. A risk assessment was completed which authorised him to be accompanied to hospital by two officers with the use of an escort chain (2 metre chain with single cuff at either end) which was to be removed for treatment purposes. Following her assessment, she was very concerned that he had an 'upper motor neurone restriction' (restriction on the spinal cord in the neck) and referred him to the consultant neurologist (specialist in the nervous system) and arranged for a magnetic resonance imaging (MRI) scan (a medical imaging technique used to visualise detailed internal structures) of his spine.

27. The man had the MRI scan on 4 March and saw a consultant neurologist at hospital on 16 April. The consultant recorded that the MRI scan confirmed that there were changes to his spine that were indicative of cervical myelopathy (pressure on the spinal cord in the neck) and canal narrowing in his neck. The consultant recommended that he be prescribed pregabalin (for neuropathic pain), and made a referral for a neurosurgical assessment at another hospital. For each appointment another risk assessment was completed which again authorised him to be accompanied to hospital by two officers with the use of an escort chain, which was to be removed for treatment purposes.

28. On the 13 August, the man was admitted to hospital for a cervical spine operation by a consultant neurosurgeon. He remained in hospital for five days before being discharged back to Stafford. Again a risk assessment had been completed that authorised two officers to be with him with the use of an escort chain that was removed as directed by hospital staff.

29. The day after his return from hospital, the man saw Prison Doctor B who recorded that he was recovering from the operation well and that there was no further need for him to be precribed pregabalin.

30. In the months that followed, the man had 37 separate interventions with healthcare staff. These included prison doctors, nurses, visiting physiotherapist and a visiting podiatrist. HE also had two outpatient appointments with the consultant neurosurgeon to follow up his cervical spine surgery. This was in addition to him being given his medication by nurses on a daily basis. His prescribed medication included salbutamol (for COPD), Clenil Modulite (for COPD), Tradorec, naproxen (anti-inflamatory), gabapentin (for neuropathic pain), Lansoprazole (for gastric conditions), Lactulose (for constipation), senna (plant extract laxative) and paracetemol.

31. On 31 August 2010, a nurse was called to his cell as he complained of shortness of breath and a tight chest. The nurse recorded that his blood pressure was 135/78 (within normal limits) and, following discussion with Prison Doctor B, arranged for him to be taken to the emergency department at hospital for further assessment and treatment. A risk assessment was completed which authorised him to be accompanied to hospital by two officers with the use of an

escort chain, to be removed for treatment purposes. He was returned from the hospital at 9.00pm that same night with no discharge information of what assessment or treatment had been given or was required.

32. The next day, the nurse saw him and recorded that there had been no discharge information from the hospital. The nurse recorded his blood pressure as 133/69 (within normal limits).

33. In the weeks that followed, the man had 14 separate interventions with healthcare staff. These included prison doctors, nurses and the visiting podiatrist. It was recorded that he complained of pain in his right leg and hip and constipation. Prison Doctor A prescribed Tramadol (for moderate to severe pain relief). This was in addition to him being given his medication by nurses on a daily basis.

34. On 8 November, the man saw the doctor as he complained of extreme pain when walking. The doctor recorded that he was limping quite severely, made the diagnosis of osteoarthritis in the right hip, and referred him to the orthopaedic consultant for an assessment of a possible total hip replacement. The doctor also increased the prescribed Tramadol dose from 100mg to 300mg to be taken every 24 hours.

35. The man next saw the doctor on 6 December when he complained of pain in his right hip and also pins and needles from his right shoulder to his hand and down the right leg. The doctor noted that he had been last seen by the neurosurgeon in May, and referred him for a further assessment. He continued to be seen by nurses on a daily basis for the issue of his medication.

36. On 26 January 2011, the man saw an orthopaedic surgeon at hospital for an assessment of his right hip. A risk assessment was completed which authorised him to be accompanied to hospital by two officers with the use of an escort chain which was to be removed for treatment purposes. The surgeon confirmed that x-rays showed that he had significant osteoarthritis and required hip replacement surgery. The surgeon discussed the potential complications of the operation, which included stroke, heart attack, gastric ulcers, deep infection and leg length inequality with him, as well as the expected overall results and benefits. He agreed to have the operation and the surgeon confirmed that following the operation he would remain in hospital for four to five days.

37. From 27 January to 29 June, the man saw nursing staff on a daily basis for his medication. He also saw the dentist on two occasions and the orthopaedic occupational therapist visited his cell. This was to ensure that everything was in place for him following his hip replacement surgery. This included that his bed was at the correct height and that he had a chair with a booster cushion, a raised toilet seat and an extended hand grabber.

38. The man was admitted to hospital on 30 June and his hip replacement operation was performed by an orthopaedic consultant. For his admission to hospital another risk assessment was completed which authorised him to be

accompanied to hospital by two officers with the use of an escort chain which was to be removed for treatment purposes.

