Investigation into the circumstances surrounding the death of a man in January 2010 at hospital, whilst in the custody of HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of an investigation into the death of a man who died at hospital in January 2010. He was serving a life sentence and had been in prison since April 2006. I extend my condolences to his family and friends and hope that this report explains the circumstances that led to his death. His daughter has recently contacted this office and asked to be included in the investigation process. I am sorry that my report has been delayed and apologise for any additional distress this may have caused.

The investigation was lead by one of my investigators. He visited HMP Maidstone and interviewed a number of staff there. He also interviewed a nurse at HMP Elmley who had met the man. One of my family liaison officers contacted the man's next of kin to discuss the investigation.

I would like to thank the Governor and his staff for their assistance during this investigation. In particular, I thank the liaison for my investigator and the family liaison officer who provided further useful information. A clinical review was commissioned from the local Primary Care Trust. They appointed a clinical reviewer to conduct the review, and I am grateful for her report.

The man took an overdose of prescription medication in December 2009. Initially it was thought that he had suffered a stroke, but he told both hospital and prison staff that he had taken an overdose of medication prescribed to another prisoner. He was stabilised at hospital and returned to HMP Maidstone on 8 January 2010. However, on his return, he was assessed as being too poorly to be managed there and was immediately transferred to the healthcare centre at HMP Elmley. The next day, the hospital contacted the prison to ask for him to be brought back to hospital, where he was diagnosed with an MRSA infection. His condition deteriorated and he died several days later.

He had previously taken an overdose of prescription medication at HMP Albany, which he said was in part because of his frustration at not being able to access an offender behaviour programme. He was moved to Maidstone, but was also not able to access the course there, and missed an opportunity to enrol on a course at HMP Usk. While I cannot be sure that his final overdose was due to the same frustrations, I am concerned that prisoners are not receiving proper and adequate information to help them either access the programmes or fully understand the reasons for delays.

I make six recommendations as a result of this investigation which concern medical practice at Maidstone and, in particular, about in possession medication.

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.

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

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SUMMARY

1. The man was remanded into custody at HMP Peterborough in April 2006, having been charged with serious offences. Whilst on remand, he made the first of three suicide attempts. He was treated at hospital and returned to the prison to await sentence.

2. On 24 November, he was sentenced to life imprisonment under the terms of imprisonment for public protection (IPP, a sentence which sets a minimum term of custody, after which release can only be authorised by the parole board). He was transferred to HMP Albany in March 2007 having started his sentence at HMP Winchester. Staff there noticed that he seemed to be low in mood and at times tearful. He was treated by medical staff and appeared to settle down.

3. In July 2008, other prisoners alerted staff that the man was giving his possessions and money away. They were also told that he was writing a Will. Prison staff responded by opening an Assessment, Care in Custody and Teamwork document (ACCT is a flexible, prisoner centred assessment and care planning system which aims to identify individual needs and offer personalised care and support during and after crisis in a supportive and caring environment) to ensure that he was given appropriate support.

4. The man told prison staff he was becoming frustrated with his sentence and wanted to move to HMP Maidstone where he believed that he could complete the extended sex offender treatment plan (SOTP) course. His mood improved and the ACCT was closed in August.

5. On 6 September, he did not collect his breakfast. Staff checked his cell and he was found to be drowsy. He told staff that he had taken an overdose of prescribed medication. He was transferred to hospital and told a consultant psychiatrist that a prison move had been blocked and he had hoarded tablets over a period of weeks. Following treatment, he was discharged back to prison with a recommendation that he should be assessed by mental health workers in the prison. The consultant also suggested that he should not be prescribed codeine or opiate based medication if possible.

6. The man was transferred to HMP Maidstone on 9 October and quickly settled into the prison regime, although he was unhappy to discover that Maidstone did not run the SOTP course. He applied to transfer to another prison.

7. An application for parole was refused in June 2009, and a recommendation made that he attend the extended SOTP course. He decided to appeal this decision but continued to engage with the regime at Maidstone. Staff at the prison made regular entries in his personal record that his behaviour in the prison was very positive and he was well liked by

both prison staff and prisoners. Staff at Maidstone made enquires about a possible transfer to enable him to undertake the SOTP Course.

8. On 28 December, prisoners were seen gathered outside the man's cell. When staff went to the cell they found him to be unresponsive. Healthcare staff on the wing at that time examined him and they believed that he had had a stroke. He was transferred to hospital by emergency ambulance. He was assessed at the hospital and thought to have taken an overdose of opiates. Once stabilised, he was transferred to Maidstone Hospital. He told prison officers that he had taken an overdose of other prisoner's medication.

9. Eleven days later, on 8 January, hospital staff contacted Maidstone to discuss discharging the man. Prison staff raised concerns about the limited medical facilities which were available. Nevertheless, he was discharged back to the prison the following day. Prison healthcare staff assessed him as being too ill to be managed at Maidstone, which does not have in patient facilities. Arrangements were made to transfer him to HMP Elmley, where there is an inpatient's unit, and he was taken there by taxi.

10. The next day, the hospital contacted the prison and asked for him to be returned as soon as possible. Test results had shown that he had contracted MRSA (metillin resistant staphylococcus aureus, a type of bacteria that is resistant to some antibiotics). He returned to hospital, but his condition deteriorated and he died.

