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Investigation into the circumstances surrounding the death of a man in November 2010 at HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report into the circumstances surrounding the death of a man in November 2010, at HMP Maidstone. The man was being treated for several illnesses and saw the doctor on the morning of his death. He refused to attend a hospital appointment and signed a disclaimer form. He returned to his cell and was later found on the floor and unresponsive. Cardio pulmonary resuscitation (CPR) was not performed as the man was cold to touch with no sign of life. His death was confirmed by the prison doctor at 12.21pm. The man was 50 years old. I extend my sincere condolences to his family and friends.

One of my investigators carried out the investigation. A post mortem examination was carried out on behalf of Her Majesty's Coroner for Mid Kent and Medway District. The post mortem determined that the man died of natural causes due to lung cancer and a tumour in the heart sac.

A review of his healthcare at Maidstone was commissioned by the West Kent NHS Primary Care Trust (PCT). I am grateful to a nurse for carrying out the clinical review and attach it as an annex to my investigation report.

I would like to thank the Governor of Maidstone and his staff for their help and assistance with this investigation. I am especially grateful to the liaison officer who provided exceptional liaison in her organisation of interviews and support to my investigator.

In her comprehensive the clinical reviewer makes 18 recommendations, seven of which I endorse and the remainder are sent directly to the Primary Care Trust. The recommendations concern healthcare service delivery, policies and procedures, communication, the provision of resusci-aid face shields and support of staff. I am also pleased to recognise areas of good practice within the healthcare service at Maidstone.

In this final report the prison service has accepted three of the recommendations and partially accepted four recommendations. The man's family have read the report and were satisfied with its contents they did not raise any further issues for consideration. A copy of this final report will be sent to them.

Thea Walton
Deputy Prisons and Probation Ombudsman **July 2011**

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SUMMARY

1. The man was recalled to prison in March 2010 less than two months after being released from HMP Maidstone. He was returned to custody at HMP Lewes and transferred back to Maidstone on 25 March. He was assessed by healthcare staff who noted his medical history of substance and alcohol misuse, smoking, mental health disorders and arthritis in his legs. His medication was reviewed and his prescription updated.

2. From March to September, the man was seen on numerous occasions in the healthcare unit for medication reviews and appointments. He was referred to the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATs) team and mental healthcare services. (The CARATs team specialise in assisting prisoners with substance misuse problems.) The man's appointments with the doctors mainly focussed on pain relief and requests for medication.

3. During this period, security information reports indicate that he was suspected of 'trading' his medication on the wing in exchange for tobacco. His increasingly poor mobility was assessed by the disability liaison officer and he was given a mobility scooter to allow him access to the healthcare unit and other areas around the prison.

4. Following an examination by a doctor on 14 September, the man was escorted to the accident and emergency department of a hospital as he was experiencing shortness of breath and low blood pressure. He returned to the prison later that day, with appointments to be arranged for follow up medical investigations.

5. The man went to the healthcare unit on the morning of 8 November, to collect his medication. The pharmacy technician noted that he was breathless and advised that he should be seen by a doctor. Before the doctor's appointment, the man saw a Registered Mental Health Nurse (RMN) for a review. The RMN also noted that the man was short of breath. He became abusive whilst discussing his medication.

6. A short while later, a doctor attempted to examine the man who, by this time, had become agitated and demanded medication. As the man had a pre-arranged hospital appointment for that morning, the doctor advised him to go to the hospital where he could be fully assessed. The man refused to go to the appointment and signed a disclaimer form. He then returned to his cell.

7. About 11.40am, an officer was carrying out a routine check of prisoners on the wing. She was unsure whether the man had returned to the wing from the healthcare unit, so she went to his cell. On arrival at the cell, she found him unresponsive on the floor lying in a pool of blood. The officer ran to the wing office for assistance calling for urgent medical assistance and an ambulance on her radio.

8. A Principal Officer (PO) and another officer responded to the call and went to the man's cell. They helped officers to place the man on his back and assessed his medical condition. Officer McMahon removed some elastic bands from the man's mouth. At 11.47am, a nurse arrived at the cell and following her assessment of the man's condition no CPR was undertaken. Ten minutes later paramedics attended and took control of the man's medical care. The doctor, who had just left the prison, returned at 12.21pm and confirmed his death.

9. I make seven recommendations, four for the head of healthcare, one for the head of healthcare and the Prison Project Group, one for the head of healthcare and the Governor and one for the Governor. Those recommendations encompass service delivery, improving policies and procedures, communication and staff support. I acknowledge the remaining recommendations held within the clinical review and the identified areas of good practice within the healthcare service.

THE INVESTIGATION PROCESS

10. The investigation into the man's death was opened on 12 November 2010, when my investigator visited Maidstone. She met the liaison officer and the family liaison officer. My investigator reviewed the man's prison and medical files and asked for copies of relevant documents to be forwarded to her. Later she met with the doctor for a short informal meeting and visited the man's cell on Kent wing.

11. The Ombudsman's terms of reference and notices of investigation were sent to the prison in advance of my investigator's visit. No members of the Independent Monitoring Board (IMB) or the Prison Officer's Association (POA) asked to see my investigator. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, staff and prisoners. The POA is the trade union for prison officers.) My investigator's contact details were made available to their representatives.

