Investigation into the death of a prisoner at HMP Stafford, in December 2006

Report by the Prisons and Probation Ombudsman for England and Wales

May 2007

This is the report of an investigation into the death in December 2006 of a man. The man, who was 69 years old, died at Mid Staffordshire General Hospital whilst a prisoner at HMP Stafford. The post mortem gives the cause of death as bronchopneumonia.

The man had suffered from various ailments throughout his period in custody. He was transferred to the hospital on 27 November 2006 after medical staff became concerned when he experienced vomiting, diarrhoea and dehydration. The man underwent several medical tests and was diagnosed with pneumonia on 8 December.

My colleagues and I would like to extend our condolences to the man's family for their loss.

The investigation was carried out on my behalf by one of my investigators. In addition, South Staffordshire Primary Care Trust (PCT) carried out a clinical review of the man's treatment while in custody. The PCT's review panel was chaired by their Head of Integrated Governance. The panel found that the man's medical needs in prison were assessed and treated appropriately in line with the care he would have received in the community. A copy of the panel's report is annexed.

My report contains four recommendations derived from the clinical review. Perhaps the most important of these concerns advice to staff on bedwatch duty concerning the risks associated with MRSA.

I have also identified three examples of good practice..

Stephen Shaw CBE
Prisons and Probation Ombudsman **May 2007**

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SUMMARY

The man was half way through a six year sentence when he died in Mid Staffordshire General Hospital (SGH) of bronchopneumonia. He had transferred to HMP Stafford six months after being remanded in custody. Since arriving in prison, the man had suffered from many ailments. The records seen by my investigator, and the findings of the clinical review, confirm that he was treated in a timely and appropriate manner.

At 69 years old, the man was over the retirement age and did not have to work whilst in prison. But his ill health prevented him from doing most forms of work even if he had wished to do so. His time during the day was spent on his wing. When he felt able, he would sometimes assist the officers by sorting prisoners' laundry. The man enjoyed listening to music and would often talk to staff about this and borrow CDs from the wing office. The man who died also talked fondly of his dogs. When he died, prisoners from his wing collected money to donate to the RSPCA.

Although he had experienced ill health throughout his period in custody, the man became very poorly at the end of November 2006. He was admitted to SGH on 27 November after prison healthcare staff became concerned that he was dehydrated. He had experienced vomiting and diarrhoea, as well as having low blood pressure.

It was noted at the hospital that the man's general condition was deteriorating and he was transferred to the critical care unit on 28 November. He was assisted with ventilation and sedated. Restraints were only used when he was conscious, and the risk assessments were regularly reviewed and the escort chain was removed when his condition deteriorated. Given the man's offence and his location within the hospital, this appears appropriate.

The man who died contracted MRSA on 4 December 2006. This was reported, albeit the records show it was some four days after the MRSA was discovered. He was treated and found clear of MRSA on 12 December. My report considers the advice given to staff about MRSA to ensure they are protected whilst carrying out their duties.

A microbiologist diagnosed the man with pneumonia on 7 December. He remained in SGH where he continued to receive treatment and undergo further tests. The man was discharged from the critical care unit to another ward on 22 December (prison healthcare staff had believed he was being discharged from the hospital, which caused some confusion).

During the early hours of 26 December 2006, bedwatch officers logged that the man had experienced a very restless night, settling only at about 4.00am. When a nurse came to take his medical observations at 6.10am, she found that he was unresponsive and pressed the emergency bell for the assistance of other hospital staff. Sadly, the man had passed away.

THE INVESTIGATION PROCESS

1. My investigator requested all the relevant prison records including medical records and core prison record. She also visited HMP Stafford.

2. Notices to staff and prisoners were displayed by the prison. These invited anybody with information to talk to my investigator. In this instance, no-one raised any matters of concern.

3. South Staffordshire PCT was asked to carry out a clinical review. The Head of Integrated Governance, established a panel which looked at the man's prison medical record and hospital records. A Risk Manager for the PCT, acted as liaison with my investigator. I thank the panel members for their report which is annexed to this one.

