Investigation into the circumstances surrounding the death of a man, at HMP Elmley, in February 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is the report of an investigation into the circumstances of the death of a man on 17 February 2008. The man was a remand prisoner at HMP Elmley, and aged 73 years. He died at Medway Maritime Hospital having been admitted on 2 February. A subsequent post mortem determined that his death was due to bronchopneumonia. My colleagues and I would like to extend our condolences to his family and all those touched by his death.

The investigation was led by one of my Fatal Incident Investigators. An independent review of the man's medical care in prison was commissioned from the Chief Executive of Eastern and Coastal Kent Primary Care Trust and carried out by a doctor. I am most grateful for their assistance. I would also like to thank the management and staff at HMP Elmley for their co-operation during the course of this investigation.

The man was remanded into custody at HMP Elmley in August 2007. He was not in good health on reception into prison but his healthcare needs were properly assessed while he was there. He frequently refused treatment for his heart condition, despite being made aware of the consequences of doing so both by hospital and prison medical staff.

In November 2007 the man took an overdose of prescribed medication and was placed on the Assessment, Care in Custody and Teamwork procedure to support him during the time he was considered to be at risk of harming himself.

In early February 2008 the man's cellmates called for help after he had become unwell and fallen in his cell. He was taken to hospital where he was never fully aware of his surroundings. Police investigated the circumstances surrounding the injuries which had led to his admission to hospital, but no evidence suggested he had harmed himself or that others were involved. The man gradually deteriorated over the following two week period, culminating in his death.

I judge that the man received appropriate and timely care at Elmley, although he did not always accept that care and advice. I do not believe his death was preventable.

I make two recommendations, both about medical record-keeping at Elmley. I must apologise for the significant delay in issuing this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2010**

CONTENTS

SUMMARY

The man, a prisoner at HMP Elmley, died on the morning of 17 February 2008 at Medway Maritime Hospital. He had been under escort there since his admission as an emergency on 2 February. He was 73 years old.

The man had been remanded in custody for trial in August 2007 for a number of serious offences. He was not in good health when he came into prison, having suffered several heart attacks and other health problems. Healthcare staff contacted his community doctor and his healthcare regime was reviewed.

The man asked to be given vulnerable prisoner status on arrival in prison. This was granted but he was lodged in the prison's In-Patient Department (IPD) until accommodation became available in an appropriate houseblock. The man underwent further medical tests to monitor his health.

In late September 2007 the man experienced chest pains and was advised that he should be admitted to an outside hospital. He refused to be admitted to either a hospital or the IPD, and signed a refusal of treatment disclaimer form to that effect. His treatment continued and the prison doctor requested further tests, altering some of his medication in line with the results. In October the man collapsed complaining of chest pains but refused to be admitted to the IPD at Elmley. He was taken by emergency ambulance to Medway Maritime Hospital where he later refused treatment and discharged himself from hospital. Hospital staff made him aware of the risks to his health resulting from his refusal. The hospital staff did not consider him to be at risk of self harm. While he was at hospital his property was cleared from his cell and his wedding ring was found. Concerns were raised by the officer who cleared the cell that removal of his wedding ring, refusal of treatment and other factors could indicate an attempt to end his life.

When he returned to Elmley, the man was admitted to the IPD for observation but refused to remain there. He signed a further disclaimer and returned to his cell. Three days later, he again discharged himself from hospital following admission for a suspected heart attack and once more refused admission to the IPD, again signing a disclaimer.

In mid-November the man admitted taking an overdose of prescribed medication during the previous night. He was taken to hospital by ambulance returning to Elmley late the same evening where he refused to be admitted to the IPD. An Assessment, Care in Custody and Teamwork (ACCT) document was opened on his return and remained open for two weeks. (ACCT is the Prison Service procedure to assess, observe and support prisoners who are considered at risk of harming themselves. Within the ACCT document, staff set out problems and possible trigger points and drew up a multidisciplinary plan to give support through a period of crisis.) Staff removed his in-possession medication, and from then on the administration of his medication was supervised.

At the end of December the man again complained of chest pains. The doctor treated him, requested tests and referred him to the Rapid Access Chest Pain Clinic at Medway Maritime Hospital. The clinic made an appointment for 9 January 2008

but because of a shortage of prison staff he did not attend. Due to that failure, the Primary Care Trust policy on missed appointments was implemented and no further appointment was made. A re-referral was sent to the hospital on 18 January.

The man complained of chest pain on 29 January and remained in his cell for the day. On 2 February, he went to bed and fell asleep but became noisy and restless which worried his two cellmates. He woke, sat on the edge of his bed appearing disorientated and unwell. He fell to the floor cutting his head. While one cellmate tried to stop his head bleeding, the other called for help.

Night and nursing staff went to the cell and administered first aid. The man was not responsive and was clearly unwell. Nursing staff decided that he should be taken to outside hospital and an emergency ambulance was called. He was admitted in the early hours of 3 February.

The man's cellmates were asked by the night duty staff how he had become injured and unwell, but they were unable to add anything further to the information they had already given. The following day they were moved to the Segregation Unit while police interviewed them about the man. Prison staff established that no injuries or marks were present on their bodies. The man did not tell prison escorting staff how he came to be unwell. No evidence was found connecting his cellmates to the man's sudden illness and four days later they were released back to their normal prison location.

On arrival at hospital the man's condition was not hopeful and his next of kin was contacted. Later that day he showed a marked improvement and his outlook was thought to be more positive. He remained under escort but was not subject to restraint except for a period of three days between 6 and 9 February. His condition gradually deteriorated until he died in the early morning of 17 February 2008.