39. Following his surgery and physiotherapy assessment, the man was discharged back to Stafford on 3 July. As there is no 24 hour healthcare at the prison, arrangements had been made for the wing staff to check on him every 30 minutes to monitor his wellbeing, to see if he needed assistance or had fallen when using the toilet.

40. During the following two days, the man was reviewed on seven separate occasions by medical staff. It was recorded that he told staff he was feeling well, had no pain just a dull ache from his hip. His blood pressure was recorded as 121/60 (within normal limits) and that the operation wound was clean and dry and the dressing was changed. He was told that he had to wear his post operative stockings for at least six weeks, to prevent blood clots in his legs, and to continue the exercises as advised by the physiotherapist. Uniformed staff working at night checked on him every hour.

41. On the morning of 6 July, the man told two nurses that his right calf was swollen but he had chosen not to wear the post operative stockings. His blood pressure was taken and recorded as 104/98 (within normal limits) and it was noted that he continued to smoke heavily. On Prison Doctor B's advice, he was admitted to the emergency department at hospital for an assessment of a possible deep vein thrombosis (DVT) (formation of blood clots in the veins). A risk assessment was completed which authorised him to be accompanied to hospital by two officers with the use of an escort chain which was to be removed for treatment purposes. He returned to Stafford later that day with no evidence having been found of DVT in his right leg. Again he was monitored hourly through the night.

42. Over the next 12 days, the man saw healthcare staff each day, including two separate reviews with Prison Doctor A. He also saw the physiotherapist who recorded that he had no difficulty in sitting or standing and getting in and out of bed. He was advised to continue with his exercises and to walk with a shorter stride. Uniformed staff checked on him hourly through the night until 11 July when he said that he was feeling very well and his mobility had greatly improved. It was agreed by healthcare and uniformed staff that the night time observations should cease.

43. On 19 July, the man saw a nurse when he collected his medication at 8.45am. He told the nurse that he had chronic stomach pain. The nurse told him that she would see him after medications had been issued. The nurse, accompanied by another nurse, saw him in his cell at approximately 10.20am. He told the nurses that he was feeling very poorly. His blood pressure was taken and recorded as 114/67 (within normal limits). The nurse said that she would return to see how he was later in the day. The nurse returned later and he said he was feeling better and had eaten his lunch.

44. He saw healthcare staff on each of the next two days and there were no issues or concerns, however on Friday 22 July, when a nurse saw him at

approximately 2.00pm she found him on his bed complaining of abdominal pain. The nurse recorded that he could not tolerate his abdomen to be touched. He told the nurse that he had been taking his prescribed medication which included senna (bowel stimulant) and lactulose (stool softener). The nurse spoke to Prison Doctor B on the telephone who recommended that he be sent to hospital for further assessment. He was taken to hospital by ambulance but returned later that same day with a discharge letter from the registrar at the emergency department, which advised no further prescription of Tramadol, but to continue the use of senna and lactulose and a high fibre diet.

45. On Monday 25 July, Prison Doctor A saw him in his cell. He told the doctor that he had eaten and drunk fluids but had not had any bowel movement despite taking senna and lactulose. The doctor examined him and recorded his blood pressure as 106/78 (within normal limits). The doctor prescribed movicol (for constipation) instead of lactulose and senna

46. The next morning, following unlock at approximately 8.10am, an officer went to the man's cell as he had not been seen collecting his medication. The officer found him lying on his bed clearly in a distressed state. The officer went immediately to the medication hatch and asked a nurse to come straight away.

47. The nurse, without delay, went straight to see him. The nurse found him still lying on his bed, conscious and breathing but apparently delirious. The nurse noted that there was green bile stains around his mouth and she was unable to get a blood pressure reading. Using her radio she requested an emergency ambulance and asked for Prison Doctor B to attend.

48. Within two minutes the doctor arrived at the cell. He recorded that the man was very pale, confused and groaning, his blood pressure and pulse were weak. The paramedics arrived at 8.25am and, assisted by the doctor, gave him some initial treatment to stabilise his condition. The doctor recorded his blood pressure as 97/47 (below normal limits).

49. At 8.57am, the man was taken to hospital by the paramedics. He was accompanied by two officers who, following a risk assessment, used an escort chain which was to be removed for treatment purposes. Following an initial assessment at hospital of his condition, a governor authorised the removal of restraints.

50. By 1.30pm, a consultant surgeon told prison staff that the man's condition was very critical and his death was imminent. The prison chaplain contacted his wife to inform her of her husband's condition. She said she would come to the hospital as soon as possible.