4. HM Coroner for Staffordshire South was informed of the Ombudsman's investigation. He kindly provided my office with the post mortem report. An inquest date has been set for 3 May 2007. The Coroner will receive a copy of this report before the inquest.

5. One of my Family Liaison Officers contacted the man's children to offer them the opportunity of involvement in the investigation. A copy of the draft report was sent to the family. The man's daughter has since asked why she did not know that her father was in the hospital for the length of time he was. My investigator has asked the prison if the family were informed. The records she was provided with show that on 8 December a bedwatch officer made an entry saying that a hospital nurse was going to contact the family and that the man's son had been contacted before. The man's daughter is certain this did not happen. Unfortunately, the records do not note when this previous attempt was or if the nurse did contact the man's son on the 8 December so I am unable to answer this question fully.

HMP STAFFORD

6. Stafford was built in 1794 and apart from the period 1916 - 1940, has been in continuous use as a prison ever since. It holds 627 category C prisoners. F wing can accommodate up to 145 vulnerable prisoners over four landings. The bottom landing can accommodate 24 prisoners in single cells. All prisoners on the wing work unless there are medical reasons they cannot do so, or unless they are past the retirement age.

7. There is a medical hatch on the ground level landing between E and F wings. E and F wings also share a full-time nurse who oversees the sick parade, treatments and sees prisoners on the wing throughout the day as necessary. There is no in-patient facility at Stafford.

8. The number of elderly prisoners appears to be increasing. However, the regime in most prisons reflects the needs of those of working age. A Principal Officer (PO), who works on Stafford's vulnerable prisoner unit, has proposed that the prison work in partnership with Age Concern. This would involve Age Concern coming into the prison for a few hours a week to provide support for older prisoners. Areas to be covered might include: independent living skills, information and advice, exercise and workshops. At the time of my investigator's visit, the PO had just submitted the proposal to one of the governors.

Bedwatch

9. When a prisoner is admitted to an external hospital bed, they are normally escorted by a minimum of two prison officers who remain with the prisoner throughout the period of admission. This is commonly known in the Prison Service as a 'bedwatch'. Depending on the length of admission, the bedwatch officers will rotate. All bedwatch staff keep a log of events known as 'bedwatch logs'.

Restraints - Escort chain

10. An escort chain is usually used as an alternative for handcuffs to allow for situations such as a prisoner needing to go to the toilet. The escort chain has a longer length of chain, with handcuffs at either end. One end is attached to a prison officer's wrist and the other end is attached to the prisoner's wrist.

11. Escort chains can also used by bedwatch staff when at the bedside of a prisoner who has been admitted to an external hospital. Because of their extra length compared to standard handcuffs, escort chains allow the prisoner to be more comfortable whilst in a hospital bed. This type of chain is commonly referred to as a 'closeting chain'.

KEY FINDINGS

12. The man was remanded into custody at HMP Gloucester on 15 July 2003. That day, the man told a member of the chaplaincy that people were worried he might do "something stupid" himself and that he was depressed. The member of staff opened a F2052SH (a suicide and self-harm log).

13. After appearing at court on 22 July, it appears the man was transferred to HMP Blakenhurst. He was still on the open F2052SH. The F2052SH review at Blakenhurst noted other previous attempts to take his life before he came into custody. The man was monitored for a further two days until staff felt he was no longer a risk to himself. The man transferred to Stafford on 12 December 2003.

14. The clinical review notes that the man suffered from many ailments during his time in custody, including angina for which he carried a glyceryl trinitrate (GTN) spray to ease the pain. The man also had an irregular heartbeat and he claimed to have had ankylosing spondylitis (arthritis involving the spine) since he was 18 years old. The clinical review notes that the man's medication became additionally complicated as his tolerance to some of the drugs was low. It was reviewed in secondary care, although the clinical review comments that reviews by primary care are good practice. (The clinical review covers the man's assessments and treatment in more detail.)