HMP Elmley activated their contingency plan for a death in custody which was modified to take account of the fact that he had been seriously ill and in hospital. A member of the chaplaincy at Elmley, who was also the prison's Family Liaison Officer, contacted, visited and supported the man's family until after the funeral at which he officiated.

Following a post mortem examination of the man's body, an interim certificate of the fact of death was issued by the Coroner on 21 February giving a provisional cause of death as bronchopneumonia and a head injury. Further examination of body samples established that the injury to his head was not a contributory factor and the blood analysis was inconclusive. The pathologist concluded that the man died of bronchopneumonia

I make two recommendations directed at the Eastern and Coastal Kent Primary Care Trust and concerning the way medical records are kept at Elmley. I am pleased to note that both recommendations have been accepted and acted upon.

INVESTIGATION PROCESS

1. My investigator visited HMP Elmley on 4 March 2008. He met the liaison officer who gave a full briefing about the circumstances surrounding the man's death. He met the then Governor on the following day and briefed her on progress made.

2. The investigator also spoke to representatives of the Prison Officers' Association and the Independent Monitoring Board. Notices to staff and prisoners were published inviting anyone who might have information relating to the man to make themselves known to the investigator. One prisoner spoke to the investigator and was formally interviewed. He also met relevant prison staff, including members of the chaplaincy and medical department.

3. Kent Police considered the circumstances of his death but decided after the post mortem examination they were not suspicious. The initial post mortem took place on 20 February 2008. Samples were taken for further forensic examination and the final post mortem report was received by my office on 29 April 2009 and was in part responsible for the late delivery of this report.

4. The Chief Executive of Eastern and Coastal Kent Primary Care Trust, was asked to commission a clinical review - which was carried out by a doctor. The report of the review was received on 3 June 2009, following receipt of the final post mortem report.

5. The investigator interviewed relevant staff and prisoners involved in the events surrounding the man's death. This included one of his cellmates, but the investigator was unable to contact the second cellmate who had been discharged from prison. The cellmate was also discharged from prison soon after the interview. The investigator wrote to him at his address with a copy of the interview notes for checking, signature and return. To date there has been no response.

6. One of my own family liaison officers contacted the man's wife, as his listed next of kin, to inform her of my investigation and to invite her to ask any questions or raise any issues for consideration. At the time of issuing this report no concerns have been raised directly with my office. I understand, however, that some issues were raised with the Elmley family liaison officer about the settling of the man's affairs and who was able to address and resolve them. I hope this report, should the man's family choose to receive it, provide them with a better understanding of his time in custody and the events leading to his death.

HMP ELMLEY

7. HMP Elmley is a category B local prison for convicted and remanded adults and remanded young offenders. It has an operational capacity of 985, which includes the healthcare centre and segregation unit. The main accommodation is provided in five houseblocks holding between 183 and 240 prisoners each.

8. A report of a full inspection by HM Chief Inspector of Prisons in 2006 and an unannounced follow up visit in 2009 raised no issues relevant to matters surrounding the man's death. Similarly, the last available Independent Monitoring Board (IMB), report published in October 2007, five months before his death, raised no issues germane to the investigation. (The IMB is a body of volunteers from the local community who monitor day to day prison life and ensure standards of care and decency are maintained.)

9. Healthcare at Elmley is delivered by the Eastern and Coastal Kent Primary Care Trust. All staff working there are appropriately qualified, and a full-time doctor is available every weekday. Medical cover is provided during the weekends and evenings by doctors from a local practice. Appointments to see a doctor are generally triggered by the prisoner making an application.

10. The healthcare centre has an outpatient department and an inpatient department for up to 29 prisoners. At night, a nurse is in charge of the centre as well as having responsibility for healthcare cover for the rest of the prison. A night patrol officer, who is not medically qualified, also works in the healthcare unit. Both the nurse and the officer carry cell keys in a sealed pouch for emergency use only, but do not carry any other security keys. When the nurse is called away, he/she is escorted by one of the duty Night Orderly Officers.

11. During the man's time at Elmley the recording of medical notes was in transition. Healthcare staff ran a dual system consisting of the longstanding Continuous Clinical Record which was handwritten and paper based. The second, and parallel, system was Electronic Medical Information System (EMIS) which was implemented in May 2006 although not designed specifically for use in prisons. Paper records were then transcribed onto the EMIS record. Accepted policy was that when transcription took place a clinician validated ten per cent of the transcribed entries. However, no record of that validation process is evident.

12. Both of these systems have been phased out in favour of System 1, a general practitioner system that includes a module for prison use. Electronic recording of medical information at Elmley now starts at reception and all medical data entered for each prisoner is stored in the system. The exception is where prisoners' notes pre-date the implementation of the new system and are transferred in from prisons not operating the electronic record. Relevant information from that group is transcribed from paper based sources onto the computerised record. Again, accepted practice is that when transcription

takes place ten per cent of those entries are subject to a validation check by a clinician.

KEY EVENTS

13. The man was in police custody from 6 August 2007 overnight until his reception at Elmley the following day. He had been remanded in custody by magistrates for trial at Crown Court. During that time, forensic samples were taken by a police custody nurse who also supervised the administration of his prescription drugs. His was further remanded by Maidstone Crown Court in August, October and November. He was due to return to court on 31 March 2008.

14. On his reception into Elmley, the reception nurse assessed the man and noted that he had a number of health problems, including several heart attacks in the past, angina and an enlarged prostate. He also reported a substantial weight loss of four kilos in one week. The nurse noted that he appeared a little deaf. She referred him to the prison's medical officer for a review of his treatment and medication. The man nominated his wife as his next of kin.