12. A family member was known to be in custody at Lewes and so Maidstone's family liaison made initial enquiries with their family liaison officer. Once she had established that it was not appropriate for this person to act as next of kin, further extensive enquiries were made by both family liaison officers and they traced the man's former partner, the mother of his two children. The former partner agreed that she was the man's next of kin.

13. A clinical review was commissioned with West Kent NHS PCT. A clinical quality review nurse, carried out that review on their behalf.

14. On 19 November, one of my family liaison officers spoke to the man's ex partner and a chaplain, mentor to his brother. She had no specific concerns about the man's time in prison, other than why his cancer had not been diagnosed before he died. The chaplain mentioned that neither he nor the man's brother had any issues to raise. I trust this investigation report will address this question adequately for the man's family.

15. My investigator, a senior investigator and the clinical reviewer interviewed prison and healthcare staff on 6 and 7 January 2011. A week later, my investigator interviewed two prisoners and a member of healthcare staff.

16. One of my family liaison officers spoke to the man's former partner and a chaplain to ask if there were any issues for consideration in this report. The man's former partner had no specific points to raise other than to question why his cancer had not been diagnosed earlier, which I trust is adequately considered later in my report. Additionally, the comprehensive clinical review offers an in depth examination of all of the man's physical and mental health conditions.

HMP MAIDSTONE

17. HMP Maidstone was built in 1819 and is a category C prison, which accommodates male prisoners. (A category C prison holds prisoners deemed as a medium risk of escape.) In May 2009, the prison held 600 prisoners in four residential houses and a segregation unit. Of the 600 prisoners, 200 are foreign nationals (FNP).

18. The prison does not have a 24 hour healthcare unit. The healthcare unit is staffed from 8.00am to 5.00pm by nursing staff and uses an on call locum doctor service. There is no inpatient facility at the prison.

19. The former Chief Inspector of Prisons completed an unannounced inspection of Maidstone in December 2009. This followed a full inspection in 2007. In an extract from the summary of her 2009 report she said:

> "It is always pleasing to report on progress following a critical inspection, and staff at HMP Maidstone deserve considerable credit for what has been achieved since our last visit. Considerable progress has also been made to remedy a range of other weaknesses, including the previously poor standards of cleanliness and hygiene. There remains scope for further improvement in both purposeful activity and resettlement, but the distance travelled in a short space of time is commendable."

20. An extract from the IMB annual report 2010, on the healthcare services noted:

> "The staffing level is still below full complement and bank staff are often called upon to cover shifts. The new prisoner electronic records 'System 1' has been introduced but, regrettably, it is not interactive with the new P-Nomis system which is also in use. Clinical Governance meetings were better supported for a while by the PCT but this has since tailed off again. The Board has been advised that HMPs East Sutton Park, Blantyre House and Maidstone prisons which are clustered for Healthcare provision by the PCT is to be put out to tender during 2010. The Board receives few legitimate complaints from prisoners about healthcare provision."

21. The clinical reviewer, in her assessment of the man's clinical care, notes that there are still staff shortages at Maidstone and healthcare staff should be supported in their professional development.

22. The man's was the fourth death at Maidstone this year. All of the deaths were from natural causes, but only one other prisoner died of cancer. That death was subject to a separate investigation and there were no serious shortcomings of note in that case.

KEY EVENTS

23. The man was re-called to prison in March 2010, after failing to comply with his licence conditions. He was taken to HMP Lewes. His history of taking intravenous drugs and alcohol misuse were noted in his medical record and it was recorded that he was a smoker. The man had previously been treated for mental health problems. His prescription was updated to include:

    - Omeprazole for gastric problems
    - Seroquel (also known as Quetiapine) for depression and mental health disorders
    - Lycria (also known as Pregabalin), for nerve pain and paracetamol and ibuprofen for pain relief.

    It was also noted that he had arthritis in his legs and a disability needs assessment form was completed although the man told the staff that he did not consider himself to be disabled.

24. A nurse saw the man on 11 March and wrote that he was experiencing pain in his ankles. He asked the nurse for Tramadol, a strong medication for pain relief. The nurse prescribed ibuprofen gel, a pain relief cream to rub into his ankles and paracetamol. Five days later, the nurse prescribed Tramadol for the man, following information that he had been given this medication whilst living at the approved premises in Brighton. He was noted to be over weight at 98 kilograms (15 stone).

25. An entry in the man's medical record noted that he did not attend a doctor's appointment on 23 March. Two days later he was transferred to Maidstone. His electronic medical records were accessible to the healthcare staff at the new prison and his medication was continued. On 29 March, the man failed to attend an appointment at the well man clinic.

26. A doctor wrote that the man was seen in the healthcare unit on 29 March and asked for more Tramadol. The doctor had already been in contact with his healthcare colleagues at Lewes, who told him that they had advised the man to stop taking Tramadol. (Tramadol is pain relief which is opiate based and could lead to addiction. Also it is a popular drug for illegal misuse in a prison setting.) All his other medication was continued as prescribed in Lewes.