11. I make six recommendations as a result of this investigation. They refer to the medication in possession policy for prisoners, the administration of medication, communication between HMP Maidstone and the hospital, record keeping, sentence planning and the allocation of SOTP courses.

THE INVESTIGATION PROCESS

12. Following notification of the man's death, the investigation was allocated to one of my investigators. He visited Maidstone and spoke with staff who had come into contact with the man. Notices were posted to staff and prisoners about the investigation, inviting them to contribute if they wished. No prisoners came forward to take part in the investigation.

13. The investigator was provided with all the relevant prison records for the man. They included his main prison record, medical records and statements made by staff after he died. He also visited the cell where the man was taken ill.

14. The local Primary Care Trust identified a clinical reviewer to carry out a review of the man's clinical care whilst he was at Maidstone. I am grateful to her for producing a timely and useful review.

15. The investigator also contacted HM Coroner to inform him of the scope and nature of my investigation and to request a copy of the post mortem report. The Coroner will receive a copy of my report to assist him in his enquiries into the man's death.

16. The investigator interviewed nine prison officers and five healthcare staff, four from HMP Maidstone and one from HMP Elmley. The clinical reviewer also interviewed two doctors involved in the delivery of primary healthcare services at HMP Maidstone.

17. One of my family liaison officers contacted the man's sister, his nominated next of kin. This was to explain the purpose of my investigation and to provide an opportunity to raise any issues his family had about the care he received. She said that she had no concerns at that stage about the care her brother received in prison. She said that he had always been very complimentary about the care he received and told her that both staff and prisoners were always very good to him. She mentioned that other prisoners would help him by collecting his meals when his legs were particularly bad. She spoke very positively about the care and support she had received from Maidstone following her brother's death, particularly from the family liaison officer.

18. The man's sister said her brother had tried three times to take his own life. She felt that his feelings of despair may have been compounded by problems regarding a transfer to complete a sex offender treatment programme. She said her brother was often terribly depressed, particularly regarding the length of his sentence, but on other occasions would seem positive about the future. She mentioned that he had written in a diary (which had been returned to her with his belongings) that "by March I will be with my Dad", who had died some years previously.

19. She said they came from a large family of nine boys and three girls. One of the man's daughters contacted my office in November 2010 and spoke

with both the investigator and family liaison officer. She daughter said she knew very little about the circumstances of her father's death and asked to receive a copy of my report when it was available. The man's sister and daughter will have the opportunity to see and comment on the draft report. I hope the findings of my investigation help to answer any questions they may have about the circumstances of his death.

Response to the draft report

20. The report was issued in draft to the man's sister and daughter. Having considered the findings of the investigation the man's daughter raised concerns about the treatment of her father's MRSA and the decision to discharge him from hospital given the extent of his health needs at this time. She asked why Maidstone prison did not consider sending her father back to hospital rather than transferring him to Elmley.

21. It is not within my remit to comment on the treatment the man received in outside hospital, nor is the decision by hospital staff to discharge him. In her assessment of the man's clinical care, the clinical reviewer concluded that in her opinion he should not have been discharged from Maidstone hospital at this time. I would like to draw attention to her comments regarding my third recommendation in which she says the issue of inappropriate discharge has been taken forward by her manager via the Clinical Quality Review Meetings held with the Acute Primary Care Trust. I hope this provides some reassurance to the family and demonstrates the seriousness with which this matter is regarded.

22. It is within my gift to consider the actions of prison healthcare staff on receiving the man back to Maidstone. Given the options available at this time, I consider staff carried out a prompt and thorough assessment of him and that their decision to transfer him to a nearby prison with more adequate healthcare facilities was appropriate and reasonable. His daughter also requested clarity about her father's escort from the hospital. I have added information to the report which I hope provides further clarity about this.

23. The man's sister commented that she would have expected prison staff to have noticed there was a problem with him after he took an overdose on 28 December, given an officer entered his cell twice that morning without eliciting a response. She said she was however appreciative of the care her brother received in prison and did not wish to raise anything further.

24. The draft report was also issued to the National Offender Management Service (NOMS). Their response to my recommendations is included in the report.

HMP MAIDSTONE

25. HMP Maidstone was built in 1819 and is a category C prison, accommodating adult male prisoners. (Prisons are categorised A, B, C and D according to the seriousness of the prisoners offence and the risk posed to the public should they escape. Category A prisons house the most dangerous prisoners with category D being the least secure and are generally known as open prisons.)

26. The prison does not have a 24 hour in patient healthcare unit, but there is a healthcare team which serves the prison between 8.00am and 5.00pm. There is also a locum doctor on call service.

HM Chief Inspector of Prisons

27. The former Chief Inspector of Prisons completed an inspection of Maidstone in 2007. In her report, she said:

> "Staff–prisoner relationships were mixed but aspects of diversity were managed well, with particular attention paid to the of the large number of older and disabled prisoners …Maidstone suffered from a lack of investment in its regime. Prisoners received timed appointments to see the GP. Access to the primary care mental health service was straightforward. Several visiting health professionals held regular clinics in the prison."