15. Due to the nature of his alleged offences he asked to be considered a vulnerable prisoner and placed in the vulnerable prisoners unit (VPU). (The VPU enables prisoners to be segregated from the main population for their own protection if they fear for their safety as a result of their offence, debts or bullying for other reasons.) The unit was full and he was located in the Healthcare Centre (HCC) in patient department (IPD) as a temporary measure until space became available in Houseblock 4, the VPU. The relevant Cell Sharing Risk Assessment (CSRA) indicates that he was not at risk of self-harm. (CSRA is a process to identify risks to other prisoners and a factor when allocating either single or multiple occupancy accommodation.) The man also completed a disability questionnaire. This showed that he had difficulty negotiating stairs and walking long distances because of arthritis and angina, but needed no special facilities or equipment to carry out his normal activities.

16. The man remained in IPD overnight, and on 8 August was seen and examined by a prison doctor who noted his history of arthritis, angina and heart attacks. He also recorded that the man had undergone a coronary angiography (an examination of the heart using x-rays and a probe inserted into a major blood vessel) and that he had, in the past week, been examined by his own general practitioner for a prostate problem and was waiting for test results. The doctor telephoned the man's doctor and he agreed to send the results to Elmley. A fax was sent by Elmley to his doctor's surgery with his consent for disclosure of the details.

17. The doctor prescribed treatment for the man's medical conditions which included ramipril and aspirin for his heart condition, simvastatin to control his blood cholesterol level, dutasteride for his prostate problems, etoricoxib, an anti-inflammatory drug, quinine sulphate for leg cramps at night and codeine phosphate a painkiller. All were noted on his Prescription and Administration chart as initially being from his own supply and subsequently provided by the prison. The doctor found the man fit for discharge from IPD to a normal

prison location. No places were available in Houseblock 4 and an Initial Segregation Safety Screen form was completed to assess his suitability for segregation and to allow temporary location in the IPD until a place became available. He remained there until 10 August when he transferred into Houseblock 4.

18. The man underwent a secondary health and well person assessment on 13 August. During that assessment he told a nurse that in addition to angina, arthritis, hernia and an enlarged prostate, his left kidney was functioning at 40 per cent of normal capability. He also revealed that he smoked 20 cigarettes daily. He signed a Declaration of Commitment to the Elmley compact which included an agreement to voluntary compliance testing for drugs. On 14 August he had a prison officer became his Personal Officer and the man started working as a wing cleaner.

19. The following day (15 August) the man reported to triage staff (who provide the first line of non emergency medical help) on Houseblock 4 that he needed more quinine sulphate tablets for his leg cramps, indicating that he required 2 x 300mg. A Healthcare Worker (HCW) referred the request for re-prescription. A note initialled DP (believed by the Nursing Manager to be a locum doctor) was then added noting that night cramps were not relieved by quinine 300mg, the word "not" appears to have been struck through. An action note follows recording the words "600mg nocte" (at night) and in parenthesis "got it in the past and no ADR" (adverse drug reaction). The note also contains the abbreviation "HS = nad" (heart sounds – nothing abnormal detected).

20. The man's computerised EMIS record notes the same two entries, the first of which is recorded as not being signed and the second with the inclusion of the word "not" without the strike through. An entry dated 15 August on the man's Prescription and Administration Chart records the 600mg quinine sulphate prescription which was faxed to the pharmacy. It was not dispensed and an accompanying note, probably written by a weekly sessional doctor at Elmley, recorded "incorrect dose" and "unlicensed use". On the following day the quinine sulphate was re-prescribed by the same at the original dosage of 300mg once daily at night which was dispensed.

21. The man's doctor sent two radiological reports on 17 August confirming the results of tests undertaken on 11 July and 1 August 2007. One referred to a chest x-ray which confirmed that the man had no abnormalities in his heart and lungs. The other confirmed that an ultrasound examination of his abdomen showed no abnormalities and that his prostate was not enlarged.

22. The man continued on his medical regime until 26 September when he complained of experiencing chest pain for the previous few days. An unsigned note in the Continuous Clinical Record showed that he had told his landing officer but had not been seen yet. The medical officer would see him that morning and scan results were awaited. (The EMIS transcription records that the note was signed by C. Oladapo.) The prison doctor later examined him and advised that he should be admitted to the coronary ward at an

outside hospital. The man refused to be admitted to either the hospital or to the prison IPD. After the prison doctor explained the treatment required, both he and the doctor signed a refusal of treatment form. It is recorded that the doctor altered the man's treatment, stopping his prescription for etoricoxib and ramipril, and gave him a nitro spray (to relieve the symptoms of angina). A note "Beta Blocked C.I." (cerebral infarction) was also made. No corresponding Prescription and Administration Chart entry confirming the alteration is evident, and the record shows that the medication was continually administered until 3 October after which it ceased.

23. The weekly sessional doctor reviewed the man on 11 October and recorded on EMIS that his symptoms were suggestive of benign prostatic hyperplasia (BHP) (enlarged prostate gland). The doctor noted that the man had maintained a steady weight since reception, having been investigated by his own doctor for a substantial weight loss before coming into prison. The doctor commented that he should stop the dutasteride for his prostate problems as it was ineffective and start using Flomaxtra (tamsulosin) instead. The man was also to remain off the angiotensin converting enzyme (ACE) drug ramipril. The doctor requested a number of tests including a full blood count, urea and electrolytes, glucose, liver function test, serum lipids, bone profile and a thyroid function test. He also prescribed a 28 day supply of the medicines he had recommended which were given to the man in his possession on 13 October.

