

**Investigation into the circumstances surrounding the
death of a man in hospital in May 2012
while in the custody of HMP Maidstone**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2012

This is the report of an investigation into the death of a prisoner at HMP Maidstone. He died of a stroke caused by a blood clot in May 2012. He was 54 years old. I offer my condolences to his family and friends and to all those affected by his death.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a clinical review into the standard of healthcare the man received while in custody at HMP Maidstone. Maidstone prison co-operated fully with our enquiries.

The man, who had previously been in general good health, collapsed in his cell on 4 May. He was taken to hospital, where tests confirmed that he had had a stroke. The following day he was transferred to another hospital for possible surgery but this was discounted. Plans were being made to transfer him back to the first hospital but he suffered a heart attack and another stroke. He was put on a life support machine but died.

Efforts were not made to contact the man's family until he was put on a life support machine. At that stage the prison discovered that the contact details they had were out of date. Eventually the police were able to contact his sister, who then informed his daughter. He was pronounced dead at 5.45pm, with his daughter and sister at his bedside.

The investigation has found that the care the man received while at Maidstone was equivalent to what he would have received in the community. It appears there is nothing the prison could have done to predict or prevent his death. However, there are some lessons for Maidstone to learn from this sad event. The initial emergency response in the prison was swift but there was a delay in calling an ambulance. It is also a concern that his family were not informed of his admission to hospital with a serious illness, so were unable to see him before he lost consciousness.

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

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Prisons and Probation Ombudsman

October 2012

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SUMMARY

1. The man was sentenced to three years imprisonment on 4 June 2011, and was taken to HMP Highdown. He transferred to HMP Maidstone on 6 October. It was his first time in prison. He did not have any significant health concerns during his time in custody. He suffered from depression and high blood pressure, both of which were managed using medication. He had no other health concerns before his collapse.
2. The man became unwell in his cell during the evening of 4 May. His cell mate called an officer for help and when the officer arrived, he collapsed. The officer radioed an emergency and a nurse attended, who after examination considered that he had suffered a stroke. An ambulance was called and he was taken to the local hospital.
3. The man's security risk was assessed as low, he did not have control of the left side of his body and no restraints were used. After he had been in hospital for a short time, he became extremely agitated and was pushing hospital staff away from him. He was also pulling at his drip and at the wires that were attached to him from monitoring equipment. The escorting officer thought that his behaviour was becoming a risk to hospital staff and an escort chain was authorised, which remained on overnight. The following morning, the escort chain was removed at the request of hospital staff, who now considered that his behaviour was linked to his condition.
4. Although it is a requirement for prison staff to notify a prisoner's next of kin if they are admitted to hospital with a serious illness, the man's family were not told that he had been admitted to hospital on 4 May and were not contacted until several days later, after his condition had significantly deteriorated and he was on a life support machine. This meant that his family were unable to see or speak to him while he was conscious. He was pronounced dead at 5.45pm that evening.
5. We agree with the findings of the clinical review that the care the man received while at Maidstone was equal to what he might have expected in the community. Prison staff would not have been able to foresee or prevent his death. We make four recommendations in relation to calling an ambulance as soon as an emergency arises, informing a prisoner's family of a serious illness in a timely manner, retrieving contact details for next of kin from phone records, and ensuring that debriefing sessions are held after every death in custody.