28. There was also a follow up inspection in September 2009 and in her report she commented that whilst work on offender management was progressing well, work with IPP prisoners was limited. However, she also commented that the prison had made considerable progress in addressing issues identified in the 2007 inspection.

Ministry of Justice performance ratings

29. The Ministry of Justice publishes quarterly ratings which scores each prison's performance. In the latest ratings in 2010, Maidstone was assessed as a good performing prison.

Independent Monitoring Board (IMB) report.

30. Every prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community, whose role is to ensure standards of decency and care are maintained. They have full access to prisoners and every part of the establishment, and produce an annual report for the Secretary of State for Justice.

31. In their annual report published in 2010, the IMB commented on the provision of healthcare services. They said:

“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, 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 health care provision.”

32. The man’s death is the seventh death at HMP Maidstone, since 2004 when this office took responsibility for investigating deaths in prison custody. There are no direct similarities between this and the other investigations.

Suicide and self harm monitoring

33. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners’ individual needs, and provide individualised care and support before, during and after a period of crisis. Once an ACCT is closed a post closure review should take place within seven days.

KEY EVENTS

34. The man was remanded into custody in April 2006 at HMP Peterborough having been charged with serious sexual offences. He was 76 years old when he entered prison.

35. The clinical reviewer has confirmed from the prison medical file that the man was registered as disabled. However, it has not been possible to determine when his registration took place. He reported that he had a history of asthma, arthritis and prostate surgery prior to coming into custody.

36. On 25 June 2006, whilst still on remand, the man made the first of three suicide attempts. He took an overdose of promethazine, which had been prescribed for the treatment of nausea. He was admitted to the Intensive Care Unit at hospital for treatment. Four days later, he was assessed by a registered mental health nurse (RMN) and found to have no long term mental health issues. At the assessment, he said that he had taken the overdose to help him sleep, rather than commit suicide, and that he did not intend taking an overdose again. A recommendation was made that he be reviewed by a community psychiatric nurse specialising in the care of the elderly. The clinical reviewer found no reference in the medical record that this recommendation was carried out.

37. On his return to Peterborough the next day, the man was given support and monitored under the ACCT process as a result of the overdose. He told staff on13 July that he deeply regretted trying to take own life and explained that "things got on top of him and he had had enough". The ACCT procedures were closed on 20 July.

38. He was sentenced to life imprisonment by a Crown Court on 24 November 2006. He was sentenced under the terms of indeterminate period of imprisonment for public protection (IPP, a sentence which sets a minimum term of custody, after which release can only be authorised by the Parole Board). He had to serve a minimum of three years and six months before he could apply for release on parole.

39. After initially serving his sentence at HMP Winchester, the man was transferred to HMP Albany on 26 March 2007. He was noted to be suffering from mood swings and was also seen to be tearful. He was initially prescribed mirtazapine, an anti depressant, and he was supervised taking this prescription for one month. He was allowed to have other medication, including pain killers, in his possession, at that time. (This means that he was given a supply of the drug to administer himself, rather than receiving each dose individually from healthcare staff.)

40. In January and February 2008, the man underwent orthopaedic surgery for carpel tunnel syndrome (carpal tunnel syndrome is thought to be caused by compression of the median nerve in the wrist, which causes numbness) in both of his hands. He was diagnosed as glucose intolerant

in January 2008 and his weight, diet and exercise regime were discussed at that time.

41. In May, his prescription for mirtazapine was discontinued because he was responding well to an increasing dose of amitriptyline (an anti-depressant which can also be used as a pain killer) prescribed to address hip and knee pain. The clinical reviewer comments that mirtazapine was recommenced in July 2008, although the medical record does not make it clear why or if he continued to receive amitriptyline.

42. On 24 July, a second ACCT was opened by staff at Albany as they were concerned that the man might harm himself. Information had been passed to prison staff that he had been giving possessions and cash away and that he was writing a Will. He told staff that he did not think his sentence and offender behaviour courses were progressing. When he moved to Albany, he had realised that it was to a prison which was too far away from his elderly friends who would be unable to visit him.

43. He continued to be supported using the ACCT process. During a review meeting with staff, he said that he had reached a standstill in his sentence and so he wanted a move to Maidstone. He was reviewed regularly and on 18 August the ACCT was closed. The closing comments were that he was "feeling a whole lot more positive than previously and has changed his stance regarding programmes here".

44. A few weeks later, on 6 September, the man was found to be drowsy in his cell having not collected his breakfast. He told staff that he had taken an overdose of paracetamol, mirtazapine and amitriptyline. He had also written a will and a letter which were placed on the table in his cell. He was transferred to hospital and admitted to the Intensive Therapy Unit (ITU).

45. He was stabilised and, following further tests, hospital staff decided that he had not taken paracetamol. Before he returned to prison, he was reviewed by the consultant psychiatrist for older people's mental health. He told the psychiatrist that he felt that a move to HMP Maidstone had been thwarted. He said that he had been hoarding tablets over a period of weeks prior to his suicide attempt but had no depressive symptoms. The consultant suggested that his level of suicide risk should be taken seriously as there was evidence of planning and forethought. His medication should be reviewed and more closely monitored. The consultant also suggested that it was vitally important that codeine or opiate based medications were avoided in his case, as they are highly dangerous in an overdose. He should have another assessment from the prison mental health in reach team to assess whether he required antidepressant treatment or ongoing psychological support.