24. On 14 October the man began working in the headphones workshop where he was considered to be courteous and compliant. In the late morning of the following day, 15 October, he collapsed in the houseblock dining hall complaining of chest pains and difficulty breathing. The healthcare worker designated as "Hotel 1" examined him. (At Elmley, Hotel 1 is the first point of contact in the event of a medical problem arising in the prison.) He found that the man's pupils were small but reactive, and over a period of about 15 minutes his blood pressure was erratic. He also took note of his pulse, blood sugar and blood saturation level (the amount of oxygen present in the blood, commonly known as "sats"). The healthcare worker offered the man a glyceryl trinitrate (GTN) spray – a medicine to ease the symptoms of angina – which he accepted. He also noted a bruise at the back of his head and that he had refused to be admitted to the IPD.

25. The healthcare worker asked for the ambulance service to be called. The prison's medical officer and another doctor attended the man until he was taken to Medway Maritime Hospital. The man later refused treatment there and discharged himself from hospital returning to Elmley. A "Discharge against Medical Advice or Refusal of Treatment" form from the Accident and Emergency Department at the hospital, signed by the man before discharge, said that he was made aware of the risks to his health by his actions and recorded that he refused to say why he did not want treatment. Significantly, it was also noted that there was no "suicidal ideation" (no thoughts of harming himself). The form was signed as being witnessed on 18 October, i.e. after he had been discharged from hospital, but the signature is illegible. His discharge report from the hospital identifies a diagnosis of angina pectoris

(the inability of the coronary arteries to fully meet the demand for blood by the heart).

26. While the man was at the hospital, a member of staff an officer cleared his personal property out of his cell and his wedding ring was found in his cupboard. The officer reported the find to healthcare staff. He told them his concerns that – in conjunction with the man refusing treatment and information from fellow prisoners that he had not eaten much recently and was not taking his medication as prescribed – there was a possibility that he was attempting to end his life. It is not known exactly who the officer reported the matter to and no written account of that report or any follow up action is available.

27. When he returned to Elmley the man was admitted to the IPD for observation because of his angina and coronary heart disease. Notes made at the time of his admission indicate that he was "Non concordant with treatment plan". The man refused to remain in IPD and at 6.23pm signed a disclaimer refusing further health management, witnessed by a nurse. He then returned to Houseblock 4.

28. The man had a remand hearing at Maidstone Crown Court on 17 October 2007 at which his next court appearance was set for 7 November. The Continuous Clinical Record indicates that on 18 October he again discharged himself from Medway Maritime Hospital following an admission for a suspected anterior myocardial infarction (a heart attack centred in the frontal section of the heart). He said that he felt fit and well and refused to be admitted to IPD. He again signed a disclaimer refusing admission for a period of observation and wrote that he understood the consequences of so doing. The note was witnessed by a doctor and nurse. A note dated 24 October indicated that he had subsequently refused any blood tests even after further advice.

29. The man asked for codeine on 31 October to reduce cramps and pains in his hands. He had used up four weeks supply in three, and the prescription was repeated at a dosage of two 200mg tablets to be taken once daily. A repeat prescription was issued for his other medication and he was placed on the list for a flu vaccination. The man was further remanded at Maidstone Crown Court on 7 November and a trial date set for 31 March 2008.

30. In triage on Houseblock 4 on 14 November the man complained that he had suffered numbness and a lack of feeling in his left foot for over a week. He was referred to the doctor. His in-possession medicines were re-prescribed but it is unclear from the Prescription and Administration Chart whether or when he received them.

31. On 16 November at 2.30pm a nurse was called to Houseblock 4 to see the man who was reported to have slurred speech and was restless. An officer advised the nurse that he had been told that the man had taken an overdose of quinine sulphate during the previous night. The man admitted this. The nurse gave him oxygen and took him to the IPD in a wheelchair. He was then

taken to hospital by ambulance, arriving at 7.17pm. The officer undertook to open an Assessment, Care in Custody and Teamwork (ACCT) document when the man was discharged.

32. The man returned to Elmley at 11.00pm. He refused to be admitted to the IPD, insisting that he was "fine", but demanded his night dose of medication. The night duty nurse refused to do so because of his overdose and referred him to the medical officer for review the following morning. An unsigned review dated 17 November in the Continuous Clinical Record notes that his comments on his decision to overdose were "seems a good idea at the time" and "I do not have such plans now". The reviewer noted that because of the overdose the man's medication would be supervised in future and that he had been told of that decision.

33. An officer opened an ACCT document at 9.30am on 17 November. During the assessment interview the man explained that his actions were a result of his inability to cope with being in prison and that felt he was too old to be there. He also said that it was a half-hearted attempt at harming himself and he would not repeat it. The action plan included the withdrawal of in-possession medication, supervision of his medication, staff support during the day and at night, and he was to remain in his cell with his cellmates. At the first case review at 3.45pm that day the man was considered to be at low risk of self-harm but the ACCT document was to remain open until 26 November. The man was monitored and remained positive with one exception. On 19 November, he told his Personal Officer, that he was going to die and he wanted it to be on his own terms. The Personal Officer was concerned about his state of mind and brought the matter to the attention of the other staff involved in his care.

34. A few days later, on Saturday 24 November the Personal Officer again spoke to the man who said that he had been feeling down but was now feeling better. He also expressed a wish to change his job from the headphones to the balloons workshop because of the low wages. The Personal Officer agreed to ring the Labour Control office on Monday to see whether it was possible, and the man subsequently began work in the balloon workshop on 12 December. No further negative feelings were reported and the ACCT document was closed by mutual consent following a second case review on 26 November. An ACCT closure interview took place on 4 December during which the man was in good spirits with no immediate problems. No further action was considered necessary.

35. On 9 December 9 the man told his Personal Officer that he had a small pain in his chest which he in turn reported to healthcare staff. The personal Officer recorded the matter in the man's Record of Events at the time and said during a later interview that he had telephoned healthcare to report it. No record of that report is evident in his Inmate Medical Record (IMR).