THE INVESTIGATION PROCESS

6. The Ombudsman's office was formally notified of the man's death on 7 May 2012. Notices about the investigation were subsequently issued to staff and prisoners at Maidstone asking anyone who had relevant information relevant to the investigation to contact the investigator. No one came forward.
7. HM Coroner for Mid Kent and Medway was informed of the investigation. A copy of the investigation report will be sent to the Coroner. A copy of the post-mortem report was received on 31 May 2012.
8. A clinical reviewer was appointed by the local PCT to conduct a review of the clinical care the man received in custody. The clinical reviewer received copies of all relevant medical and prison documentation relating to the man. The clinical review was received on 13 June.
9. The investigator visited Maidstone on 15 May 2012. She met the Deputy Governor, an Independent Monitoring Board (IMB) representative and staff who had been involved in the man's care. She was shown where he lived and the facilities that were available to him. She received all documentation relating to his time in custody. She reviewed prison and health records and liaised with the Governor throughout the course of the investigation.
10. On 12 June, 2012, the investigator and the clinical reviewer interviewed the man's cell mate, the prison family liaison officer (FLO), two officers and a member of healthcare staff.
11. One of the Ombudsman's family liaison officers contacted the man's daughter shortly after his death, to explain the remit and purpose of the investigation and to ask her if she had any questions she would like considered. His daughter had no questions or issues at that time.
12. The man's family received a copy of the draft version of the report as part of the consultation period. Having considered the investigation findings, his family indicated to my family liaison officer that they had found the report informative. They were however unhappy with what they deem to be conflicting information in individual interview transcripts. They will take forward the issues that they have identified in transcripts at the inquest.
13. The report was also issued for consultation with the Prison Service. Paragraph 14 has been amended and the responses to the recommendations have been added to the recommendations page.

HMP MAIDSTONE

14. HMP Maidstone accommodates up to 600 adult male prisoners. The prison's healthcare unit has no in-patient facilities and does not provide 24 hour care. There is nursing cover from 8.00am to 6.30pm on weekdays and from 8.30am to 5.30am on weekends. Daytime doctors' surgeries are provided by a local practice of general practitioners (GPs) and an on call locum service supplies out of hours cover.

Her Majesty's Chief Inspector of Prisons

15. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an announced inspection of Maidstone in 2011, and in relation to healthcare found that:

“Primary care provision was reasonable, with an appropriate range of services. Waits for routine GP appointments were short, and for the dentist satisfactory. Prisoners told us that health service staff were polite and respectful ... Effective reception screening enabled health and disability needs to be identified quickly and appropriate referrals made. Prisoners with long-term conditions were well managed on an individual basis.”

Previous deaths at Maidstone

16. In the two years before the man died, there have been five other deaths from natural causes at Maidstone. There are no similarities between the previous deaths and that of the man's.

KEY EVENTS

17. The man arrived at HMP Highdown, from court, on 4 June 2011. He had received a three year sentence and it was his first time in prison.
18. He had a routine reception health screen¹. He said that he had a history of gout², depression, high blood pressure and was a smoker. He told the nurse he was a heavy drinker in the community and he completed an alcohol detoxification programme at Highdown. He was prescribed antidepressants and medication to help reduce his blood pressure.
19. On 1 August, he transferred to HMP Lewes, before moving to HMP Maidstone on 6 October. When he arrived at Maidstone, he had a health screen with a nurse. His blood pressure was recorded as 135/72 (within the normal range) and he was offered help to stop smoking which he declined. He did not have any immediate health concerns.
20. Aside for treatment of gout, there are no significant entries in the man's on-going clinical record. He shared a cell and the investigator interviewed his cell mate and an officer on his wing. Each said that they could not recall him ever complaining of feeling unwell or having a headache. The cell mate said that they had a good relationship and they would talk openly with each other. The man went to the gym regularly and was trying to keep fit. He worked as a wing cleaner.

4 May 2012

21. On 4 May 2012, the man went to work as usual. There is no record of him feeling unwell during the day. At about 4.40pm, he ate his dinner in the dining room. An officer said that at 5.00pm the man went into the wing office and asked to be moved to a single cell as he was a cleaner and had been on the wing for some time. The officer explained that such prisoners are usually moved to a cell on their own as they become available. The officer said that he told him there was no space to move him at that time, but he would be kept in mind if a cell became free. He said he appeared satisfied with this and went back to his cell. The officer said that the man did not complain of feeling unwell and he did not have any concerns about his health.
22. The cell mate said that when the man returned to the cell he started to make a joke about the cell mate smoking. The man then said that his nose felt blocked. When he spoke, he was slurring and sounded as though he was drunk. He tried to blow his nose, but stumbled and fell onto his bed, which was the lower bunk.
23. The cell mate was very concerned and ran to the wing office which was only about six doors along the landing. The officer said he did not know the exact time, but it was approximately five minutes after the man had left the wing office

¹ All prisoners are given a first reception health screen to identify any immediate health concerns and to identify past medical history, including mental health.