27. The man's security file indicated that, whilst attending the healthcare unit on 3 April, it was suspected that he had been using illegal substances due to his behaviour speech and eye pupil size. An entry three days later, recorded that his cell had been searched but nothing was found.

28. Later that day, a nurse saw the man for a secondary health screen. (This usually takes place up to 72 hours after the prisoner has arrived into custody.) His observations were recorded as blood pressure 120/80, (an average reading is 130/80), with a pulse rate of 102 beats per minute (bpm), (an average is between 60-100 bpm). The nurse referred the man to the Counselling, Assessment, Referral, Advice and Throughcare Service

(CARATs) team. (The CARATs team specialise in assisting prisoners with substance misuse problems.)

29. A nurse assessed that it was not appropriate for the man to have all his medication in his possession on 7 April. Instead, arrangements were made for him to collect his medication each day from the treatment hatch.

30. A doctor prescribed the man some cream on 13 April because he had sore skin on his shins. The man asked for more Tramadol and Pregabalin and the doctor explained to him that Tramadol should be responsibly prescribed within a prison environment. Instead the doctor prescribed paracetamol and ibuprofen for pain relief. Later that day, the man was seen by the CARATs team and an extensive plan was produced to address his substance misuse.

31. A mental health assessment was conducted by a student nurse on 14 April. The assessment noted that the man had a history of self harm and attempts of suicide from 1997 to 2004 however, he had not self harmed for over five years. A care plan for his mental wellbeing was started and it was noted that the man had previously been diagnosed with an anti social personality disorder and was to be offered regular appointments with a consultant psychiatrist.

32. Five days later, a doctor examined the man and referred him to an orthopaedic consultant for Dupuytren’s disease affecting his fourth and fifth fingers. (Dupuytren’s disease occurs when the skin tissues contract, causing the fingers to bend.) On 27 April, a doctor wrote that the man had again asked for an increase in the dosage of Pregabalin. However, the doctor noted that the same dosage would continue and referred the man for a psychiatric assessment.

33. On 1 May, security information was received from officers indicating that the man was selling Tramadol to other prisoners. According to the report, the man was holding the tablet between his teeth during supervised medication, returning to his cell and then removing the tablet from his mouth. The man was asked about this and denied the allegation by saying ”someone was stirring up trouble”.

34. Four days later, the man was seen by the mental health in reach team. His mental health history was noted and a further review was planned for a month later.

35. The man saw a doctor on 11 May for a medication review. He told the doctor that he needed more Pregabalin and Tramadol. The doctor noted that the man showed, ”inconsistent behaviour by limping when coming to healthcare then seen to be walking comfortably around the prison”. They discussed the use of drug seeking behaviour and a doctor wrote that the man, “left in good spirits and almost agreeing that he may be inappropriate in his requests”.

36. On 15 May, a security report noted that the man was suspected to be involved in illegal substances misuse, along with five other prisoners. It was recorded that wing staff would monitor the situation.

37. The man walked out of an appointment with a doctor on 7 June. Three weeks later, a doctor saw the man and noted that while he was still asking for more Pregabalin he "presented evidence of addressing addictive behaviour". The doctor explained to the man about using medication responsibly and its potential for misuse.

38. On 1 July, the man had a consultation with a doctor, after complaining of swelling and bruising to his knees and ankles. The doctor prescribed paracetamol, ibuprofen and Amitriptyline, (an anti anxiety drug which also used to treat nerve pain). Amitriptyline was prescribed as the doctor noted that, whilst the man had strength and sensation in his legs, he needed stronger pain relief and Pregabalin should be avoided.

39. On 2 July, the man was escorted to an appointment at the orthopaedic department at a hospital. Following an examination of his hand, it was noted that it was not Dupuytren's disease but the result of an old injury caused by a broken glass. No further treatment was deemed necessary.

40. Two weeks later, a psychiatric nurse on the mental health in reach team, saw the man for an assessment. The nurse noted his previous history of involvement with mental health services. The man told the RMN that he would like to reduce his psychiatric medication but felt this was not an appropriate time to do this. He said that he was not considering harming himself. The RMN wrote that the man would continue to be monitored by the mental health in reach team and his wellbeing would be supervised.

41. A security report as submitted on 15 July indicated that the man was still allegedly selling his medication on the wing. Healthcare and wing staff were asked to be vigilant.

42. The man walked out of another appointment with the doctor on 22 July. A week later, a doctor noted that he saw the man who complained of bruising and swelling to his legs. However, on examination, the doctor did not observe any of these signs. He prescribed ibuprofen and paracetamol.

43. The RMN wrote in the man's medical record on 27 August that he continued to complain about his pain relief medication. The nurse advised him that this should be discussed with the doctor. The man assured the mental health nurse that he had no thoughts of self harm.

44. Five days later, a doctor saw the man and told the doctor that his pain was worsening. The doctor increased his dosage of Pregabalin. Following a discussion with a pharmacy technician and a RMN, the doctor wrote, "Further discussion with the RMN. Concerned that he [the man] may be requesting med [medication] increase for disingenuous [dishonest] reasons." The doctor

agreed to withhold the increased dosage of Pregabalin and said that the man should see a doctor, who knew him well.