36. A doctor reviewed the man on 17 December in the outpatients department. The man told the doctor that he had vomited blood on 7 and 8 December, but that there had been no repeat since. The doctor noted that he had no

dyspepsia (indigestion) and concluded “for Barium swallow and meal” (a process where the patient swallows a radio opaque drink which is then observed by x-ray while it goes through the stomach and gut). The EMIS transcription records: “Barium swallow normal. On 7.12.07 and 8.12.07 he vomited blood, a small amount and no other vomitus. No vomiting since. No dyspepsia. For Signed doctor.” Although the EMIS entry indicates that the barium meal had been carried out and was normal, this was not the case. There is no evidence that a hospital appointment was made or the test was carried out. It is possible that the handwritten words “barium swallow + meal” were mis-read and transcribed as “barium normal”.

37. The man used the special sick process on 31 December complaining that he had chest pain which had lasted for three weeks. (Special sick is a means by which a prisoner can seek medical attention without a scheduled medical appointment.) His blood oxygen sats level and pulse rate were measured and he was referred to a doctor who examined him. The doctor prescribed lansoprazole (a medicine to combat the effects of too much acid in the stomach) for his epigastric pain (pain in the upper central region of the abdomen), requested an ECG (electrocardiogram - to measure the rhythm of the heart), and referred him to the Rapid Access Chest Pain Clinic at Medway Hospital where he was subsequently given an appointment for 9 January 2008. The man was called for an appointment on 2 January to see the prison doctor on Houseblock 4 but did not attend.

38. The man did not keep the clinic appointment for 9 January. An unsigned undated note on the original appointment letter says “No Staff”. The clinic wrote on 10 January confirming that he had failed to attend or cancel the appointment and explaining the Trust policy of not sending another appointment. They discharged him from the service. A further two notes, again undated and unsigned, on the appointment letter read “needs re-referring” and “Copy of referral sent to Medway Hospital 18/01/08”. A note, also written (unsigned and undated) on the failure to attend letter from the hospital said: “Sent out as an emergency on 03/02/08 to Medway’s A&E.”

39. The designated “Hotel 1” nurse (the first response in the event of a medical problem within the prison), made a routine visit to the man on Houseblock 4 at 9.10am on 29 January. He had taken his morning medication and was experiencing tightness in his chest. The nurse gave him a dose of GTN and noted his pulse and blood pressure levels. She also recorded that he was not short of breath or sweating, and his skin colour was normal. The nurse advised him to rest on his bed and made the houseblock staff aware of this advice.

40. One of the two cellmates mistakenly remembers that the man returned early from work on Saturday 2 February (workshops are not open on Saturdays). It is most likely that he remembers the man’s return to the cell on 29 January. He went on to tell my investigator that he was in their cell during the morning when the man returned complaining of chest pains. The cellmate said that the man lay on his bed all that day. He seemed alright and he believes he collected his meals.

41. On 2 February the man was still sharing cell A308 with two other men. The two cellmates slept in bunk beds on the left hand side of the cell and he had a single bed on the right side. Following the wing recreation period, at about 7.30pm the man and his two cellmates were locked in for the night. All three of them then watched a boxing match on the television.

42. According to one of the cellmates the man went to bed at around 9.00pm. Once he had fallen asleep, he began snoring and some time later started making strange noises. The other cellmate tried to wake him to ask him if he was alright but he mumbled something and tried to get out on the wall side of his bed. He then untangled himself from the bedclothes and sat on the edge of his bed facing his cellmates, again mumbling. One of them asked the man if he was alright. He replied that he was. His eyes were closed and he was rocking backwards and forwards and from side to side. The other cellmate thought he seemed "out of it". The man then leant forward with his arm stretched out towards the floor. The cellmate thought the man wanted his slippers and put them in front of him but he waved them away. The man then dropped forward onto his knees, hitting his head on the floor. He pulled himself up onto his arms and again fell forward hitting his head. The cellmate saw that the man had cut the right side of his forehead and blood was dripping from the wound onto the floor. He gave a towel to the other cellmate who used it to cover the wound.

43. At about 10.35pm one of the cellmates rang the cell call bell and began knocking on the door to get attention. At that time an Officer Support Grade (OSG), the duty night patrol on Houseblock 4, Senior Officer (SO), the Night Orderly Officer, two officers, Assistant Night Orderly Officers, were removing a prisoner on B3 landing. (The Night Orderly Officer is in charge of the whole prison during the night and carries pass keys and a cell key, whereas the assistants carry only a pass key which allows them to enter all parts of the prison except the cells. Night duty patrols carry no keys except a cell key in a sealed pouch for use in emergencies.)

44. The night staff heard a cell call bell and the banging of a cell door and an officer went to the cell, A3-08. One of the cellmates told him that the man had fallen out of bed, banged his head and cut it, and that he was moving about on the floor but not communicating with either of his cellmates. An officer called the SO to the cell. The SO opened the observation flap and saw the man on the floor of the cell between the beds. His head was towards the rear of the cell and his feet nearest to the door. He was on his right side with one arm under his body, apparently in the recovery position. One of the cellmates was at his head and appeared to be holding it with a towel pressed to it. The other cellmate was on the bottom bunk. The SO opened the door and went in with the two Assistant Night Orderly Officers.

45. As they entered one of the officers told the OSG to telephone the duty nurse. She went to the office to make the call. She told the nurse about the man and said that an officer would shortly collect her from HCC and bring her to Houseblock 4. At about the same time another of the SOs assistants joined

the staff at the cell. One of the officers left to collect the nurse, arriving in the HCC at around 10.50pm.