51. At 4.40pm, doctors at the hospital confirmed that the man had died. The Deputy Governor and a prison chaplain met the man's wife at the hospital. Stafford arranged for two officers to take her back home in a prison vehicle and waited there until a family friend came to stay with her.

52. A debrief for the staff who responded to the incident in the morning took place at 5.15pm, with another for the escort staff at 6.30pm. The care team were available for those staff who wished to make use of their service. Stafford also arranged for the man's friends and peers to meet together that evening and they were supported by staff and the chaplaincy.

53. In the days that followed, the Deputy Governor maintained contact with the man's wife to offer support and financial assistance towards funeral expenses. Arrangements were also made for her to visit Stafford where she saw his accommodation, met with staff and with prisoners who were his friends.

ISSUES

Clinical Care

54. The lead clinical reviewer and her colleagues have considered the care and treatment that the man received from healthcare at HMP Stafford, the Ambulance Service and hospital. This report can only comment on the care that he received from healthcare at HMP Stafford. However, as the clinical review has made recommendations to organisations which are outside of our remit we will share this report with the Department for Health.

55. When considering the care provided to the man at Stafford the review concludes:

> "In the opinion of the clinical review the care that he received within the prison health care setting was equitable to what would have been received had he been a community patient."

56. Specifically in relation to the treatment the man received following his hip operation the review states:

> "On 3July 2011 the man was discharged from hospital into the care of the prison healthcare staff. His cell had already been assessed by an occupational therapist prior to surgery to ensure he had enough space for rehabilitation to take place. Aids had been supplied to ensure his rehabilitation was facilitated and he could be as independent as he wanted to be. However, to ensure his safety he was placed in a cell which was more spacious than his previous one, which meant he was not sharing with anyone else.
>
> "It was noted that he was seen daily by the prison healthcare staff and they followed a care plan which addressed rehabilitation post hip replacement to guide prison healthcare staff in the care delivered to him."

57. The clinical review made recommendations concerning the use of standardised clinical letters for unplanned prisoner admissions to hospital, liaison meetings between prison healthcare and A & E staff and the review of the patients following discharge back to prison from hospital. However, we are pleased to note that the issues in these recommendations have already been addressed and therefore we do not repeat them in this report.

58. The clinical review also recommended that prison a doctor's advice to admit a prisoner to outside hospital should be documented by healthcare staff. In respect of the man's care, on both occasions he was admitted to hospital as an emergency, healthcare staff recorded in his medical record the observations made and these were also relayed verbally to a doctor who confirmed that he should be sent to hospital for further assessment. We are satisfied therefore that healthcare staff at HMP Stafford do appropriately document, at the time, decisions to admit prisoners to hospital and therefore do not endorse this recommendation.

59. Some of the clinical records from HMP Hewell were not easily read as handwriting and signatures were illegible. However we note that Hewell now has computerised records so this problem should not reoccur.

60. We agree with the clinical review that the standard of care and treatment that the man received whilst he was in HMP Stafford was equitable to that he could have expected to receive in the community.

Restraints

61. Unfortunately there have been too many reports in which we have criticised the level of restraints used when prisoners are taken to outside hospital. We have evaluated the use of restraints each time the man went to hospital. The prison has to balance the prisoner's need for privacy and dignity with its duty to protect the public.

62. We judge that the risk assessments were appropriate each time that he was admitted to hospital. We are pleased to note that staff from Stafford removed all restraints at appropriate times to ensure that he was treated with dignity and respect on his final admission to hospital on the day of his death.

Family liaison

63. Stafford contacted the man's wife immediately after the hospital had made the diagnosis that his death was imminent. Prison Service staff were at the hospital to give their condolences and offer support to her after he had died. We are pleased that the Deputy Governor arranged for two members of staff to take her back home and wait with her until a family friend arrived to stay with her.

64. In the days that followed, the Deputy Governor maintained contact with the man's wife and offered support along with the offer of financial assistance towards funeral expenses. Arrangements were also made for her to visit the prison where she met with staff and prisoners. We judge that Stafford appropriately followed the guidance set out in Prison Service Order (PSO) 2710 'Follow up to deaths in custody'.

CONCLUSION

65. It is clear that attention was paid to the man's health needs and appropriate treatment and care was provided. The standard of care received at Stafford was equitable to that which he could have expected to receive in the community.

66. The man was treated with dignity and respect at Stafford and on the occasions he was taken to hospital. We believe there was no more that staff at HMP Stafford could reasonably have done to prevent his death. Following his death Stafford appropriately followed the guidance given in PSO 2710, 'Follow up to death in custody'.

67. There are issues relating to the man's care at hospital, which are outside of our remit. These issues are set out in the attached clinical review and will be brought to the attention of the Department of Health.

    The man's wife received a copy of the draft report as part of the consultation process. She explained that she had found the report informative and well written. She had no further concerns in response to the findings of the investigation.