46. As a result of the overdose, the ACCT procedures were opened again on 12 September, when the man returned to the prison. He returned to C wing where he had lived before the overdose. Prison staff interviewed

him during the ACCT process. He told the interviewing officer that he had become frustrated with his offender supervisor, who he thought was not doing enough to help him to progress to a Category C prison. He told the officer that he wanted to progress with his offending behaviour work. He also said he had received no visits for two and a half years and wanted to be nearer his family.

47. On 15 September, he was seen by a community psychiatric nurse (CPN), who followed up on the issues identified by the psychiatrist. No evidence of ongoing mental illness was identified during this interview. It is not clear from the medical record whether his in possession medication was reviewed in line with the consultant's suggestions.

48. Prison staff supported the man's application to transfer to a Category C prison and undertake the extended sex offender treatment programme (SOTP). On 3 October, his ACCT was closed. During the closing review, he said that he felt better, and that his offender supervisor would now personally update him on the progress of his application to transfer and undertake SOTP. He said that he was fully aware of the support that was being offered and how to access such support.

49. The man was transferred from HMP Albany on 8 October. He stayed at HMP Lewes overnight whilst en route to HMP Maidstone. As a part of the reception into Lewes, he was interviewed by reception staff and a cell sharing risk assessment (CSRA, an assessment to see if a prisoner should share a cell) form was completed by Officer Roscoe. An officer noted that "LIDS [an information database] shows as an open ACCT No Document Received. He states it has been closed and has no issues".

50. When the man arrived at HMP Maidstone the next day, reception staff noted in the CSRA that he should have a cell on the ground floor as he had a recent history of suicide attempts and of being supported through the ACCT process. He was also assessed on reception to the prison by healthcare staff and his history of depression, previous overdoses and ACCT support was noted.

51. On 10 October, he was interviewed by the prison the Disability Liaison Officer. She noted in her assessment that he should be located on the ground floor of his wing, with a "buddy" to collect his meals and be allowed to keep his walking stick. She also noted that he did not describe himself as disabled. He was located on Thanet wing in a ground floor cell. He underwent a second health care screening on 14 October, and was referred to the optician to follow up previous treatment for glaucoma. His medication was also noted.

52. The same day, an officer interviewed him and wrote in his personal record that he was happy to be at Maidstone, had no thoughts of suicide or self harm and was relaxed and happy. He was looking forward to receiving visits from his family.

53. On 16 October, the man again talked with the officer, who was now his personal officer (personal officers are officers who should be a prisoner's first port of call if they have any issues or concerns). He told the officer that he was unhappy to find out that Maidstone did not run the extended SOTP course and wished to transfer again so that he could undertake the course. He also told him that staff at Albany had told him that he could do the course at Maidstone and he believed that they wanted get rid of him. On 21 October, he made an application to move to another prison where he could undertake the extended SOTP course.

54. A probation officer at HMP Maidstone met the man on 4 November. She discussed his family and personal circumstances and wrote in the record of the interview that he "feels he has little to live for and had twice attempted to take his own life". She also wrote that "there is clearly some urgency necessary in facilitating progress in his SP [Sentence Plan] targets as he is 79 and not seemingly in the best of health".

55. On 14 November, the man was reviewed by the prison doctor as he had become concerned that he was losing his memory. The doctor arranged for him to be reviewed in one month.

56. The man also asked to see the Independent Monitoring Board about moving to another prison. On 25 November, the probation officer wrote in his sentence planning file, "Over recent weeks I have contacted all EX [Extended] SOTP sites- a small no [number] have replied but no good news".

57. The next day, 26 November, the probation officer recorded that HMP Usk had indicated that they would consider offering a place but needed to see the man's Structured Assessment of Risk and Need (SARN is an assessment used in prison and probation to assess future needs of sexual offenders). This document had not been received from Albany.

58. In the meantime, the man settled into Maidstone and was regularly described in his personal history as polite to staff and displaying good wing behaviour. On 29 January, the probation officer made further entries in his sentence planning documents. She also sent an email asking for further information on his SARN document which suggest that he had formalised his complaints though the Prison Reform Trust and Prisons and Probation Ombudsman. (There is no record of a complaint having been made to my office.) She wrote that she thought the offer of a place at Usk might have expired. She also wrote that he had previously attempted suicide.

59. Having been seen by the older prisoners' coordinator for a physical check up, the man was referred for further tests and, on 3 April, was diagnosed with non insulin dependant diabetes. He was given advice about how to care for his diabetes, including measuring his blood glucose level and managing his diet. He was also given medication, and referred to other

healthcare professionals (including a podiatrist) to help manage his symptoms.

60. Probation staff at Maidstone liaised with staff at Albany in order to prepare papers to enable the man to be transferred to Usk, which was running two extended SOTP courses in July. He told an officer that, as he had completed the SOTP course, he now wished to progress to the extended SOTP. He applied for consideration for early release on parole licence in June.