² A form of arthritis that causes severe pain in a joint, along with swelling and redness.

to return to his cell. The cell mate told the officer that the man was very unwell and he needed to come to their cell.

24. The officer went immediately to the man's cell and found him stumbling around. He fell and the officer tried to catch him. He said that he did not manage to catch him fully, but he broke his fall and he did not hit his head on the floor. He was conscious, but confused. Although he was on the floor, he thought he was still standing. The officer put him in the recovery position. He asked him if he had bumped his head recently and he said that he had hit his head when sitting up in bed the day before.
25. The officer radioed a "code blue"³ and a nurse responded as the emergency nurse. The officer could not remember the time and the only record of the code blue being called was in the Communications Room Log at 5.17pm. The nurse, who was in the healthcare unit, went straight to the cell. He said that he took an emergency bag with him, which included resuscitation equipment and oxygen. He estimated it took him about three minutes to get from healthcare to the cell.
26. When the nurse arrived at the cell the officer was with the man, who was laid on the floor. He was conscious, but not coherent. The nurse said that he and the officer moved him onto his bed to make him more comfortable and to make it easier to examine him. As they were moving him they noticed that he had left sided weakness and his face was drooping. The officer and nurse agreed he had symptoms of a stroke. During this time, another officer on the wing moved the cell mate to an empty cell next door and gave him his smoking supplies and offered him the support of a Listener⁴ and the Samaritans telephone⁵, which he said he did not need.
27. The nurse went to the wing office and telephoned the control room to request an ambulance at 5.17pm. It therefore does not appear that the record of the code blue being called at 5.17pm can be accurate. The nurse gave a comprehensive account of the man's condition to be given to the ambulance team. Both the officer and nurse said that the ambulance arrived within minutes and there were no delays getting the paramedics through the gate to the cell. The ambulance log shows that the ambulance arrived at Maidstone at 5.22pm and the paramedics were at the cell at 5.23pm.
28. A risk assessment is completed when a prisoner goes out of the prison to determine whether handcuffs or other restraints should be used. The risk assessment should consider factors such as the risk of escape and the risk of harm to the public and hospital staff. It should be based on an assessment of the prisoner's actual risk at the time, taking into account his health and physical condition. While the paramedics were attending to the man, a Senior Officer

³ An emergency radio call that signifies cardiac or respiratory arrest, severe breathing difficulties or any event considered as life threatening.

⁴ Listeners are trained prisoners, selected and supported by Samaritans to offer confidential emotional support to prisoners 24 hours a day.

⁵ The Samaritans is an independent organisation which has trained volunteers that will listen to prisoners' concerns. Prisoners are able to talk freely and in confidence with the Samaritans on a 24 hour basis using a dedicated phone provided on request.

(SO) and the nurse completed the escort risk assessment for the man to be taken to hospital. It was agreed that he was not to be restrained as his condition was so poor and he was a low risk of potential escape or harm to the public.