45. On 3 September, a consultant forensic psychiatrist saw the man for an assessment. The doctor noted that the man was not depressed and did not display psychotic symptoms. However, she noted that he was suffering from short term memory loss and some disorientation. The psychiatrist ended her assessment by asking for the man to be reviewed by the doctor and the mental health in reach team.

46. Four days later, the doctor saw the man following his psychiatric assessment. The doctor noted there was "mild enlargement of the liver", but no lumps were found, and there was some swelling to his legs. The man told the doctor that he was short of breath when walking. The doctor diagnosed congestive cardiac failure, a condition caused by too much fluid in the body, and prescribed Furosemide to help reduce swelling and fluid retention. On 8 September, following an appointment at the smoking cessation clinic, the man was prescribed nicotine patches. Two days later, he failed to attend the next smoking cessation clinic appointment.

47. A doctor examined the man on 14 September, who was short of breath, pale and clammy with a low blood pressure reading of 90/60. The doctor asked for an electrocardiogram (ECG) to measure his heart rate and rhythm. The ECG indicated that the man had an abnormal heart rhythm, so the doctor arranged for him to be escorted to the accident and emergency department at a hospital. The man was seen by the hospital doctors, but refused blood tests. He was discharged and returned to the prison later that day. A 24 hour heart rate machine, to measure his heart activity, would be arranged through an out patient appointment.

48. The following day, a doctor saw the man and stopped his Amitriptyline prescription. Four days later, the man told healthcare staff that his medication had been stolen from his cell. He made an application and received a lockable box to store his medication in, which was supported by the healthcare manager.

49. The man did not attend a smoking cessation clinic on 28 September. A doctor reviewed him on 5 October and recorded that two weeks ago he had been escorted to hospital for further observations on his physical health. The doctor wrote that the man was alert, his blood pressure was stable at 122/80 and he was waiting for an out patient appointment with the cardiology department. The following day, an entry in the man's medical record noted that this appointment was arranged for three weeks time.

50. A doctor saw the man on 5 October and noted that his blood pressure remained stable at 122/80. His chest was clear with no signs of fluid on his lungs. Two weeks later, a consultant forensic psychiatrist assessed the man. The doctor wrote that he was agitated throughout the meeting and was asking for more pain relief medication. The psychiatrist found no evidence of

psychotic symptoms and the man told the doctor that the medication Quetiapine was helping with his feelings of anger.

51. The man and the psychiatrist discussed the possible side effects of Quetiapine for a person with heart problems and he agreed to reduce the dosage which would be reviewed to ensure his mental health was not compromised. He told the doctor that he was not considering harming himself, was sleeping well and had a stable appetite. The psychiatrist concluded the meeting by writing that the man would be regularly seen by the mental health in reach team.

52. A nurse was called to see the man in his cell on 4 November, as he was complaining of pain in the chest and abdominal area. The nurse noted his blood pressure was 100/60 with an elevated pulse rate of 98 bpm and a blood oxygen level of 98 percent. The nurse prescribed Gaviscon, an indigestion remedy, and advised him to contact the healthcare unit if he became more concerned about his health.

53. An officer said at interview that the man had spoken to her on several occasions in early November saying that he was unwell. The officer noted that he seemed breathless and looked pale and was sweating. She telephoned the healthcare staff to report this. There are no entries in the man's medical records or wing history sheet noting these telephone calls.

8 November

54. A pharmacy technician saw the man at 8.55am on 8 November, when he collected his medication. She noticed he seemed breathless and asked him if he was okay. The man told the technician that he had used his inhaler. She advised the man to wait in the healthcare unit and see the doctor.

55. A RMN saw the man shortly after he had collected his medication, for a review. He told the mental health nurse that he wanted to see the doctor. The RMN noticed that the man had parked his mobility scooter outside the consultation room and, despite having walked only a short distance, was pale and obviously short of breath. However, the nurse told my investigator that he seemed better ten minutes later.

56. The man complained of pain in his chest but became abusive when the RMN refused to increase his medication. The mental health nurse explained the side effects of Quetiapine to the man, reminding him that his dose was being reduced as it could affect his heart. The RMN recorded that the man, "refused to listen and talk about any specific health problems other than demanding that his medication was increased".

57. At 9.43am, a doctor saw the man who repeated to the doctor that he wanted more medication. He refused to explain his symptoms but kept repeating that he wanted more medication. The doctor knew that the man was due to go to hospital that morning as an out patient and that his physical health would be assessed whilst he was there. However, the man signed a disclaimer

refusing to go to hospital for his appointment. He told the doctor that there was nothing wrong with him and he was short of breath because he was angry that his medication had been reduced.

58. The man allowed the doctor to examine his chest for half a minute then refused to let him continue unless he prescribed more medication. He then walked out of the consultation. My investigator could not establish from his records what time the man returned to the wing that morning.

59. At about 11.40am, an officer was on duty in the wing office. Her role that morning was to monitor movements, that is to register prisoners who had returned to the wing from elsewhere in the prison for lunch. As lunchtime approached, she realised that all but one prisoner, the man, had been "marked off" and she recalled he had gone to the healthcare unit that morning. The officer telephoned the healthcare unit and they confirmed that the man had already returned to the wing. She used the tannoy system to call him to report to the wing office.