61. The possibility of a transfer to Usk appears to have been interrupted by an instruction from the lifer manager's office at Maidstone. It stated that the policy that IPP prisoners staying at a prison until the outcome of their parole applications, applied to him. (This policy is covered in Prison Service Order (PSO) 6010, which is entitled "Generic Parole Process".) As such, he stayed at Maidstone and was not transferred to undertake the extended SOTP at Usk.

62. The man had applied for consideration for release on parole licence in June and he received the Parole Board's decision on 7 July. His application was rejected with the recommendation that he should complete the extended SOTP programme.

63. On 20 July, he was reviewed by the prison doctor after complaining of neck pain. His medication was continued and he was referred for physiotherapy.

64. A week later, he discussed his situation with an officer. He told the officer that he was waiting to see a legal representative as he was considering appealing against his parole decision. The officer wrote in his record that there seemed to be confusion over which course he needed to complete, whether this had to be done before release and which prison could provide the course.

65. In an interview with an officer on 27 August, the man said that he was determined to stay positive about the courses which he needed to do. At that time, he did not have a job in the prison but was socialising with new prisoners of a similar age and had started to use the exercise yard again.

66. On 17 September, he was seen by a consultant opthalmologist, following a screening undertaken because of his diabetes. He was referred for bilateral cataract surgery, which is an operation to address cloudiness affecting his eyesight.

67. Later the same month, he complained of pains in his knees. He was seen by a doctor, who prescribed codeine, an opiate based pain relief drug, to be taken twice a day. He was reviewed in October and advised to use his pain relief only if he needed it. He continued to maintain good relationships with wing staff and the comments recorded on his personal record show him to be keen to progress his sentence plan.

68. He was drug tested on 20 October, and tested positive for opiates. This was thought to be because he was taking prescribed codeine and so no disciplinary action was taken. On 26 October, his medication was reviewed and he was advised to continue to take one codeine tablet a day.

69. On 17 November, he discussed his situation with an officer. The officer wrote that he was working in a prison workshop which he was enjoying. He also said that he had no news about a prison move but was patient and willing to wait as he understood that moves take time to organise.

70. The man was reviewed by the physiotherapist on 2 December. The physiotherapist decided that he could manage his own exercise regime and he was discharged. Some time later in December, he attended a review for his asthma. There were no concerns and he was advised to carry on taking his medication.

71. The investigator has seen a copy of an email trail which ends on 21 December. This shows that the man had been selected to be transferred to HMP Bure on 30 December to undertake the Extended SOTP. I can find no evidence of this being discussed directly with him.

72. On 28 December, an officer commenced his duties on the man's wing at 8.30am. The officer unlocked the cell and said good morning to him. He did not reply, so the officer looked into the cell and saw him on his bed. He could see that he was breathing. (28 December was a Bank Holiday when prisoners are allowed to stay in their cell in the mornings.)

73. The officer continued with his duties and went back to the man's cell at approximately 10.15am to undertake routine checks of the fixtures and fittings on the cell. This is known as the cell fabric check. The officer thought that he remained asleep during the check. Once he had completed his checks, he moved on to the next cell.

74. At approximately 11.45am, the officer was going about his duties when he noticed a group of prisoners standing at the entrance to the man's cell. Another prisoner, who was friends with the man, had gone into his cell and found him to be unresponsive.

75. Wing staff immediately called healthcare staff to ask them to attend. However, at the time the call was made, the nurse from the healthcare team came on to the wing having planned to see another prisoner. This meant that the man was assessed more quickly. The nurse found him lying face down and breathing in a very laboured way and showing weakness on his left side. The nurse thought that he had probably had a stroke.

76. An ambulance was called and the man was transferred to hospital. He was assessed and found not to have had a stroke. The team at the

hospital believed that he might have taken an overdose of opiates. He suffered a fit and was transferred to the intensive therapy unit (ITU). On the assumption that he had taken an overdose, prison staff opened the ACCT support procedures for him whilst he was in hospital on 29 December. Staff were to make hourly observations and engage in conversation with him to ensure that he was supported. Staff at the hospital were unable to contact the man's sister, and the Methodist chaplain at the prison agreed to do so.

77. The man responded to treatment and was transferred to ITU at another hospital. On 31 December, he told an officer that he had taken an overdose of 40 sleeping tablets, a mixture of his own and other prisoner's medication. The officer wrote in the bed watch log that he said he tried to take his own life "over moving prison" but it was not worth it and he would not try again. The officer also wrote that his statement "must be taken in context with medication that he is on and coming off".

78. On 2 January, the man was screened for MRSA which is a routine procedure at hospital. He was found to have traces of the bacteria on his body and he was treated with anti bacterial body wash. Doctors also ordered blood tests on 7 January.

79. Four days later, an officer wrote in the man's bed watch log that "it remains obvious that he is unhappy at how he has been treated previously". At 9.00pm on the same day, an officer wrote on the bed watch log that the man

> "… spoke about how he's going to go to the new prison now, it seems that this situation was over a simple misunderstanding which could have been resolved through simple communication with staff."