29. At 5.56pm, after the paramedics had finished examining the man, they took him to hospital. When he was in the ambulance, the paramedics said that his symptoms were not completely consistent with a stroke and considered that he might have had a bleed on the brain. He was apparently very agitated.
30. He was taken to hospital. Two officers escorted him. He had a computerised axial tomography (CAT) scan⁶ and was admitted to a ward.
31. One officer said that the man started to become more agitated, pushing nurses, pulling at his drip and the wires of the monitoring equipment. At about 7.00pm, the officer spoke to the SO about applying restraints as he thought the man's behaviour was becoming a risk to staff. He was told that if he thought he needed to be restrained then an escort chain⁷ could be applied. He asked the hospital nursing staff if they had any medical objections to restraints being applied. They said they did not, however if his condition deteriorated then they would need to be removed. He applied the escort chain and agreed it could be removed in an emergency.
32. The man remained under restraint with an escort chain overnight. Entries in his bedwatch log⁸ said that he was still agitated and kept asking for the escort chain to be removed. His behaviour was said to have been extremely inappropriate towards hospital staff, including trying to touch nurses and therefore restraints remained in place.
33. The following morning nurses indicated that his behaviour might have been a side effect of his condition and asked for the restraints to be removed. Nurses could not use his paralysed arm to take blood samples or administer medication and they would have difficulty using his right arm with the escort chain in place. A senior manager at Maidstone and the SO were asked for authorisation to remove the escort chain. Although his agitated and erratic behaviour had not changed this was authorised.
34. The man complained of a headache. He had another CAT scan, the results of which, according to an entry in the bedwatch log showed some "changes". There is no record of what these changes were. It was thought he might need surgery and he was transferred to another hospital at 7.30pm that evening.
35. It was recorded in his bedwatch log that the consultants at the hospital did not think that he had suffered any brain damage and that he could possibly move

⁶ Also known as a CT scan. An X-ray procedure that uses a computer to create detailed images of the inside of the body for diagnosis.

⁷ A two metre long chain with a cuff at each end. One cuff is attached to the prisoner and the other to an officer.

⁸ Regular entries are made in the log regarding significant events, a prisoner's behaviour, any changes in their condition and conversations between the prisoner, escorting staff, prison staff and medical staff.

back to the first hospital later that day. At 7.15pm, he said that he had a very bad headache again. He was also continually pulling his catheter out.

36. The next morning the man had a blood test done as he had a high temperature. At 2.33am, the hospital's emergency nursing team were called as he had gone into cardiac arrest. The emergency team managed to resuscitate him and he was put on a life support machine.
37. At 3.20am, once he was stable, bedwatch officers informed the senior officer in charge of the prison that night that his condition had deteriorated and his next of kin needed to be contacted. He had further scans to determine the extent of his condition.
38. At 3.25am, the escort officers were told that the contact telephone number the man had provided for his daughter was not working and staff were trying to find an alternative number. At 5.10am, prison staff said they were still trying to find alternative contact details for his daughter. Hospital staff contacted the police to see if they could find any next of kin details. The police eventually made contact with his sister and told her that he was very unwell in hospital. His sister then let his daughter know, who rang the prison at 7.40am and asked what had happened. She said that she had spoken to her father the day before he had collapsed and he had been fine. She said that her father had an address book with her new contact details in it and she was very upset that she had not been told sooner. (In fact, her father had not written her address in his book before his collapse, and it was found on a slip of paper in his cell.)
39. An entry in the bedwatch log says that at 8.32am, escort officers were told by hospital staff that the man was brain dead and was being kept alive by life support machines. They were asked to move to the visitors' room, which they did.
40. The man's sister and daughter arrived at the hospital at approximately 11.15am and were taken straight to see him by the hospital doctor. The prison had appointed a family liaison officer (FLO) and she arrived with another FLO, just after the family. They waited in the family room to talk to the man's daughter and sister once they were ready.
41. At 2.09pm, the man's daughter went to the family room and spoke to the FLO. She reiterated that she was extremely upset that she had not been told sooner that her father was in hospital. It was explained that the prison only had access to contact details on the electronic prison record system and her contact details had not been updated. The FLO gave her a "Help at Hand" booklet which contained her contact details and explained the support that was available to the family. She then returned to her father's bedside.
42. The man was pronounced dead by a hospital doctor at 5.45pm that evening. His daughter said she did not wish to speak with the FLO again at that time, but she asked if the Chelsea football shirt he had been wearing when he was taken to hospital could be left so she could lay it on his chest. This was given to her and both FLOs left the hospital.

Post-mortem report

43. A post-mortem examination was held on 9 May 2012. The man's cause of death was recorded as a stroke caused by a blood clot. There was no evidence of trauma caused by a head injury and the pathologist concluded that he would have had a stroke irrespective of any head injury.