60. The man did not respond to the call and so the officer went to his cell. When she went into his cell, she saw him lying face down on the floor in a pool of blood. She put her hand on his left shoulder and called his name, but got no response. The officer ran back to the wing office, calling the control room on her radio to ask for healthcare staff to come to the wing for a medical emergency. The officer also asked the control to call for an emergency ambulance. Together with another officer she returned to the man's cell. Following the officers were a principal officer (PO) and her colleague.

61. When the officers went back into the cell, the PO asked two officers to help her turn the man on his back. One of the officers noted that the man's face was covered in dark dried blood, his body was cold to touch and he was naked from the waist up. The PO felt for a pulse in the man's neck and wrist and could not find one. What appeared to be a large brown elastic band was in his mouth. One of the officers removed the elastic band, and the PO saw that the man's tongue was swollen and blue. His neck and chest area were purple and blue. There was a considerable amount of blood on the man's face and forehead.

62. The PO used an officer's radio to repeat the call for emergency assistance from the healthcare unit as she believed that the man had died. The PO decided not to start cardio pulmonary resuscitation (CPR) and her decision was supported by the officer who is a trained first aider.

63. Seven minutes after the original call, at 11.47am a nurse arrived at the man's cell. She examined him and found that he was unresponsive, with no pulse and cyanosed (blue skin colour). Less then ten minutes later, a paramedic arrived and also decided the man. The doctor had just left the prison when he received a telephone call to return. He returned at 12.21pm and confirmed that the man had died. A governor held a de-brief for all the staff involved at 3.00pm.

Family Liaison

64. As soon as she was notified of his death, the prison's family liaison officer, started the process of identifying the man's next of kin. Following an enquiry with the family liaison officer at HMP Lewes, it was agreed that the man's brother, a serving prisoner, would not be in a position to act as his bother's next of kin. Extensive enquiries were made by both family liaison officers and eventually the man's former partner was identified as his next of kin. Another brother was also traced.

65. The man's former partner and brother were visited by the family liaison officer and, with their agreement, the senior officer arranged the man's funeral which the prison paid for. The family liaison log was completed with clear and concise entries.

ISSUES

66. A review of the man's medical care at Maidstone was carried out by a registered general nurse. The nurse reviewed the man's medical files and interviewed healthcare staff, both independently and jointly with my investigator.

Overview of the man's physical health

67. The man's community medical notes recorded a history of epilepsy however, he had not had a fit for two and a half years and was not prescribed medication for this condition. Gabapentin was prescribed for his leg pain and this drug is also used to treat epilepsy. There is no evidence that the man had an epileptic fit or anything similar during his time in custody.

68. Whilst serving a previous custodial sentence at Maidstone in 2009, the man was referred to an orthopaedic surgeon for knee pain. Following an appointment and an x-ray, the man was diagnosed with osteoarthritis and it was thought he would benefit from knee replacement surgery. As the man was preparing to be released from prison, he was not placed on a surgical waiting list and a letter should have been sent on his release, from the healthcare unit, to his community doctor for a re-referral. This was not followed up and the man's appointment for a re-referral was over six months late. The clinical reviewer said,

> "There is no evidence in the healthcare records to suggest that the man was seen again at a hospital for the osteoarthritis in his knee, or that he was listed for the proposed surgery after he returned to Maidstone. It is noted in the healthcare records that the man's frequency of visits to healthcare increased, as did his requests for pain relief."

69. I therefore endorse the clinical reviewer's recommendation for the attention of the head of healthcare.

The head of healthcare should ensure there is a system in place to identify a significant delay following a referral of a prisoner for review by another healthcare provider.

70. However, there are conflicting accounts about the level of the man's disability. On reception into Maidstone, he told the nurse that he did not consider himself to be disabled. On his secondary health screen document completed on 6 April 2010, it was recorded that, while the man was unfit for activities, he had no problems with knee pain.

71. From information in his medical records, it was noted that the man used a mobility scooter. Seemingly he was allocated the scooter by the prison's disability liaison officer (DLO). Despite her efforts to contact the DLO, my investigator has been unable to verify when this decision was made and what liaison took place between the DLO and healthcare staff. Other than contradictory accounts given by staff during interview for this investigation, it

is unclear why the scooter was given to the man. Healthcare staff explained to my investigator that he had the scooter for reasons that varied from his osteoarthritis to his increasing shortness of breath.

72. I therefore endorse the clinical reviewer's recommendation for the attention of the head of healthcare.

The head of healthcare should develop clear policies and procedures for the referral of prisoners to the disability liaison officer and requests for disability aids.

73. Historical medical records indicate that the man had low level hepatitis C, a liver disease. During his previous time in custody in 2009, he was seen by a clinical nurse specialist for blood borne viruses when his hepatitis C was discussed. Due to his impending release from Maidstone, the nurse said she would write to his community doctor and advise that he should be referred to a gastroenterologist (a doctor specialising in abdomen and stomach). The man took this letter on his release to hand to his newly registered doctor but it is not clear whether the community doctor took this forward.

