INVESTIGATION INTO THE CIRCUMSTANCES OF

THE DEATH OF A MAN

IN NOVEMBER 2004

WHILST IN THE CUSTODY OF HMP MAIDSTONE

Report by the Prisons and Probation Ombudsman
for England and Wales

November 2005

This is the report of an investigation into the circumstances surrounding the death of a man on 27 November 2004. The man died from heart disease in his cell at HMP Maidstone. He was 70 years old.

I would like to extend my sincere condolences to his family and to those touched by his death.

I am sorry for the length of time it has taken to complete this report. The investigation was initially opened by one of my Assistant Ombudsmen. Following her retirement, the investigation was taken over and led by one of my other colleagues. An independent review of the man's medical care in prison was carried out as part of the investigation.

We would like to thank the management and staff at HMP Maidstone for their assistance and co-operation during the course of this investigation.

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

Contents

Summary

The investigation process

Background

The events leading up to the man's death

The prison's response following the death

Findings and Conclusions

Recommendations

Good practice

Summary

After sentencing, the man was first received into HMP Belmarsh in February 2003. He transferred to Maidstone in mid March 2003. His First Reception Health Screens at both Belmarsh and Maidstone showed him to be physically and mentally fit. He was taking no medication and had no reported past medical history of any significance. He did not smoke and only occasionally drank alcohol. His vital signs were not recorded at either Reception Screen. Apart from a bleeding stomach ulcer in 2002, he had no other significant past medical history.

At 11am on Saturday 27 November 2004, the man was seen in healthcare as he had vomited and felt unwell. He was also complaining of chest pain, which he said felt like indigestion and wind. He was pale, had vomited and felt sweaty. His pulse was recorded as being 98. The nurse gave him some Gaviscon and told him she would ask the doctor to see him that afternoon. He was subsequently returned to his cell.

At 12pm that day, the man was found on the floor of his cell. No pulse could be found. Cardiopulmonary resuscitation (CPR) was administered until the arrival of the paramedics who confirmed his death at 12.25pm.

The Post Mortem report indicates that the man died of Ischaemic Heart Disease.

Investigation Process

All the indications were that the man's death was from apparent natural causes. In these circumstances, I have judged 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 cause deaths has been to conduct an initial review to determine if a full investigation is justified. In this case, I decided that the circumstances did not require a full investigation, but appointed a clinician to undertake the review of his care.

My investigator initially opened the investigation and arranged for the relevant notices to be sent to the prison inviting staff and prisoners to make contact if they felt they had any information relevant to the investigation. No letters or telephone calls were received from either staff or prisoners.

Following the retirement of the first investigator, another colleague conducted a review of the health and social care the man's received whilst in custody.

The events leading up to the man's death

He reported no significant past medical history. In August 2004, he was seen by the doctor as part of a routine 'Well Man' clinic which was run by healthcare at Maidstone.

During this visit, his blood pressure (BP) was noted to be 190/110 and his weight had risen from 14st to 15.2st. At this point, he reported to the doctor that he had had a bleeding ulcer about four years previously, but that he had overcome the problem and was fit and well. The doctor felt that his raised BP was due to anxiety.

The man was followed-up by a doctor a week later on 3 September 2004. He looked well and his blood pressure was 180/90. The doctor prescribed diuretics, Bendrofluazide 2.5mg, in an attempt to reduce his BP. The doctor requested a re-check of the man's BP in one week's time.

On 10 September, he was prescribed Diltiazem 60mg, in a further attempt to reduce his BP which was then recorded as 170/90 and 190/90. Blood tests were requested which appear to have been carried out approximately one month later on 3 October 2004. The results were mainly within normal limits with a slightly raised cholesterol level of 5.4. The man was advised to see healthcare again in two to three weeks time. Due to his age, he was also given a flu vaccination in accordance with the Department of Health guidelines.

On 1 November, the man saw another doctor, who re-checked his BP which was 190/90. The doctor carried out some tests to exclude diabetes. The man reported some side effects to the medication, feeling sick and suffering from mild headaches. It was decided to continue the prescription for one month and re-check his BP. If there was no reduction or the side effects continued, his medication would be changed.

At 11am on 27 November, a nurse received a phone call in healthcare from the wing saying that the man was feeling unwell and was vomiting. The nurse asked for him to come up to healthcare. The man told the officer who escorted him that the pain felt like indigestion. On arrival, he told the nurse he was getting pain in his chest, and he was rubbing his upper abdomen. He looked pale but said he had no pain in his arms, and the nurse reports that his arm did not feel clammy. When asked if he felt sweaty he said he had been. The nurse took his pulse which was recorded as being 98 and regular but did not check his blood pressure. The man then belched and said again he thought it was wind. The nurse gave him Gaviscon tablets to treat his symptoms. The nurse said she would ask the doctor to see him when he came in later that afternoon. The man started retching, and vomited again. The nurse asked him what he had eaten. She then asked the officer whether anyone else on the wing had been sick. He said not. The nurse commented to him that his colour was better and he replied it was because he had been sick. The nurse asked the officer to keep an eye on him and to call her if he got any worse. The nurse told the doctor over the phone about the man's pain and that he had been sick. She asked the doctor whether he would see him when he came in and he said he would be there between 2.15 and 2.30pm.