Support for prisoners

44. The man's cell mate said that he was told of the death in private by a senior officer on the wing. He was again offered the support of a Listener and the use of a Samaritans telephone. The Governor issued a notice to all prisoners that the man had died, which indicated the support that was available. Prisoners who were subject to suicide prevention monitoring procedures were reviewed.

Support for staff

45. When a prisoner dies in custody a 'hot debrief' is expected to be held with staff involved to ensure they have an opportunity to discuss with each other any issues arising, and for support to be made available. The investigator was told by staff who had been involved in the emergency response that they were not aware of a hot debrief being held. An officer said that he was told of the man's death during the wing's morning meeting. He said that during the meeting all staff were offered support from the care team. Both the officer and nurse said that they were content with the support that had been made available to them.

Support for family

46. Both FLOs met two of the man's daughters on 9 May. His money was returned along with some of his property (the remainder of his property was returned on 22 May). It was confirmed that the date the memorial service at the prison would be held on 15 May. The FLO provided a travel warrant for two people to travel to Maidstone to attend the service.
47. The man's daughter and her partner attended the service. They visited her father's cell and met the Governor to discuss her concerns. The memorial service was led by a prison chaplain. Many prisoners and members of staff attended the service. Several prisoners who had known him stood up and said a few words about him during the service.
48. The funeral was held on 26 June. A financial contribution was made by the prison and the chaplain led the service. A FLO attended the funeral.

ISSUES

Clinical care

49. The man did not have any significant health concerns during his time in custody. The clinical reviewer concludes that his gout was treated appropriately with pain relief. He received medication for blood pressure, but he had no blood tests to assess cholesterol or kidney function. The clinical reviewer considers that it would have been best practice for him to have been tested regularly, but concludes that it was highly unlikely that this omission contributed to his death.
50. We agree with the findings of the clinical review that the man's death could not have been foreseen or prevented. The first emergency response in the prison was timely, although there was a delay calling an ambulance.

Calling an ambulance

51. The Director of Offender Health and the Chief Executive Officer of National Offender Management Service wrote to all prison Governors and Directors and Heads of Healthcare on 12 February, 2011. The letter highlights the importance of calling an ambulance as soon as possible in an emergency. Any delays can have a significant impact on the patient's chances of survival, so staff should not wait for healthcare to attend.
52. The officer said that he did not call an ambulance because he believed he had to wait for healthcare staff. An ambulance was called for the man at 5.17pm, about ten minutes after he had collapsed in his cell.
53. Maidstone's emergency response protocol does not advise staff when to call an ambulance or who can call an ambulance. The investigator has been told that the protocol is being revised. We suggest that the Governor ensures the protocol is clear that anyone should be able to request an ambulance and one is called as soon as an emergency situation arises in line with the guidance. Ambulance requests can always be stood down if it is found on later assessment they are not needed.

The Governor should ensure that, in line with national instructions, an ambulance is called immediately and staff do not wait for healthcare staff to make an assessment.

Informing the man's next of kin of his admission to hospital

54. Prison Rule 22 says that "if a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of a mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed".
55. The man was taken to hospital with a suspected stroke on 4 May. He was in a poor condition and movement on the left side of his body had been affected.

Although tests were being done to determine an exact diagnosis and prognosis it is apparent that he was clearly very ill yet his family were not contacted. On 5 May, he was transferred to another hospital as it was thought he might need surgery. His condition remained poor, but his family were still not told of his admission to hospital. The fact that a prison FLO was not appointed until 7 May did not help. The SO told the investigator that his condition started to improve while he was in hospital and his condition was not thought to be life threatening. There were discussions about sending him back to the first hospital, which is why his family was not contacted.

56. Despite the man's death being unexpected, his family should have been contacted when he was first admitted to hospital, in line with Prison Rules.

The Governor should ensure that families are informed when a prisoner is admitted to hospital for a suspected serious medical condition.