74. When the man returned to Maidstone on 1 March 2010, his hepatitis C condition was not mentioned in his medical record other than to note that he had tested positive, but had normal liver function. The clinical reviewer said,

> "It is notable practice that both HMP Maidstone and HMP Lewes are addressing the need to risk assess, identify, vaccinate and treat prisoners with blood borne viruses."

75. The man was known to be a cigarette smoker and smoked cannabis regularly. At interview, one of his friends told the investigator that the man was a heavy smoker and would trade his medication for tobacco. The man attended a smoking cessation clinic but chose not take it any further. He told other prisoners that he found giving up smoking to be difficult.

76. The clinical reviewer commented that the man's history of smoking and alcohol misuse is likely to have been a contributory factor in the development of his lung cancer.

The man's undiagnosed lung cancer

77. The cause of the man's death was established by the post mortem to be malignant pericarditis, (a tumour in the heart sac), related to lung cancer. Despite weight loss being a symptom of cancer, the man's weight remained consistent from when it was measured 1 March and 10 November 2010 when his weight was confirmed at the post mortem as 98kgms.

78. The man had been seen in the accident and emergency department at hospital on 14 September, when he was diagnosed with atrial fibrillation, (abnormal heart rhythm). Two outpatient medical investigations were

arranged for the man. He refused the tests on the first occasion and refused to go at all on the day he died.

79. From the medical records made available to the clinical reviewer, it appeared that a chest x ray was not taken on 14 September. The reviewer has not had access to the man's hospital records and so no other results are available for this investigation. If he had been to his appointment on 8 November for the heart scan, it is the clinical reviewer's opinion that the tumour in his heart sac would probably have been found. None of the typical symptoms of lung cancer, other than breathlessness, were identified, despite his frequent contact with various prison healthcare professionals.

80. The clinical reviewer noted that the man's life style of smoking, alcohol and substance misuse were almost likely contributory factors in his death.

Risk of self harm

81. The man had five reported attempts of self harm between 1997 and 2005. He was referred to mental health services on his reception into Maidstone on 25 March 2010. He was regularly assessed by the mental health services and gave no sign that he might harm himself during this last sentence.

82. When he was found unresponsive in his cell on 8 November, there were elastic bands in his mouth, which an officer removed elastic bands. At interview, the officer said the bands were inside his cheeks and did not block the airway. My investigator tried to establish whether the elastic bands were used by the man to harm or suffocate himself. However, she confirmed with staff that this was unlikely. My investigator was told that the man would often play with elastic bands by wrapping them around his teeth and then stretch them to snap onto his face.

83. A RMN told the investigator that he was unaware of the man's habit of playing with elastic bands. However, playing with elastic bands can be used to elevate emotional distress. The man's medical records did not note that any healthcare professional advising him to use elastic bands in this way. The findings of the post mortem report note that the man's death was of natural causes and so I do not think that the presence of the bands had a bearing on his death.

The man's substance misuse

84. The man had a history of alcohol and substance misuse dating back to his teenage years. Whilst there was no evidence of depression or psychosis, but a possible diagnosis of Korsakoff's Syndrome, which has an added possibility of dementia. (This is a brain disorder caused by lack of vitamin B, associated to heavy alcohol use over a number of years.) To counteract these symptoms, the man was prescribed Thiamine and vitamin B. He was reviewed by a nurse on 21 September, who noted the treatment for Korsakoff's Syndrome.

85. The man attended group and one to one sessions to address his substance misuse difficulties. The clinical reviewer comments that the man participated in his substance misuse care plan which helped him deal with his drug and alcohol misuse. However, it was noted by both healthcare and wing staff that the man continued to have ”drug seeking tendencies”. His security file indicated that he was highly suspected to be ”trading” medication on the wing and this was known by some staff when they were interviewed. A wing manager spoke to the man about these allegations but he firmly denied any involvement. Staff were alerted to the suspicion and monitored his movements on the wing.

86. I appreciate that it was difficult for healthcare staff to strike the balance between managing the man’s ongoing pain in his legs and the suspicions that he was trading medication. It was clear from his medical records that the doctors discussed their concerns about his regular requests for pain relief and other medication with the man.

87. I endorse the clinical reviewer’s acknowledgement of good practice by the CARATs team for their record keeping and support to the man.

Pain relief

88. I also recognise the difficulty of balancing a repeated request for pain relief with the security implications of dealing with a prisoner suspected of trading their medication. However, I share the clinical reviewer’s concern that there was no evidence of a pain assessment tool being used to gauge his pain. At interview, The doctor said that the man’s pain assessment was made by observing his mobility, his activity levels and information from wing officers.

89. It is recommended through the National Institute for Health and Clinical Excellence (NICE) guidelines that,

> “When caring for a person with osteoarthritis, or any other long term condition, a holistic assessment should be made to determine the impact of the disease on the person’s health and well being. Healthcare professionals should then formulate a management plan in partnership with the person with osteoarthritis.”

90. As there was no management pan for the man’s osteoarthritis, endorse the recommendation from the clinical reviewer for the head of healthcare.

The head of healthcare should use a pain assessment tool to complement clinical judgement.