15. In the last six months of his life, the man who died was seen regularly by prison healthcare staff. He was also seen at outside hospital on several occasions. Healthcare staff would also see the man on the wing if they were passing by. This demonstrates a caring approach, although the clinical review comments that the visits were not formally logged and that they should have been.

16. The man was seen by a consultant cardiologist at Mid Staffordshire General Hospital (SGH) on 18 July 2006. He was diagnosed with paroxysmal atrial fibrillation (abnormal heart rhythm) and a heart murmur. He was awaiting an echocardiogram (heart ultrasound) and was given a halter monitor for a week. (A halter monitor is a portable device used to measure the electrical activity of the heart over an extended period of time.) There does not seem to have been any feedback to the prison healthcare staff of the results.

17. The prison's medical officer wrote to a consultant gastroenterologist at SGH on 9 August. The medical officer was concerned about possible malignancies in the man's stomach or colon. There is no recorded outcome of this referral.

18. The man continued to be unwell over the next few months and was losing weight. On 22 November, he went to the healthcare treatment hatch on the wing complaining of a pain in his neck. The nurse noted that he looked very pale and had become dizzy and sick. The man was taken back to his cell and advised to rest. The doctor saw him later that morning. He noted that they had not had the results of the echocardiogram which had taken place a month earlier, and asked for this to be followed up.

19. On 26 November, the man was seen by nursing staff and again felt unwell and nauseous. The staff gave him some Complan and fresh milk, and he was encouraged to drink more fluids. It was also noted in the medical record that the man was not managing to keep his cell clean, and the prisoners responsible for cleaning the wing were asked to help.

20. The following day (27 November), the man was seen by healthcare staff in his cell. He was experiencing nausea, vomiting and diarrhoea again. He was thirsty and dehydrated. Although it is not recorded in the medical record, the man was taken to SGH.

21. For the next week and a half, the man was in a poorly condition and had been moved to the critical care unit. He was on assisted ventilation and sedation. On 4 December, during a routine surveillance test on a cannula (a tube to withdraw fluid or insert medication), it was found that the man had contracted Methicillin-resistant Staphylococcus aureus (MRSA). On 5 December, hospital staff queried if the man might have community acquired pneumonia (infection of the lungs) which is a leading cause of illness and death. A microbiologist diagnosed this on 8 December, and the man was prescribed the necessary medication.

22. The finding that the man had contracted MRSA was not reported until 8 December. The reason for the delay is unknown, but treatment was commenced that day. That night a nurse advised the bedwatch officers to wash their hands before leaving. On 12 December, following two clear blood screens, the man was found to be free of MRSA. (The post mortem shows that no infection was present at his death.) The man's prison medical record (IMR) first mentions the infection on 14 December.

23. There is an entry on 8 December that bedwatch officers on duty at the time were told about MRSA, but it is not clear what subsequent officers were told. According to the bedwatch log others were informed on 21 December, after treatment had already been administered. They were understandably concerned for their health and were given leaflets and advice about handwashing and hygiene. Although the advice was doubtless of use to them, it would have been preferable for all staff to be given information prior to taking over the bedwatch duties.

24. The man's condition had improved by 13 December. Given this improvement and the possibility that he might become more active, a risk assessment was carried out and an escort chain was applied after discussion with the man himself.

25. The critical care unit outreach was working towards discharging the man from the unit to another ward. This happened on 22 December and seems to have caused some confusion with the prison's medical staff. Their notes suggest the man was to be discharged from the hospital, and they had begun to seek advice on a suitable care plan. The clinical review determines that the man was not considered fit for discharge from hospital.

26. During the early morning of 26 December, the bedwatch officers logged that the man had experienced a disturbed night, vomiting, coughing and moving about. However, by 4.00am he had settled.

27. A hospital nurse came to take the man's medical observations at 6.10am. the man was unresponsive and she pressed the emergency bell. Other medical staff attended. Sadly, the man passed away.

28. The post mortem records that he died of bronchopneumonia.

29. After the man's death, the prisoners on his wing at Stafford had a collection. The proceeds were donated to the RSPCA as the man had supported animal charities.

