Investigation into the circumstances surrounding the death of a man at Maidstone General Hospital in December 2006 whilst in the custody of HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of an investigation into the circumstances surrounding the death of a man in December 2006. The man died at Maidstone General Hospital whilst in the custody of HMP Maidstone. The post mortem examination showed the cause of death as pneumonia, following other medical complications. The man was 67 years old.

I would like to extend my condolences to the family and friends of the man for their loss.

The investigation was principally the responsibility of one of my investigators, however further work has been carried out by another colleague. A clinical review was also commissioned to examine the medical care and treatment the man received at Maidstone prison. This was undertaken by an employee from West Kent Primary Care Trust (PCT) to whom I am most grateful.

I would also like to take the opportunity to thank the Governor of HMP Maidstone, and her staff for their full co-operation.

I make four recommendations in this report. Notwithstanding that the family liaison following the man's death was not handled well (a matter that the Governor has acknowledged in a letter to the man's son), two of my recommendations are to commend staff for the way in which they offered support to the man during his final days.

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

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SUMMARY

The man died in December 2006 at Maidstone General Hospital.

The man had been sentenced to eight years imprisonment in March 2003. On his arrival in HMP Elmley, his medical condition was described as 'complex' due to chronic degenerative disease of the lumbar spine that caused severe pain at times. He had difficulty with his mobility, was on morphine for chronic back pain, was on clonazepam for muscular spasms, and had venous hypertension and gross peripheral oedema to his lower legs.

In December 2003, the man was transferred from HMP Elmley to HMP Maidstone where he was located in the Vulnerable Prisoners Unit (VPU). For a couple of years the man was looked after by healthcare staff at Maidstone prison in conjunction with a consultant at Maidstone General Hospital. He had two admissions and numerous outpatient appointments – some requiring additional treatments or investigations.

At one time it was thought the man might have a malignant stricture of the common bile duct, but this was later discounted in favour of chronic pancreatitis.

In December 2006, the man became unwell in the early hours of the morning with vomiting and breathlessness. He was later transferred and admitted to Maidstone General Hospital. The man remained in hospital undergoing further tests and investigations and during this time his health deteriorated. He contracted Clostridium Difficile (C. Dif), which required him to be barrier nursed. Handcuffs were removed and the man was moved to a side room, although two members of prison staff stayed with him.

His death four days later was from pneumonia.

The family raised several issues including the way the man's death was notified to them and issues surrounding the handling of property. In response to these matters, the prison held its own internal, simple enquiry which resulted in a number of recommendations.

The clinical review concludes that the man received appropriate care whilst at Maidstone General Hospital. It also says that the care the man received whilst in custody was equitable to that he might have expected if he had been out in the community.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Maidstone on 10 January 2007. She was given access to the man's prison records and shown the wing where the man was resident prior to his admission to hospital. Notices of my investigation for staff and prisoners were given to the Governor for display around the prison. No members of the Prison Officers Association (POA) or the Independent Monitoring Board (IMB) were present or expressed a wish to see my investigator at this time.

2. West Kent Primary Care Trust was asked to undertake a clinical review of the care that the man received while in custody. The reviewer was asked to look at the entries in the man's clinical record and the quality of these entries. The clinical review was also to judge whether the care the man received at HMP Maidstone was the same as he would have expected to receive in the community.

3. One of my Family Liaison Officers contacted the man's son on 24 January 2007. He complained about the way the prison had dealt with matters regarding his father's personal property. This included the manner in which some items were returned to him and the disappearance of items that were of sentimental value.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, a copy of my report was sent to the Coroner to assist him in his enquiries into the man's death.

5. This report was completed by another colleague of mine.

HMP MAIDSTONE

6. Maidstone is a Victorian prison. In October 2003, its security level was reduced from category B to category C. Maidstone is made up of four residential wings. It offers several offending behaviour courses including Enhanced Thinking Skills and the Sex Offender Treatment Programme.

7. Maidstone does not have a 24 hour healthcare facility and has limited scope to care for someone with complex medical issues. Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, reported in her unannounced inspection, dated November 2004:

> "Healthcare staff responded to the healthcare needs of the prisoners. For example prisoners over the age of 65 arriving at Maidstone were assessed in line with the National Service Framework for Older People and one of the GP's held a weekly older persons' clinic. Healthcare and discipline staff also worked closely to ensure that the specific needs of individual prisoners were met."