46. Both of the cellmates reiterated to the SO what one of them had originally told one of the officers. One of the cellmates was holding a towel to the man's head and there was a small pool of blood on the floor. The SO took over from the cellmate holding the towel and moved the man into a sitting position. He also removed the towel to look at the wound and saw a small cut of about one quarter of an inch on the right eyebrow. He replaced the towel and increased pressure on the wound in an attempt to stop the bleeding completely. He talked to the man throughout this time but his eyes were closed and he was mumbling incoherently. The SO and one of the officers lifted the man onto his bed to make him more comfortable

47. Both of the cellmates were told to leave the cell and they waited outside with the officer. One of the other officers noted that they appeared concerned for the man's welfare. The two men were then temporarily moved to Ward "A" in the HCC, given a hot drink and returned to their cell after the man was taken to hospital.

48. The officer, a locally retained firefighter with Kent Fire Brigade, is trained in first aid, the use of defibrillators, oxygen therapy, cardio pulmonary resuscitation and basic life support. He joined the SO in the cell and was monitoring the man's condition when the nurse arrived a few minutes later bringing with her an emergency response bag. He continued to assist her. The nurse found him unresponsive and noted that his pupils were pinpointed and there was no reaction in them when she examined them with a torch. His breathing was steady and regular and he did not seem uncomfortable. She also saw that the man had a superficial cut on his upper right eye which was not bleeding or swollen. She took the man's blood pressure and pulse and attached an oxygen saturation monitoring machine to his finger. His blood pressure was a little low and he had a fast pulse which concerned her. His blood oxygen sats level was 98 per cent. He looked grey and unwell. The nurse told the SO that the man needed to go to outside hospital. He contacted the Communications Officer by radio and instructed that an emergency ambulance be called.

49. The nurse and an officer agreed that, although the man's respiration was satisfactory, oxygen might help him. The officer took the oxygen bottle and equipment from the emergency bag and discovered that the bottle was empty. The nurse went back to the HCC to collect a replacement and his medical notes. She returned to the cell within five minutes and connected the oxygen to a facemask, placing it over the man's face. She saw in his medical notes that he suffered from angina and had complained of chest pain a few days earlier. She gave him two puffs of GTN spray into the mask.

50. The nurse then went to the houseblock office to write a hospital admission letter and listed the medication the man was taking. She also spoke to his two cellmates. They told her that he had started to act strangely about an hour before falling out of bed, and they were concerned that he might have

taken an overdose of drugs. The nurse questioned why they thought that and they explained that it was just a feeling. The nurse feels that it was a genuine caring reaction with no anger or hostility from them. She had no feeling that anything was wrong.

51. When she returned to the cell the nurse noted that the man's pulse had risen. At about 11.30, an emergency ambulance arrived and she briefed the crew as they took over from her. The crew took him to the ambulance in a portable chair. A SO and officer escorted the man to hospital. Another SO authorised the use of a closeting chain, also known as an escort chain, as he considered the man to be too frail to be restrained by handcuffs. (This is a long chain with a handcuff at both ends. An officer is handcuffed to the prisoner via the chain which is long enough for the prisoner to be able to use the toilet or be examined.) However, the chain was not in fact used.

52. The ambulance and escort left Elmley for Medway Maritime Hospital at around 11.50pm, arriving at about 12.30am on 3 February. The man was examined at around 3.00am and admitted to Bronte Ward, the Medical Assessment Unit (MAU). The man's prognosis was not hopeful and the escorting staff were told by a SO to report his condition to the prison hourly. By 7.20am, the chaplain at Elmley had contacted the man's wife, his next of kin. However, by 10.35am escorting staff had reported a remarkable improvement and his prognosis was much more favourable. His wife contacted the ward at about midday with a view to visiting when medical staff could give a more certain opinion of the outcome. Escorting staff were instructed by Elmley to report his condition less often, at two hourly intervals. One of the escorting officers sought the advice of medical staff about the use of restraints and recorded at 1.50pm their opinion that while the man was still sedated he should not be handcuffed. Restraints were not used.

53. On 4 February, following the man's admission to hospital the two cellmates were placed in the Segregation Unit whilst police investigated how the man became injured and unwell. The men were searched and examined by prison staff to establish whether they had any marks or injuries to their bodies, and were interviewed by police. They returned to the houseblock after police and prison enquiries were completed four days later. No evidence was found implicating them in the man's condition. (I have not considered the matter further, and do not criticise the decision to segregate the cellmates while the police were making their inquiries. However, it seems apparent that their conduct was in fact blameless; indeed, they had shown sensitivity to the man's needs.)

54. The man remained unresponsive and his condition worsened during the night of 3/4 February and he was moved to the intensive care unit (ICU). Doctors thought that he had suffered a serious stroke and he remained semi-conscious and incoherent throughout his time in the ICU.

55. During the afternoon of 6 February, one of the escorting officers telephoned the (PO) the Orderly Officer at Elmley to ask why the man was not handcuffed. She explained that while he was semi-conscious there was no

need for restraints to be used, but should he become conscious then the closeting chain was to be applied. As he was conscious the officer attached the chain to the man and the other escorting officer. The officer reported that during her eight hour duty the man was fidgety, incoherent and apparently confused. He regularly pulled out his catheter and tried to get out of bed. She also reported that he tried to speak to the escorting staff but his speech was slurred and unintelligible, which appeared to frustrate him. The man was moved from the ICU back to Bronte ward at around 9.30pm that evening.