80. On 7 January, the hospital contacted Maidstone to discuss discharging the man. A nurse told the hospital that there were limited medical facilities at Maidstone. He was made aware that the man used a catheter and crutches, and asked the hospital to confirm that he was able to manage independently himself before he was discharged. He was discharged and escorted back to prison by prison officers in a taxi the next day. The Person Escort Record (PER) for that journey noted that whilst he was very frail he was able to move about independently with the assistance of crutches. The PER is a document which accompanies prisoners between prisons and other locations such as hospital and courts. It serves a communication tool about risks that a prisoner poses on escort and provides a chronological record of the journey. The urinary catheter remained in place and the hospital had instructed him how to clean it.

81. The man returned to his cell before being assessed by healthcare staff. They concluded that there were not sufficient medical facilities to look after him properly at Maidstone and arrangements were made to transfer him to HMP Elmley, which has a dedicated hospital wing. He was transferred again by taxi with officers to Elmley and admitted into the

prison's hospital wing at about 7.20pm. He was interviewed on reception by a nurse, who completed the required documentation for admission.

82. On 9 January, the man told staff at Elmley that he regretted taking the tablets and was looking forward to returning to Maidstone to continue his courses. Later that day, Elmley received a telephone call from Maidstone Hospital requesting him be returned to hospital. The results from his blood tests had shown that his MRSA infection was more serious than originally thought. He left Elmley at 4.00pm, arriving at the hospital at 5.00pm.

83. On arrival at hospital, he was admitted to the medical assessment unit. He was diagnosed with MRSA bacteraemia (meaning that bacteria were present in his blood). His condition began to deteriorate and he developed bilateral pleural effusions (excess fluid that envelopes the lungs), pneumonia, an abscess on his spleen and a deep vein thrombosis (a blood clot).

84. On 13 January, a governor conducted a prison management visit. Following a risk assessment he decided that because the man was so ill restraints need no longer be used and he authorised their removal. One of Maidstone's family liaison officers spoke to the man's sister to update her, and agreed to contact her again should her brother's condition change.

85. The man's condition continued to deteriorate and, on 18 January and after discussions with medical staff, he requested that he should not be resuscitated if he were to stop breathing. Medical staff agreed to keep him comfortable.

86. On 20 January, the man was given the last rites and was placed on the Liverpool Care Pathway (a care approach which is used to improve the quality of care to the dying in their last hours). The family liaison officer spoke to his sister to inform her of his condition. He passed away a few days later.

87. The man's sister, who he had named as his next of kin, was informed of his death by medical staff at the hospital. This was followed up by a telephone call from Maidstone prison. She was very appreciative of the care and support offered to her brother. She told my family liaison officer that although she was offered assistance by the prison with funeral costs, it was her brother's wish to pay for his own funeral, which he organised and paid for in advance. She was also highly appreciative that the prison helped arrange and pay for transport so that his daughters could attend the funeral.

88. Staff were informed of the man's death by way of briefings and notices put around the prison.

89. On 5 July, the Coroner for Mid Kent and Medway sent my investigator a copy of the man's post mortem report, which gives the cause of death as multi organ failure and sepsis (infection of the blood). No toxicology tests were undertaken, and it is therefore not possible to comment on the specific drugs which he took as an overdose.

ISSUES

Clinical care

90. A clinical reviewer was appointed to conduct a clinical review of the man's care by the local PCT. She has identified that, while some aspects of his care were equitable with what would be expected in the community, there were other contributory factors in his death that were not managed as well. In conclusion, however, she considers that, given his age and range of illnesses, his death was unlikely to have been avoided.

Medication in possession

91. Following an attempted overdose in September 2008, when the man said he had taken a combination of prescription drugs, a consultant psychiatrist at hospital advised that he should not be prescribed opiate based medications. However, a year later, he was prescribed codeine to address pains in his knees, and this medication was given "in possession".

92. When interviewed, a prison doctor said that he was not aware of the advice from the consultant. (His colleague also confirmed that he had not seen the advice and that he issued a repeat prescription, although for a reduced dosage.) The doctors thought that the move from a paper-based to electronic record system might have been the cause of this oversight.

93. The clinical reviewer has found that, following the man's arrival at Maidstone, no assessment was made of his suitability to hold medication "in possession". Although Maidstone has a policy covering in possession medication, which says that a risk assessment should be carried out on any patient being considered for in possession medication, it would seem that the policy was not followed.

94. Another reason why in possession medication should only be issued after a full risk assessment is that medication is often used as currency in prisons, and prisoners sometimes sell, or are bullied because of, the prescription medication they have in their possession. The man told staff, after his overdose at Maidstone, that he taken a supply of another prisoner's medication. It is impossible to prove whether this was indeed the case, but I would urge both the Governor and Head of Healthcare to ensure that all staff are aware of the issues surrounding the misuse of medication and the dangers this can pose.

The Head of Healthcare should ensure that the policy for in possession drugs is reviewed and updated where necessary in accordance with current practice. In addition, the Head of Healthcare should ensure that risk assessments are conducted before medication is issued in possession, and that the outcomes of these assessments are noted on the relevant medical records.