8. Ms Owers went on to say that, "there were good links with the primary care trust and other healthcare providers, and a very good system of clinical governance had been established."

9. A letter appeared in the January 2007 edition of *Insidetime* (a national monthly newspaper for prisoners) in which a prisoner from Maidstone wrote as follows: "…I've been in Maidstone prison for over three years and during that time, for various reasons, I have had a considerable amount of contact with the healthcare department mainly mental health issues. The care I've been given has always been first class and I've had access to whatever healthcare professionals I have needed, be they doctors, nurses, psychologists or psychiatrists …"

EVENTS PRIOR TO THE MAN'S DEATH

10. The man first arrived at HMP Maidstone from HMP Elmley in August 2003, but the medical officer refused to accept him. This was because the man was on prescribed morphine and appeared too unwell for healthcare staff at the prison to cope with his medical condition. The man was then under the management of the pain clinic at Kent and Canterbury Hospital.

11. The man was discharged from the pain clinic on 1 December 2003. He arrived at HMP Maidstone for a second time on 12 December 2003. On arrival it was noted that he was still not a well man. Indeed, the medical officer considered sending the man back to Elmley where they would be able to provide 24 hour medical care. However, as one of the main reasons for the man's transfer was to enable him to receive family visits, the medical officer agreed to keep him at Maidstone. Transfer to Maidstone was also part of the man's sentence plan as it was hoped he would engage in Offending Behaviour Programmes (OBPs).

12. At this time, the man was noted to have difficulty with his mobility, and walked with the aid of two sticks. He was located on Thanet wing on the ground floor.

13. On 16 July 2004, the man was admitted to Maidstone General Hospital with anaemia. He underwent a series of tests and was treated with blood transfusions which required him to be an inpatient for several days. The man was discharged back to prison on 29 July with no definitive diagnosis, although a malignancy of sorts was suspected.

14. The man spent many months returning to hospital with nausea, abdominal pain, diarrhoea, oedema (excessive accumulation of fluid) and cellulitis (infection deep within the skin). He had several admissions with further investigations including blood tests, ultra sounds, and a colonoscopy. There are various entries in his medical record which show he had swelling of the lower legs, painful and hot legs and a possible abdominal malignancy or cancer of the pancreas, although no confirmed diagnosis.

15. On 9 February 2005, the man complained of abdominal pain. He was taken to the healthcare centre for examination by the medical officer. The medical officer diagnosed that the man was having mid gastric spasmodic pain with nausea. The pain was causing the man to be short of breath. The medical officer advised that the man should be seen at Maidstone General Hospital. The man spent two nights in Maidstone General undergoing tests, but no alteration to his treatment was recommended.

16. In March, a further episode of illness saw the man admitted to Maidstone General. He was in hospital from 18 March until 24 March. The reasons were recorded as leg and scrotal oedema.

17. Several outpatient appointments followed for further investigations. In a letter dated 15 April from a Consultant Physician at Maidstone General, it was reported that "The man's overall condition has improved". The letter also said: "All investigations for a [gastro intestinal] malignancy have been reassuringly

negative and I think the underlying problem has been chronic pancreatitis with a benign biliary stricture."

18. The man was seen and monitored by healthcare staff at Maidstone prison. Regular blood tests were performed to monitor the pancreatitis. A further admission to Maidstone General occurred in May 2005, again due to his chronic pancreatitis.

19. On 2 September 2005, the man was told that his wife had passed away. He was allowed to attend her funeral, albeit under escort.

20. Throughout the latter part of 2005 and into 2006, the man suffered inflamed and swollen legs. These episodes required treatment with antibiotic therapy. In late December 2006, the clinical record said that the man had no new problems and his legs were no worse.

21. In December 2006, the man was reported to be breathless, vomiting and looked ill. The medical officer requested that the man be admitted to Maidstone General. At 2.39am, the man was taken to the hospital by ambulance under the escort of two officers. The man was also in handcuffs at this time due to the nature and seriousness of his offence.

22. On arrival at the hospital, the man was described as acutely unwell. His symptoms were vomiting, dehydration, hypotension (very low blood pressure), shortness of breath, malnutrition as a result of not eating very well recently and a painful distended abdomen. A CT scan showed that the man had an enlargement of the small bowel with a small amount of ascities (a collection of fluid within the abdominal cavity), but there were no obvious signs of any obstruction.