ISSUES CONSIDERED

Assessment and medical treatment

30. The man was seen regularly by healthcare staff while in HMP Stafford and discipline staff would also notify healthcare if they had any concerns. The clinical review panel has looked at the man's prison medical records. The panel's report says that his assessments and treatments were taken seriously and dealt with in a timely and appropriate manner. The panel also notes that the man who died was treated in a caring way.

31. The clinical review panel has said that the man's medication was complex, and should have been reviewed in primary care rather than secondary care. The panel has made a recommendation to this effect which I endorse.

    A process for primary care reviewing the medicines management of complex patients should be considered by prison healthcare. This should be in line with PCT recommended good practice.

32. It has been mentioned that the man was seen regularly and in a caring manner by healthcare staff. However, there were occasions when healthcare staff would see him if they were passing by, which unfortunately was not subsequently recorded. I appreciate that this shows a serious and compassionate attitude in caring for the man who died, but all interaction should be recorded appropriately.

    All healthcare staff checks on patients, including informal checks, should be recorded in the relevant medical records.

33. The man suffered from many different medical complaints whilst in prison. On the basis of the clinical review and my investigator's own observations, I judge that his medical care in prison was comparable to that he would have received in the community.

Accessibility

34. HMP Stafford was built over 200 years ago. Like many other jails, the prison was not designed with the needs of prisoners with disabilities or mobility problems in mind. A common solution is to give such prisoners a cell on the ground floor, and I am pleased that Stafford was able to provide a ground floor cell for the man who died. One of the cells he occupied was opposite the food servery; others were not far from the servery. He was also well placed to be able go to the landing offices if he needed anything.

35. The medical hatch is at the end of F wing. It was not far for the man to go and, when necessary, healthcare staff would see him in his cell.

Restraints

36. When the man was out of the critical care unit, he was restrained using an escort chain. I am satisfied that the risk assessments were reviewed on several occasions and that this action was appropriate.

Risk of infection to staff

37. It is clear that the man was diagnosed with MRSA on 4 December, and although some staff were warned about the risk, not all bedwatch staff were. Bedwatch staff have a difficult role and should not be exposed to the additional hazard of infection.

    Infection control education should be provided for prison staff in relation to MRSA and other infections, especially staff on bedwatches.

Liaison between prison and hospital

38. On several occasions, secondary care did not report the results of tests and investigations but prison healthcare was diligent in pursuing the outcome.

39. After the man was treated in the critical care ward, the prison believed that he was about to be discharged and, appropriately, began to prepare a nursing care plan. In the event, the prison discovered that inaccurate information had been provided and that the man who died was actually being transferred to another part of the hospital.

    Liaison between hospital and prison staff during an inpatient stay should be reviewed to ensure there is clear communication throughout.

GOOD PRACTICE AND RECOMMENDATIONS

Good Practice

1. Healthcare staff treated the man medical complaints in a timely, relevant and caring manner.

2. The location of the man's cell was appropriate and allowed him easy access to the areas he needed.

3. Although not directly related to the man who died, Stafford prison is looking at an initiative to provide purposeful activity for older prisoners by working in partnership with Age Concern.

   The prison have responded that this should be in place by January 2008

Recommendations

The clinical review panel has made several recommendations concerning medical arrangements. I endorse these recommendations as follows.

1. A process for primary care reviewing the medicines management of complex patients should be considered by prison healthcare. This should be in line with PCT recommended good practice.

   This has been accepted and will be discussed at the next medicines management meeting with the area pharmacist.

2. All healthcare staff checks on patients, including informal checks, should be recorded in the relevant medical records.

   This has been accepted and weekly random audit checks of prisoner's medical records are now being conducted by the healthcare manager.

3. Infection control education should be provided for prison staff in relation to MRSA and other infections, especially staff on bedwatches.

   This has been accepted and the healthcare manager will discuss with the infection control team at the PCT.

4. Liaison between hospital and prison staff during an inpatient stay should be reviewed to ensure there is clear communication throughout.

   This has been accepted and the healthcare manager or representative now telephones the hospital for daily updates. This is then reported back to the Governor.