95. During an interview with a nurse, the clinical reviewer asked whether he was aware that the consultant psychiatrist had advised that the man should not be prescribed opiate-based drugs. He replied that it was for doctors to prescribe drugs and that, even though he was aware of the consultant's advice, he did not think that any of the nursing staff had challenged the prescription. The clinical reviewer believes that nursing staff should not administer a medication if they believe it is not in the best interests of the patient (this is known as contra-indication). I agree, and make the following recommendation.

The Head of Healthcare should ensure that registered general nurses do not administer a medication which they believe is contra-indicated for a patient's needs, without clarifying with the prescribing medical practitioner and obtaining an explanation as to why the prescription has been issued.

Communication between HMP Maidstone and the hospital

96. The clinical reviewer considers that the man should not have been transferred from hospital back to HMP Maidstone on 8 January 2010. This was a clinical decision which is outside my Terms of Reference, although I would recommend that both the Governor and Head of Healthcare read the relevant section of the clinical review.

97. However, the clinical reviewer also mentions that communication between the hospital and the prison could have been improved. In particular, she notes that the prison did not receive a transfer letter from the hospital when the man was discharged, and also that conversations between staff and the hospital should have been recorded better.

The Head of Healthcare should ensure that protocols are in place with local hospitals so that transfer letters are sent with any prisoner being discharged from hospital to prison.

The Head of Healthcare should ensure that all conversations regarding discharge are accurately recorded in the appropriate medical records.

Management of long term health issues

98. As noted above, the clinical reviewer has found that the man was able to access appropriate healthcare services to help him with his diabetes. She also notes that there is an older prisoners' coordinator at Maidstone, which she views as good practice. She also makes some recommendations on this issue, which I do not repeat here but again suggest that both the Governor and Head of Healthcare fully appraise themselves with her suggestions.

Clinical record keeping

99. The clinical reviewer also comments in her clinical review about the standard of record keeping in the man's medical records. While I again refer the reader to the clinical review on this issue, I make a recommendation of my own.

The Head of Healthcare should ensure that all staff accurately and fully record all relevant information on the appropriate medical records, in accordance with professional record keeping guidelines.

Access to the Sex Offender Treatment Programme (SOTP)

100. It is clear that the man was highly frustrated at not being able to progress through his sentence planning programme. This was almost certainly a factor in the overdose he took while at Albany, although it is not clear whether it was a factor in the overdose he took shortly before he died.

101. This is not the first investigation I have undertaken where difficulties in sentence planning progression are likely to have been a factor in a suicide attempt. I appreciate that courses are often oversubscribed, and that population pressures can mean that transfers are often difficult to achieve. However, I do not think that it is acceptable for a man of his age to be moved around the prison estate with no real plan as to how he might complete the correct offending behaviour courses. In particular, his move from Albany to Maidstone appears to have been misguided, as Maidstone does not provide the course that he required.

102. It is also unfortunate that the man then remained at Maidstone while his Parole Board hearing took place, which meant he missed the opportunity to attend a course at HMP Usk. (The Parole Board rejected the application, saying that he needed to attend an extended SOTP course, the very course he had been trying to attend for some months.) A place was arranged for him at Bure to attend the course, but it seems likely that he had not been told this when he took his overdose.

103. In considering this matter, I believe there are two aspects that need to be addressed. The first is a local matter for Maidstone. Staff told my investigator that the man could not be moved to Usk to attend the course because it was "policy" that those with outstanding Parole Board hearings should not be moved. I have consulted PSO 6010 which, at section 2.5.1, deals explicitly with this issue. I quote the paragraph in full [where an action in a PSO is mandatory, it is highlighted in italics]:

> "The parole process is considerably disrupted if a prisoner is transferred during the course of a review. While it is accepted that there are exceptional compassionate, security or discipline reasons for such a move, prisoners whose applications for parole are underway should not normally be transferred before their parole

dossier has been completed. Only in exceptional circumstances may prisoners be transferred. This may be appropriate, for example, where it is necessary to transfer the prisoner to complete offending behaviour work as identified through the sentence planning process. In cases where this has been necessary *Governors must inform the Parole Board and PPCS of the reasons for the move.*"

104. It is clear from the PSO that it covers the exact circumstances in which the man found himself. He was at Maidstone and had applied for parole, but during this process could have gone to Usk to "complete some offender behaving work as identified in the sentence planning process." I believe that staff at Maidstone have not fully understood this provision of the PSO. It is clear to me that the provisions of the PSO allow for prisoners to be transferred in order to address offending behaviour issues, without which it is much less likely that a parole application would be successful.

The Governor should ensure that staff are aware of the provisions of PSO 6010, and specifically section 2.5.1, which deals with the transfer of prisoners with outstanding Parole Board hearings.

105. There is also a wider issue, however. The man was frustrated in his attempts to address his offending behaviour, which was likely to be a condition of any attempt to obtain parole. (This was borne out by the failure of his parole application.) While it is unrealistic to expect the National Offender Management Service (NOMS, who are responsible for prisons in England and Wales) to be able to significantly increase the number of SOTP places which it can offer, especially given the current financial restrictions, I would urge them to review how prisoners are informed of the best way to access courses, and the likely length of time before they are able to go on a course.