23. Treatment for the man's symptoms and further investigations were carried out, including ECG and further CT examinations. Fluid replacement therapy and medication were administered. A naso-gastric tube and urethral catheter were inserted to aid the man's clinical management.

24. An initial diagnosis was given as acute intestinal obstruction, with possible colonic cancer. At that stage it was explained to the man that he might require surgery. Later that day, the subject of resuscitation in the event of an emergency was discussed with him. The man opted not to be resuscitated in the event of a cardiac arrest, although he was to receive active treatment of symptoms as they arose. There are entries in the bed watch log that indicate staff at the prison had attempted to contact the man's next of kin. At 11:35pm that evening, the man's son visited him. He left at 1:00am.

25. The prison told the hospital that the man was under the care of a consultant, and also that he had previously had a diagnosis of chronic pancreatitis.

26. Later the man was diagnosed as having Clostridium Difficile (C. Dif). (This is a bacterium germ that is most often acquired in hospital settings by people who have had large doses of anti-biotics. The spores for C. Dif can be transported by

those who have direct contact with the patient.) The prison contacted the Health Protection Agency (HPA) for advice regarding the cleaning of the man's room at the prison. Bed watch officers were informed of basic infection control measures. Early that afternoon, authority to remove the handcuffs was given, following a further risk assessment by a governor of the prison. Due to the nature of his offence, the man would remain with two officers at his bedside and, in the event of children visiting the ward, the curtains surrounding the man would be pulled. However, at approximately 4.30 pm. the man was moved to a side room by the nursing staff.

27. As part of my investigation, I check the entries that appear in a prisoner's bedwatch log. This is to ensure that they are sensitive, professional and relevant.

28. Within the bedwatch entries there are several that refer to the man as "not being compliant with nursing staff". These entries relate to the man pulling out his intravenous lines (IVs), and climbing out of bed when being advised to remain in bed resulting in regular falls. There are also entries referring to the man refusing to take oxygen on a regular basis. (I think this is likely to have been as a result of his confusion rather than any deliberate attempt to be non-compliant.)

29. Later on in December, officers were positioned outside of the man's side room. This was a result of the man not having control of his bowels. The officers were to remain outside the room until the man's clinical condition had improved. From the entries in the bedwatch log, it appears that the nurses were called to assist the man several times that day.

30. On the final day the man did not take his breakfast, but no other new causes of concern were raised. There are again entries that relate to the man having frequent episodes of diarrhoea.

31. At 8.20pm that evening, the man stopped breathing. In accordance with his wishes, no resuscitation efforts were made. A doctor was called to confirm his death. The doctor did so at 10:00pm.

CLINICAL REVIEW

32. The Clinical Review undertaken by West Kent Primary Care Trust (PCT) gives a full and comprehensive account of the man's medical condition from his arrival into prison until his death in Maidstone General Hospital. Of note within the review is that the man had several medical conditions that required frequent review by medical and nursing staff at HMP Maidstone. The reviewer says that the care the man received in custody was equivalent to that he could have expected in the community. There was evidence from the medical record to show that the man was referred promptly to the local hospital on several occasions. The man underwent extensive investigation before eventually being diagnosed with chronic pancreatitis.

33. It was also evident from the medical record that the man was more prone to catch infections and suffer from cellulitis. The recurrent use of antibiotics to treat these unfortunately led to his developing community acquired Clostridium Difficile. This meant that the man had to be barrier nursed for the last few days of his life. All staff and personnel in his room wore protective plastic aprons and gloves. He became seriously ill and at times his medical condition caused him to be quite confused. On a number of occasions he tried to use the commode without assistance and subsequently fell or slipped on the floor.

34. The clinical review makes a recommendation that, "prison healthcare staff consider using weight records to monitor gains or loss of weight in prisoners who are having medical investigations." This is in reference to the fact that the man was weighed on his initial reception to prison on 18 March 2003 as approximately 95.2kg. On 12 December 2003, just six months later, when he arrived at HMP Maidstone his weight was recorded as being approximately 76 kg. No action or note was taken of this weight difference. Furthermore, no evidence exists to say that his weight was monitored throughout his later investigatory period.