The man’s mental health

91. The clinical reviewer reviews the man's mental health history and interventions. Despite attention from the psychiatric services as far back as 1981, there was no evidence of a severe and enduring mental illness. According to his historical medical records, the man reported that he had

been an inpatient in hospital for hallucinations, hearing voices and paranoia. He said that he had been prescribed Quetiapine (an anti psychotic medication). At interview, a RMN said that, having researched the man's psychiatric history, "there was no real evidence of a severe and enduring mental health illness requiring that level of medication". Nevertheless, the man was prescribed Quetiapine and his dose was being reduced in line with pharmaceutical guidelines.

92. The clinical reviewer considered the discussions between mental health services and the Probation Service regarding the man's future health and social care needs was good practice.

Events on the morning of 8 November

93. The clinical reviewer makes a full assessment of the events of 8 November, when the man was in the healthcare unit. All the healthcare professionals who saw him noticed that he was unwell and short of breath. A prisoner working in the healthcare unit told the investigator that the man did not want to listen to advice from healthcare staff, despite being attended by a nurse and a doctor. He became increasingly agitated and demanded pain relief.

94. In the course of the morning, the man signed a disclaimer form to confirm that he refused to go to his out patient hospital appointment. Had he gone to hospital, it is the clinical reviewer's opinion that his medical condition would have been diagnosed. However, a diagnosis at this point is unlikely to have changed the eventual outcome.

95. Furthermore the clinical reviewer considered that the man's request for pain relief might have overshadowed his other healthcare needs. The clinical reviewer said:

> "It is acknowledged however, that the healthcare staff did have a post consultation briefing following the man's appointment with the GP (doctor) and had discussed his care, his refusal to attend hospital and the resulting risks of this decision. The man's views had been taken into consideration and they did not feel that they could have acted differently."

96. The clinical reviewer makes the following observations after consideration of the events in the healthcare unit that morning. Firstly, it would have been better practice if the man had been more closely supervised by a member of the healthcare team whilst he was waiting for his consultation with the RMN and the doctor. As well, his vital signs (that is his pulse, blood pressure and breathing, should have been monitored and recorded whilst he was waiting. Alternatively, had the man refused to be examined, a record should have been made. Also, it would have been good practice to monitor the man's condition before he left healthcare to ensure that he was fit to leave. Had the communication between healthcare staff and the wing been better, it could have enabled the officers to monitor him when he returned to his cell and report any further healthcare concerns. Finally, the reviewer comments that it

would have been good practice to arrange a follow up healthcare staff visit or appointment to the wing to determine if the man's condition changed subsequently.

97. I note the clinical reviewer's recommendation that a prisoner's health should be monitored following appointments with healthcare staff where concerns are raised about their wellbeing on the wing.

Response to the man's collapse

98. An officer went to the man's cell when she was unable to tally the number of prisoners who had returned to the wing for lunch. When she got to his cell, she found that he was unresponsive and lying in a pool of blood. The officer left the cell and returned to the wing office for assistance, whilst radioing for healthcare staff to attend a medical emergency and for an ambulance to be called. I think that it would have been more appropriate for the officer to have stayed in the cell with the man rather than return to the wing office, although this is unlikely to have had any bearing on the outcome for the man.

99. On arrival at the man's cell, the PO and an officer took over managing the emergency. At interview it was noted that only this officer had received recent first aid training. He told my investigators that, whilst he had a resusci-aid face shield in his possession, not all the staff carry them. These shields are essential for mouth to mouth resuscitation.

100. The clinical reviewer notes that it is not a current requirement for all officers to undertake CPR and keep their qualifications up to date. I therefore note the recommendation regarding first aid training and endorse the recommendation for the Governor to provide resusci-aid face shields.

The Governor should arrange for all officers trained in first aid to carry a resusci-aid face shield and that a supply is kept in wing offices.

101. A nurse responded to the emergency call to go to the man's cell. She was not given any details of the nature of the emergency but did take with her an emergency bag containing oxygen and blood pressure monitoring equipment. At the time of this emergency, Maidstone did not have a system of codes for responding to an emergency such as code blue indicating breathing and cardiac problems and code red for urgent loss of blood. A system has been developed since the man's death and laminated information cards have now been distributed to wing offices. I agree with the clinical reviewer's recommendation that the head of healthcare should ensure that the new system is appropriately used by staff.

102. When the man was discovered, the PO and officer did not start CPR as there were obvious signs that he was already dead. I do not criticise their judgment, which is consistent with the instructions in the relevant Prison Service Order. To preserve the dignity of prisoners, I therefore note the recommendation in the clinical review regarding training nurses to confirm when life is extinct.

103. At interview, a nurse told the clinical reviewer that she received very little support from her line manager at what was a particular difficult time for her following the man's death. I therefore endorse the clinical reviewer's recommendation for the head of healthcare.

The head of healthcare should ensure that all healthcare staff in their supervision receive appropriate support and be offered a one to one meeting at the earliest opportunity following a serious incident.

Communication between the wing and the healthcare unit

104. At interview an officer said the man had asked her to telephone the healthcare unit nearly everyday and she made several calls to them. In the last days before he died, she telephoned healthcare as she was concerned he was unwell. The officer said that healthcare staff did not come to the wing to see him. The evening before the man died, she had telephoned the healthcare unit to suggest that he should see a doctor the following morning.