Risk of self harm

106. In the course of his sentence, the man harmed himself three times and, on the first two occasions, the Assessment, Care in Custody and Teamwork support procedures were used effectively. Each time it seems that he wanted to progress in his sentence by undertaking a specific offending behaviour course. He took an overdose whilst he was at Peterborough. Then, at Albany, staff recognised the significance of him giving away his possessions and put the ACCT procedures in place again. He took another overdose whilst he was still at Albany and again the ACCT support mechanism kept him safe. Mental health assessments were made as were requests for further transfers.

107. Regrettably these efforts did lead to the offer of a place on a course but the man was not given the information before, on 28 December, he took a third overdose which ultimately led to his death. It is very sad that he did not share the level of his frustration with staff or prisoners and neither did they notice that he was at risk.

Use of restraints

108. I am pleased to note that the man was visited by a Governor while he was in hospital and that, as a result of this visit, a risk assessment was carried out on the level of restraint used. This led to all restraints being removed as the risk of re-offending or escape was deemed to be low.

CONCLUSION

109. The man took three overdoses of prescribed medication, one whilst on remand and two more as a sentenced prisoner. On the last occasion, he probably used other prisoner's medication although, in the absence of toxicology reports, it has not been possible to verify exactly what he may have taken.

110. This investigation highlights the fact that he was becoming increasingly frustrated with the delays in addressing his offending behaviour and in particular accessing the extended sex offender treatment programme. Although it is not clear whether he took the overdose because he was frustrated at remaining at Maidstone or because did not want to move to Bure, evidence of his frustration at Albany strongly suggests it was the former. As was noted on his bedwatch log, simple communication might have prevented his overdose and subsequent death.

111. As a result of the final overdose, he was taken to hospital. While there, he was identified as having contracted MRSA. He was discharged back to prison, despite Maidstone not having the facilities to cater for his illness, and he was quickly moved again to HMP Elmley. The same day that he arrived at Elmley, the hospital asked for him to return because his infection was more serious than first thought. He died there a few days later.

112. This is a sorry story of an elderly man who wanted to progress through his sentence by completing a specific offending behaviour course. He was sent to a prison where the course was not available and there took a third overdose. Although his death was ultimately due to an infection from the subsequent hospital treatment, I believe that his distress deserves attention by the prison and NOMS. I do not think that it is seemly for a prisoner to overdose in an attempt to reduce his risk of re-offending.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the policy for in possession drugs is reviewed and updated where necessary in accordance with current practice. In addition, the Head of Healthcare should ensure that risk assessments are conducted before medication is issued in possession, and that the outcomes of these assessments are noted on the relevant medical records.

   Accepted

   A risk assessment for having medication in possession is undertaken on all offenders. A copy is scanned onto their electronic file and a hard copy is kept in the pharmacy at the point of issue. For those who are not considered suitable to have their medication in possession their risk assessment is reviewed at least every 6 months or following any significant occurrence.

   For those who are considered suitable to have their medication in possession their risk assessment is reviewed following any change in circumstances or significant occurrence e.g. opening an ACCT document.

2. The Head of Healthcare should ensure that all registered general nurses do not administer a medication which they believe is contra-indicated for a patient's needs, without clarifying with the prescribing medical practitioner and obtaining an explanation as to why the prescription has been issued.

   Accepted

   All registered nurses have been reminded of their responsibility regarding administration of medication and now follow the NMC Guidelines on administration of drugs as detailed in NMC document Standards for Medicines Management 2010

3. The Head of Healthcare should ensure that protocols are in place with local hospitals so that transfer letters are sent with any prisoner being discharged from hospital to prison.

   Not Accepted

   There are protocols and agreements in place with the local hospitals that they will send a discharge letter out with the patient. However the hospitals frequently send the letters out by post and it can take 6 – 8 weeks for these letters to arrive.

   However my investigator received the following response from the clinical reviewer regarding this recommendation.

As you are aware, my Line Manager has raised the issue of inappropriate discharge via the Clinical Quality Review Meetings held with the Acute Trust.

In addition to this, documentation and communication within the discharge process will be the focus of a piece of work within the Safer, Smarter Care Programme undertaken by the PCT and some of our Provider Services.

I propose that we invite the Head of Healthcare and the Clinical Nurse Manager to be part of the sub-group for this piece of work, as the issues identified at the Clinical Review are similar to issues experienced by other Provider Services.

I hope this provides you with the required assurance that the recommendation made for the PCT/Acute Trust is being taken forward.

4. The Head of Healthcare should ensure that all conversations regarding discharge are accurately recorded in the appropriate medical records.

   Accepted

   All conversations with local hospitals regarding discharge or potential discharge is documented on SystmOne

5. The Head of Healthcare should ensure that all staff accurately and fully record all relevant information on the appropriate medical records, in accordance with professional record keeping guidelines.

   Accepted

   All staff have been reminded of their responsibility regarding maintaining records. They now follow the NMC Guidelines Record Keeping published July 2009

6. The Governor should ensure that staff are aware of the provisions of PSO 6010, and specifically section 2.5.1, which deals with the transfer of prisoners with outstanding Parole Board hearings.

   Accepted

   All Staff have been made aware of the provisions of PSO6010 section 2.5.1 and will liaise with sending establishments to ensure that if offender request to transfer in exceptional circumstances the disruption to the Parole process is kept to a minimum.