    Healthcare staff should ensure adequate monitoring arrangements for prisoners who show signs of unplanned weight loss whilst they are in custody.

35. The clinical review also identifies three areas of good practice, namely:

    The Prison Officers immediately contacted Healthcare at HMP Maidstone to inform the staff of the man's infection with Clostridium Difficile.

    A risk assessment of the need to use cuffs was undertaken in December 2006 that clearly documented the need for the man to be un-cuffed to allow access for medical and nursing staff to his arms to insert intravenous lines. The risk assessment was reviewed daily.

    The medical officer at HMP Maidstone, actively sought clarification on diagnosis and details of further investigations from the Consultants at Maidstone Hospital on a number of occasions that ensured the man received appropriate care.

36. It is obvious from the comprehensive records that good communication between the prison and the hospital was established. The clinical record shows that nursing staff from the prison were in regular contact with staff from the hospital. Prison officers on bed watch duty recorded full and comprehensive details to be handed on to each other. Managers visited regularly and undertook their management checks. An assessment of the need for the man to remain in handcuffs was made and a sensible decision was made to remove them.

EVENTS AFTER THE MAN'S DEATH

37. Unfortunately, following the man's death in December matters did not go according to the prison's plans following a death in custody. Maidstone has two trained family liaison officers (FLOs). However, there was some initial confusion surrounding the family being informed of the man's death. The clinical reviewer notes that according to hospital records a nurse at Maidstone General Hospital had commented that the prison was to contact the man's next of kin.

38. Neither of the two FLOs were on duty over that period and therefore the responsibility for contact fell to the night orderly officer (the person in charge of the prison during the night). He telephoned the man's son at home, but the son was working a night shift himself. The orderly officer therefore asked the man's partner to relay a message to him. This method of notification is not in the spirit of Prison Service Order (PSO) 2710, Follow up to deaths in custody, which states, "Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened." The PSO goes on to say that the guidance for FLOs on breaking news of a prisoner's death should be followed, and that would require a personal visit to the family by someone from the prison.

39. The son contacted HMP Maidstone in January 2007 regarding his father's property and possessions. Again, he appears to have been poorly dealt with.

40. My family liaison officer spoke to the son who highlighted some of his concerns to her. I have explored these where possible.

The collection of personal items by the family.

41. The collection of personal property caused significant distress to the man's family. The family described being met with a bag of personal property and being told, "you can check it if you want mate." The property was then handed over outside the prison. The family later discovered that certain items were missing, some of sentimental value. To her credit, Maidstone's Governor promptly commissioned an internal enquiry into the family's complaint on 10 January. This was carried out by a Principal Officer (PO) at the prison. From the conclusions to his report, it is clear that mistakes were made and a number of recommendations have been made. However, the PO felt that decisions had been made in an effort to prevent further trauma to the family and that staff acted with the best of intentions.

42. I have recently investigated two other deaths at Maidstone, one before and one after the man's death. In respect of those deaths, I am pleased to say that the prison was sensitive towards the family and family liaison worked well.

The Governor should ensure the local procedure for notification of deaths in custody is in accordance with Prison Service Order 2710. The prison's Family Liaison Officer should be the sole point of contact for family including handing over personal property.

The loss of two rings and a chain of sentimental value to the family.

43. The matter of these missing items was raised with the prison by the family. A governor responded in writing to the son on 24 January 2007, and a copy of this correspondence was forwarded to my office. It is apparent from paperwork that the man did in fact have two rings and a chain on his arrival at the prison. But as the prison has said in its correspondence with the family, it is the responsibility of the prisoner to look after property in his possession. It may be the case that these items were sold, stolen or simply lost. As they were in the man's possession, the prison had no responsibility for them. His cell was sealed immediately following him being taken to hospital.

44. My investigator made enquires with the Coroner's office and the mortuary and there is no record of the man having any jewellery at the time of his death.

The family was concerned that prison staff at the hospital were caring for him dressed in aprons and gloves.