105. The clinical reviewer cannot verify these details because there was no log of the calls in the man's medical record or in his wing history sheet. I therefore endorse the following recommendation for the attention of the head of healthcare and the Governor:

The head of healthcare and the Governor should ensure that a log of healthcare telephone calls between officers and healthcare staff must be maintained to ensure accurate transfer of information and audit trails.

Record keeping

106. The clinical reviewer comments that the man's medical records and the communication about his disabilities was poor. The quality of record keeping and communication is an essential element of an individual's care. Furthermore, the clinical reviewer describes her concern about the continuity of care when the man transferred between prisons and during his short term release. Previous referrals to secondary care were not followed up. Good record keeping is central to ensuring continuity of care between healthcare providers and prisons. I endorse the clinical reviewer's recommendation for the attention of the head of healthcare and the Prison Project Group.

The head of healthcare and Prison Project Group should work towards improved achievement of the prison health performance and quality indicators, with regard to chronic disease management, long term conditions care and continuity of case management.

107. The reviewer concludes her review, as follows:

> "It is not the purpose of the review to attribute blame to anyone. However, it is important to identify any areas of practice where lessons

can be learned and improvements made. Staff at HMP Maidstone have already identified two gaps in service which they have acted upon. The instigation of an urgency graded system to call healthcare assistance. The development of a CPR policy and procedures. It is intended that the recommendations made from this clinical review will promote further learning and service improvement.”

CONCLUSION

108. The man's death was caused by undiagnosed lung cancer and a tumour in the heart sac. At some point following a visit to healthcare on the morning of his death, he returned to his cell and collapsed on the floor causing an injury to his head. From the post mortem report this injury was not the primary cause of death. Furthermore the elastic bands found in his mouth were deemed to be unrelated to his death.

109. Security information indicated that the man had been suspected of trading his medication for tobacco. Whilst he denied this when spoken to by the wing manager, healthcare staff were made aware of the information and he was advised at appointment about the risks of misusing his medication. Officers were alerted and monitored his movements on the wing.

110. The clinical reviewer has completed a full and extensive investigation into the man's medical care. She concluded that there are gaps in the healthcare services at Maidstone and her recommendations reflect the improvements that should be considered and carried forward to address those issues. The reviewer also noted some areas of good healthcare practice.

111. Whilst a sudden death from cancer is unusual, I am satisfied that the man did not show any obvious symptoms of the terminal illness other than shortness of breath for which he had been referred to hospital. It is the clinical reviewer's opinion that the man received equitable care to that within the community.

RECOMMENDATIONS

The Head of Healthcare

1. The head of healthcare has a system in place to identify a significant delay following a referral of a prisoner for review by another healthcare provider.

   Partially accepted – "There is a system in place, which reports any offender who has been on the waiting list for more than 13 weeks. On discharge from prison The man was provided with a discharge summary for his new GP."

2. The head of healthcare should develop clear policies and procedures for the referral of prisoners to the disability liaison officer and for requesting disability aids.

   Accepted - "These policies are in place. All offenders are assessed on reception and if necessary a referral form, which is in the reception pack is completed and sent to the disability liaison officer. The man had been referred and that was why he had the use of a motability scooter."

3. The head of healthcare should consider the use of a pain assessment tool to complement clinical judgement.

   Accepted - "There is a clinical protocol on the prescribing of Tramadol, which has been provided by the Chief Pharmacist and circulated to all GPs. The GPs currently have access to a 'clinical pain ladder', which they can use to assess pain if they wish to."

4. The head of healthcare should ensure that all healthcare staff in their supervision receive appropriate support and be offered a one to one meeting at the earliest opportunity following a serious incident.

   Partially accepted – "All the permanent Healthcare staff at HMP Maidstone have access to clinical supervision. The problem on this occasion was between two individuals who will be reminded of the local policy. A post incident debrief was held at 15.00 hrs on the day of the incident."

The Head of Healthcare and Prison Project Group

5. The Head of Healthcare and Prison Project Group should work towards improved achievement of the prison health performance and quality indicators, with regard to chronic disease management, long term conditions care and continuity of case management.

   Accepted – "The Head of Healthcare and the Quality Assurance Group in the PCT are working towards improving the management of long term conditions."

The Head of Healthcare and The Governor

6. The Head of Healthcare and the Governor should ensure that a log of healthcare related telephone calls between officers and healthcare staff must be maintained to ensure accurate transfer of information and audit trails.

   Partially accepted – "It is totally impractical to suggest that every telephone call between the Officers and Healthcare should be recorded. Neither the Prison nor the Healthcare Department are profiled for the enormous increase in work that this would produce. However, all conversations that are deemed to be of significant importance will be recorded in the prisoners Clinical Record or on System1."

The Governor

7. All officers trained in first aid carry a resusci-aid face shield and that there is a supply kept in wing offices. These should be replaced as required.

   Partially accepted - "I can confirm that all of the first aid boxes here have 2 x resuci aids in them. So that part is accepted. The recommendation that all first aider should carry them has not been accepted. As long as all work areas have access to them there should not be a need for that action, particularly against the cost of them."