57. The man suffered a cardiac arrest and another stroke during the early hours of 7 May. He was resuscitated and put on a life support machine. It was thought that he was brain dead and hospital staff said it was imperative that his family were contacted. It was only at this point that staff started to try contacting his family. Unfortunately, the contact details for his next of kin, his daughter, were out of date and contained only her previous land line number. The day before his collapse, his daughter had given him her new address and land-line number over the telephone and he had written these down on a slip of paper. He had not had the opportunity to give these new details to prison staff. However, if prison staff had checked his telephone records they would have had access to his daughter's mobile telephone number.

The Governor should ensure that telephone records are checked for contact details in the event of an emergency.

Support for staff

58. Although prison staff the investigator spoke to were satisfied with the support that they received following the man's death, a hot debrief should have been held. Debriefing sessions give the opportunity for staff to talk about the incident, any issues that may be apparent, and is a good opportunity for all staff to be offered the support of the care team. PSI 64/2011 stipulates that:

"A 'Hot Debrief' must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including Healthcare staff, should be invited."

The Governor should ensure that debriefing sessions are held after every death in custody.

Restraints

59. The man was taken to hospital on 4 May with a suspected stroke. He was conscious, but had limited mobility as the left side of his body had been affected. It was agreed that he should not be hand-cuffed or that any other form of restraints should be used.
60. During the evening, after he had a CAT scan, he became quite agitated. He was said to have been pulling wires out of the monitoring machines and he was pushing nurses. The officer who was escorting him was concerned that his behaviour was becoming a security risk and sought and received authorisation to apply an escort chain. The hospital staff had no objections to the escort chain being applied, as long as it did not get in the way of medical treatment.
61. The escort chain remained on overnight. During the morning of 5 May, hospital staff asked for the restraints to be removed. They considered the man's presentation was a side effect of his condition and that the escort chain was hindering them administering treatment. Although his behaviour continued to be erratic, the duty governor authorised the restraints to be removed and restraints were not re-applied.
62. There did not appear to have been full consideration on 4 May whether his erratic behaviour was a symptom of his condition. Nor is it entirely clear why two officers could not manage the risk of a man who was paralysed down one side and presumably not very mobile. The escort chain itself did not appear to prevent him from posing a risk to hospital staff as the log recorded that his inappropriate behaviour continued after its application. Nevertheless, we recognise the officers' overriding concern at the time was to protect hospital staff and in the circumstances the decision was not unreasonable. The next morning the escort chain was removed and not re-applied.

CONCLUSION

63. The man did not have any significant health problems when he arrived in prison. We are satisfied that the medical care that he received in prison was equal to that he could have expected in the community. Prison staff were not able to foresee or prevent his death,
64. There was a ten minute delay in calling an ambulance, as officers relied on healthcare staff to decide whether an ambulance was needed, which is contrary to national guidance. We are concerned that the prison did not inform the man's family of his admission to hospital when they should have done. This meant that they did not have the opportunity to see him before his condition deteriorated and he was put on a life support machine.

RECOMMENDATIONS

1. The Governor should ensure that, in line with national instructions, an ambulance is called immediately and staff do not wait for healthcare staff to make an assessment.

Accepted - Local policies will be reissued and clarified to reflect the requirements of the letter from NOMS.

2. The Governor should ensure that families are informed when a prisoner is admitted to hospital for a suspected serious medical condition.

Accepted - Local policies and contingency plans have been amended to ensure that families are informed when a prisoner is admitted to hospital for a suspected serious medical condition.

3. The Governor should ensure that telephone records are checked for contact details in the event of an emergency.

Accepted - Local policies and contingency plans will be amended to ensure that telephone records are checked for contact details in the event of an emergency.

4. The Governor should ensure that debriefing sessions are held after every death in custody.

Accepted - The Governor believes that their local contingency plans reflect national instructions accurately and that they are carried out appropriately. It is not necessary for all staff involved in the man's care from 4 - 7 May to be invited to a hot debrief. However, the members of staff who were directly involved in his care at the time of his death, and the staff who were responsible for his care for the preceding 12 hours, were invited to attend a hot debrief.