56. During the night of 9/10 February, one of the escorting officers recorded that the man was still wearing handcuffs. At around 4.00am his condition had deteriorated and a doctor confirmed that he was not likely to survive much longer. The second escorting officer immediately contacted Elmley and told the Night Orderly Officer. He asked her whether it was necessary for the man to be handcuffed and she authorised their removal. The man remained restless and incoherent and was on occasions heavily sedated. During one comparatively lucid period on 15 February, both a SO and an officer noted that he had made no comment on the events that had led to him to being admitted to hospital.

57. At about 6.40pm on 16 December, hospital staff told the escorting staff that the man had developed pneumonia and had not responded well to treatment. At 8.45pm, the ward sister asked an officer for details of the man's next of kin as she considered that he would not survive the night. She contacted his family who responded that the hospital should contact them when he died.

58. The two officers who were again on bedwatch duty with the man on Bronte ward during the night. At their handover briefing they were told that he was unconscious and was unlikely to survive more than a few hours. The man was not handcuffed.

17 February 2008

59. At around 3.00am on 17 February the man was moved from the main ward to a side ward and the ward sister told the escorting staff that he was dying. He died quietly and with dignity at 4.45am. He was alone except for the nursing sister and the two escorting staff. At 4.50am the sister telephoned his family but was unable to make contact. She left a message on their answering service asking them to contact her. Once confirmation of the man's death was obtained at 5.10am an officer telephoned a SO to tell him. The ward sister wrote a letter of confirmation and at 5.45am both escorting officers left the hospital. A SO told the Duty Governor of the death at 4.55am.

60. HMP Elmley's contingency plan for a death in custody was implemented. All open ACCT documents were reviewed to ensure that prisoners who might have been affected by the man's death were properly supported. By lunchtime, the Governor had published notices informing prisoners and staff of the man's death.

61. The chaplain at Elmley and family liaison officer contacted the man's wife at about 9.30am. He offered her and her family support and any assistance. The man's wife declined a visit from prison representatives that day however arrangements were made for the chaplain to visit the family on 26 February. The chaplain gave the man's wife his contact details and spoke to her and another family member a number of times throughout the day, the last contact being at around 11.00pm. The then Governor wrote a letter of condolence on 19 February and offered assistance with the cost of his funeral.

62. On the following day (20 February), a post mortem examination of the man's body was undertaken by a Home Office Pathologist. The doctor concluded that the man had died from bronchopneumonia, but further examination of his brain and an analysis of his blood was required to establish whether a head injury or the use of drugs were contributory factors. An Interim Certificate of the fact of death was issued by the Coroner on 21 February giving the provisional cause of death as bronchopneumonia and a head injury.

63. A doctor of Kings College Hospital, London, concluded in his reports dated 12 March and 7 May 2008 that there was no evidence of serious damage to the man's brain. The blood analysis report dated 10 April 2008 by Toxicologist of Kent Scientific Services detected, but did not quantify, etoricoxib, one of the man's prescribed drugs. However, insufficient blood was submitted to allow a complete analysis and therefore no tests were performed for drugs that are commonly misused. The doctor concluded in his report dated 25 April 2008 that the man died of bronchopneumonia. I received the final post mortem report on 1 May 2009.

64. The chaplain maintained regular contact with the man's family following his death. He assisted in the settling of the man's affairs and acted as an intermediary between the family, other interested parties and the Coroner's office. The chaplain met members of the man's family for several hours at their home on the evening of 26 February to discuss the issues surrounding his death. He also returned his property and a small amount of money to them. The man's wife felt unable to be involved in the funeral.

65. The man's funeral took place on Friday 28 March at a Crematorium in Kent. The chaplain conducted the service. The man's brother, son and several other members of his family were present. Elmley met the cost of the funeral and was represented by six members of the chaplaincy and a Principal Officer who represented the Governor. Later the chaplain collected the ashes from the crematorium and took them to the man's son in the West Midlands.

ISSUES CONSIDERED DURING THE INVESTIGATION

Medical care

66. A clinical review commissioned from the Eastern and Coastal Kent Primary Care Trust on 22 February 2008 was carried out by a doctor and was received by me on 13 June 2009. The delay was due to the length of time taken by the forensic examination of post mortem samples.

67. Immediately after the man's reception into Elmley, prison healthcare staff were aware of his medical conditions and admitted him overnight to the IPD. They properly contacted his doctor to establish the monitoring that had previously taken place and his existing medication regime. The prison doctor reviewed that medication and prescribed treatment for his medical problems. Despite his later refusal to comply with parts of his treatment, medication regime and relevant advice, staff remained sensitive to his needs.

68. The clinical reviewer judges that the man had severe coronary heart disease pre-existing his reception into prison and was at a high risk of relatively sudden death. He notes that despite his apparent unwillingness to cooperate with the healthcare services they continued to try to offer him regular and exemplary clinical care in accordance with National Institute for Clinical Excellence (NICE) guidelines. He commends healthcare staff for their efforts.

69. I conclude that the care of the man received at Elmley was of a standard that was equivalent with that he could reasonably have expected to have received had he been in the community. His clinical care, even though he was not compliant with much of the advice and treatment to do with his heart condition, was appropriate to his problems as presented at Elmley.

Medical record keeping

70. During the man's period of time at Elmley, a migration from a paper-based healthcare recording system to an electronic system (EMIS) was underway. As EMIS was not designed for prison use, a more fit for purpose electronic recording system (System 1) was later implemented. This centralised the information into a single source which reduces the possibility of medical staff acting on inaccurate information.

71. It is evident that the man's healthcare notes during this transition period were not recorded with sufficient clarity, and some notes copied from one system to the other were not accurate. Validation of ten per cent of those notes, if it took place, was not sufficient to ensure accuracy.

72. Although in this instance his care was not compromised by the inaccuracies identified, inaccurate recording of medical information does not command confidence and is potentially dangerous.