45. The man was diagnosed with Clostridium Difficile (C. Dif) which is a bacterial infection. The main symptoms are watery diarrhoea, fever, loss of appetite, nausea and abdominal pain. It is diagnosed by the presence of C Difficile toxin in a stool sample. The spores of C. Dif are carried on the hands of personnel who have direct contact with infected patients or with contaminated surfaces such as floors, bedpans and toilets. Nursing staff will "barrier nurse" patients who have contracted infections such as C. Dif. Barrier nursing involves the wearing of gloves and protective clothing in order that cross infection does not occur. However, visitors do not normally need to wear the protective clothing unless they are giving personal care to the patient. There is evidence within the man's clinical record to show that prison officers were helping out at times, especially when the man defecated on the floor. It was for this reason that prison staff wore aprons and gloves as a precautionary measure.

OTHER ISSUES RAISED BY THIS INVESTIGATION

The man's transfer from HMP Elmley to HMP Maidstone.

46. When the man was originally transferred from Elmley to Maidstone in August 2003, he was swiftly returned to Elmley. There followed a three month period of negotiation between the man, Elmley and the Medical Officer at Maidstone. This resulted in the man's permanent transfer to Maidstone in December 2003. This was agreed in order to help him with his family visits, in particular from his wife. He also had to be able to walk to healthcare twice a day to collect his medication.

47. The man's wife died in September 2005. The man continued to be needy in medical terms, including getting progressively less mobile. It would have been very easy (and quite understandable perhaps) to return him to Elmley as he required more and more complex and intensive interventions. It is to Maidstone's credit that they provided good care for the man. The clinical reviewer made specific mention of the fact that the medical officer at Maidstone 'sought clarification on diagnosis and details of further investigations from the consultants at Maidstone Hospital on a number of occasions that ensured the man received appropriate care.'

The healthcare staff of HMP Maidstone should be commended for their efforts to manage the man's health needs within the prison.

Bedwatch staff participated in the man's care whilst he was a patient at Maidstone General Hospital.

48. It is evident from the bedwatch logs that staff undertaking those duties were put in somewhat difficult positions during the man's last stay in hospital. Due to his deteriorating medical condition, he was often confused and "difficult" to manage. He would climb out of bed, pull tubes out, be incontinent of faeces and refuse to comply with nursing requests. It was not possible (or seen as desirable) to use normal prison man management techniques to force the man to comply with nursing requests. It was therefore down to prison staff in conjunction with hospital staff to persuade the man to comply as much as possible. In addition, prison staff helped manoeuvre the man back into bed and cleaned up after him when he was incontinent. Again it is to the credit of prison staff that they endeavoured to help where possible.

The bedwatch staff from HMP Maidstone should be commended for their efforts during the man's last few days in hospital.

RECOMMENDATIONS

1. Healthcare staff should ensure adequate monitoring arrangements for prisoners who show signs of unplanned weight loss whilst they are in custody.

2. The Governor should ensure the local procedure for notification of deaths in custody is in accordance with Prison Service Order 2710. The prison's Family Liaison Officer should be the sole point of contact for family including handing over personal property.

3. The healthcare staff of HMP Maidstone should be commended for their efforts to manage the man's health needs within the prison.

4. The bedwatch staff from HMP Maidstone should be commended for their efforts during the man's last few days in hospital.

ADDENDUM

The man is reported to have suffered from Clostridium Difficile (C Dif) during his final stay at Maidstone General Hospital in December 2006. This resulted in him being cared for in a side room under barrier nurse conditions. Staff working with the man were required to wear gloves and protective clothing to prevent cross infection to other patients.

In October 2007 a report by the Healthcare Commission strongly criticised Maidstone and Tunbridge Wells NHS Trust, including Maidstone General Hospital, for appalling lapses in infection control procedures – in particular relation to C Dif. This report showed that some people had died in Maidstone General Hospital as a direct result of contracting C Dif whilst in their care. There has been much media coverage of these details over the past few weeks.

It is unusual for me to put comment of this nature at the end of one of my reports, but I think it is worth making the following three observations.

1. The report covers a period from April 2004 to September 2006 (the man died in December 2006). He is therefore not included in any of the statistical evidence gathered by the Healthcare Commissioners for their report.

2. Although the man certainly acquired C Dif in the days before his death, it is clear from the Post Mortem report that the cause of death was not due to the bacterium Clostridium Difficile. It was due to his underlying medical problems which caused him to succumb to pneumonia which was exacerbated by his chronic obstructive pulmonary disease.

3. As soon as the man was diagnosed with C Dif he was appropriately isolated in a side room and barrier nursed in accordance with good practice when dealing with C Dif.