The man was found collapsed on his cell floor at approximately 12.05pm. An emergency ambulance was requested. An officer phoned healthcare for medical assistance but there was no response. He heard over the radio that an ambulance had been called. Cardio-pulmonary resuscitation was commenced by discipline officers. On arrival, the paramedics took over the resuscitation. Sadly, this was unsuccessful and the man was pronounced dead.

The prison's response following the death

Staff followed contingency plans following the death in custody. The man's next of kin were contacted by the Head of Security. A notice was drafted and issued to every prisoner on the wing where the man had resided.

A hot debrief was held for staff by the head of security at 5.15pm on 27 November, the afternoon of the man's death.

The man's family (Brother in Law and Sister), visited the prison the next day and met with the Governors. Advice and support was offered to them and it was agreed that a memorial service would take place.

Findings and Conclusions

During the man's First Reception Health Screen there were no baseline observations of height, blood pressure, pulse or respirations recorded. The man's weight was however recorded to be 14st.

The First Reception Health Screen forms should be fully completed and include base line observations of blood pressure, pulse, respirations, temperature, height, weight and urinalysis.

The man was seen as a matter of routine by the doctor in the over 65's clinic on 27 August 2004, approximately 18 months after admission to prison. It was noted at this stage that his blood pressure was a little above normal levels at 190/110 and his weight had risen to 15.2st.

He was followed-up by the doctor a week later on 3 September. The man looked well and his blood pressure was 180/90. The doctor prescribed appropriate medication in an attempt to reduce his BP.

On 10 September, the man was prescribed further appropriate medication in an attempt to reduce his BP. His BP was recorded as 190/90. Blood tests were requested which do not appear to have been carried out until approximately one month later on 3 October 2004. The results were mainly within normal limits with a slightly raised cholesterol level of 5.4. There is no reference to the raised cholesterol level or steps that could be taken to help him reduce his cholesterol intake and level.

Requested blood tests should be carried out promptly and results documented in the medical record and acted upon if required in a timely and appropriate manner.

The man's BP was checked weekly for three weeks until 10 September when it was not checked again until 1 November 2004. At this time it was recorded as 190/90. It was decided to continue the same medication and to review him again in one month's time.

The regular monitoring of vital signs (particularly BP) for a patient with hypertension should be carried out and documented on a regular and frequent basis in accordance with the National Service Framework.

When the man attended healthcare on 27 November complaining of chest pain, the nurse on duty was a registered mental health nurse (RMN). She appeared to make an attempt to rule out cardiac involvement, noting whether he felt cold and clammy, sweaty or had pain in his arms. However, the fact that the man was rubbing his upper abdomen and told her that it felt like wind may have confused her attempt to diagnose the problem. The man had told the officer escorting him over to healthcare that his chest pain felt like indigestion. Despite his raised pulse rate and history of hypertension, the nurse appears not to have taken his BP. The nurse missed the classic symptoms associated with Myocardial Infarction (MI) of which the man was complaining. He was pale and sweaty, had vomited and complained of chest pain.

If an ambulance had been called at this stage, it might have improved the chances of the man's survival.

The nurse states that she reported his symptoms to the doctor over the telephone and asked him to see him when he came into healthcare. There is no documentation regarding the content of the discussion, but it appears that the doctor thought several hours later would be soon enough to assess the man.

All conversations between healthcare professionals in which a patient's condition is discussed should be clearly documented in the medical record.

The man was found collapsed in his cell at approximately 12.05pm. Resuscitation was administered by two discipline officers and continued until the paramedics arrived. An officer phoned healthcare for medical assistance but there was no response. He heard over the radio that an ambulance had been called.

The arrangements for contacting healthcare in the event of an emergency should be reviewed to ensure that staff respond promptly.

The post mortem concluded that the man died from Ischaemic Heart Disease.

Recommendations

Health

1. The First Reception Health Screen forms should be fully completed and include base line observations of blood pressure, pulse, respirations, temperature, height, weight and urinalysis.

2. Requested blood tests should be carried out promptly and results documented in the medical record and acted upon if required in a timely and appropriate manner.

3. The regular monitoring of vital signs (particularly BP) for a patient with hypertension should be carried out and documented on a regular and frequent basis in accordance with the National Service Framework.

4. All conversations between healthcare professionals in which a patient's condition is discussed, should be clearly documented in the medical record.

5. The arrangements for contacting healthcare in the event of an emergency should be reviewed to ensure that staff respond promptly.

Good Practice

1. Maidstone's routine well-man check of persons over 65 is good practice and in this case picked up a previously unknown case of hypertension.

2. The officers involved when the man first became ill, and when he was subsequently found collapsed in his cell on 27 November, acted quickly, appropriately and professionally.