Eastern and Coastal Kent PCT should ensure that healthcare staff adhere to professional standards in the completion of medical records.
Eastern and Coastal Kent PCT should review the procedure for transcribing electronic records from paper based sources. The review should focus on the adequacy of a ten per cent validation check and implement a process to record the validation.

Risk of self-harm

73. The man was in police custody from 6 August 2007 until his reception at Elmley the following day. During that time he was subject to several forensic sampling procedures by a custody nurse who also administered him prescription drugs on a regular basis. No indications of an intention to self-harm were noted.

74. Prison reception interviews also revealed no concerns about the man's risk of harming himself although he did request vulnerable prisoner status. He was separately assessed for housing in the IPD under the provisions for segregation in his own interest, and again no concerns were raised during that safety screening.

75. On a number of occasions during the latter part of 2007 the man suffered chest pains and was advised that he should be admitted to outside hospital or to the prison IPD. He repeatedly refused admission and treatment for his heart problems. Medical staff advised him of the likely consequences but he signed refusal of treatment statements both at Medway Hospital and in the HCC at Elmley.

76. While the man was at outside hospital his wedding ring was found in his cell by an officer. This, in conjunction with his refusal of treatment and other information received that he was not eating properly and not taking his medicines as prescribed, triggered suspicions that he might be attempting to end his life. The officer reported this to healthcare staff.

77. One month later the man was reported to have taken an overdose of one of his in-possession medicines which resulted in a hospital admission. He was discharged later the same evening but refused to be admitted to IPD when he returned to Elmley. The following day, healthcare staff reviewed the man's actions and withdrew his in-possession medicines. From then until his death medical staff supervised his medication. An ACCT document was opened which included a suitable action plan. It remained open for ten days and was closed following the second case review. An ACCT post-closure interview followed and no further action was considered necessary. There was no further repetition of refusal of treatment.

78. It is creditable that an officer combined all the information he knew about the man and the discovery of his wedding ring and expressed his concerns to healthcare staff. A month later the man admitted it was (in his words) a "half-hearted" attempt to self-harm. He also commented to staff during the ACCT procedures that he would die in prison and that he would determine when. Appropriate action was taken by staff.

79. I judge that the man's risk of self-harm was correctly monitored and properly assessed. Appropriate strategies were put in place to minimise the risk that he would repeat his attempts at self-harm. It is likely that repeated refusal to comply with medical advice and treatments for his heart condition did have an adverse affect on his health, but the extent of that harm is not known.

80. In the opinion of the pathologist the man died as a result of bronchopneumonia. It is unfortunate that the post mortem examination of his blood samples was not able to conclude whether the ingestion of drugs during his last few days at Elmley played any part in his death.

Family concerns

81. No concerns were raised by the man's family directly with either my family liaison officer or investigator. I am aware that some concerns were raised with the Elmley family liaison officer which were addressed by him and resolved. I hope that this report adequately explains the events and circumstances that led up to the man's death and gives a measure of insight into how he died.

The use of restraints

82. Because of the man's condition when he was taken to hospital on the night of 2 February, handcuffs or other mechanical restraints were considered unnecessary although they were available to the staff undertaking the escort.

83. He remained semi-conscious and largely unresponsive during his final stay in hospital, but during the afternoon of 6 February the escorting officer telephoned the Orderly Officer at Elmley, to ask why the man was not handcuffed. She explained that because he was semi-conscious there was no need for handcuffs, but should he become conscious then the closeting chain was to be applied. The officer took the view that he was sufficiently awake and active to use the chain. She attached it to him and the other escorting officer. The officer reported that during her eight hour duty the man was fidgety, incoherent and apparently confused. He regularly pulled out his catheters and tried to get out of bed.

84. During the night of 9/10 February an officer recorded that the man was still wearing handcuffs. When his condition deteriorated at around 4.00am and a doctor confirmed that he was unlikely to survive much longer, the second escorting officer contacted the prison who authorised the removal of handcuffs. The man remained restless and incoherent and on occasions was heavily sedated.

85. I judge that the use of handcuffs was properly and sympathetically assessed given the man's age and infirmity. There was a period of three days when handcuffs were used. I am satisfied that this was proportionate in the circumstances and am pleased that the cuffs were removed when his condition altered.

CONCLUSION

86. The man went into prison with serious medical conditions having suffered several heart attacks. He did not always co-operate with his treatment regime and on several occasions signed disclaimers for the refusal of treatment. He neglected himself and admitted taking an overdose of prescription medication. Those circumstances triggered concerns on the part of one officer who reported the matter to healthcare staff.

87. The man's health worsened over time and eventually led to him being admitted to hospital and subsequent death. It is evident that he received a good standard of care and treatment in the management of his health needs, despite the restrictions placed on healthcare professionals by his refusal to be treated. The standard of care given to him was at least of an order that could be expected had he been in the community.

RECOMMENDATIONS AND RESPONSES

1. Eastern and Coastal Kent PCT should ensure that healthcare staff adhere to professional standards in the completion of medical records.

   Eastern and Coastal Kent PCT accepted this recommendation and commented that:

   "Medical records now fully computerised, which is an ongoing process monitored by the team. With the implementation of the Systmone this process will be more efficient as a result of modules being directly written to suit prison health.
   We have a Clinical auditor now appointed tasked to implement an annual audit plan to include monitoring and review of Health record management."

   The action has been completed

2. Eastern and Coastal Kent PCT should review the procedure for transcribing electronic records from paper based sources. The review should focus on the adequacy of a ten per cent validation check and implement a process to record the validation.

   Eastern and Coastal Kent PCT accepted this recommendation and commented that:

   "A Trained Trainer is now on site and delivers summarising training to all new relevant staff immediately."

   The action has been completed