Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Swaleside in June 2009

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of an investigation into the circumstances surrounding the death of a man at hospital in June 2009. He was serving a lengthy prison sentence at HMP Swaleside. He was 58 years old and died of pancreatic cancer. I would like to offer my sincere condolences to members of the man's family and all those who were affected by his passing.

I am aware that his family found the man's imprisonment very difficult. However, they told one of my family liaison officers that they were very happy with the support they have received from the prison's family liaison officer. I hope that my report will help answer questions they have raised with my office. Where issues have been raised outside my remit, I have asked the Governor of Swaleside to take these forward. These are set out in greater detail in the Investigation Process section of my report.

My colleague conducted the investigation on my behalf. In addition, a review of the man's medical care was undertaken by the clinical reviewer on behalf of the local Primary Care Trust. I am very grateful to her for her advice and valuable contribution to my report. I would also like to thank the Governor of Swaleside and his staff for their cooperation. I am particularly grateful to the prison's family liaison officer who provided a very high standard of prison liaison and ensured the prison documentation was in good order.

My investigation has not found any common factors between the circumstances surrounding the man's death and previous deaths at Swaleside.

I make three recommendations. The first relates to establishing a protocol between the Primary Care Trust, the Head of Healthcare and the Governor, to ensure that timely and accurate information is provided to the prison by secondary healthcare services. The second relates to the Head of Healthcare ensuring that all healthcare staff are trained to use the electronic system of recording so that paper records are not used alongside the electronic version. The third recommendation arises from whether it was appropriate for the man to continue to be placed in restraints once he had reached hospital. He had a long standing history of poor mobility and was actually immobile at the time of his admission to hospital in 2009. While the safety of the public is paramount, risk assessments must be balanced and proportionate and tailored to the individual.

My recommendations aside, I judge that the care the man received at Swaleside was of a high standard and exceeded that which he would have received in the community. This reflects very well on Swaleside and on the National Offender Management Service as a whole. The National Offender Management Service has accepted my recommendations and their response is on page 24 of my report.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2010**

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SUMMARY

In February 2002, the man was sentenced to 14 years imprisonment. He was 52 years old. This was the first prison sentence he had served in this country. The sentencing Judge remarked that he was extremely ill with a reduced life expectancy. He suffered very poor mobility because of his obesity and had a number of long standing medical problems such as high blood pressure, diabetes, cerebrovascular disease, ulcers on his legs, and kidney problems. He had been located in the inpatient healthcare unit at HMP Swaleside until he was admitted to hospital a few days before his death at hospital in June 2009.

Initially, the man was remanded to HMP Wandsworth. Records show that upon conviction he asked to serve his sentence at HMP Erlestoke in Wiltshire to make it easier for his family to visit from Reading. This request was not granted because Erlestoke could not meet his medical needs, and because it is a category C prison and he was a category B prisoner.

In October 2003, the man transferred to Swaleside where he was placed in his own cell on the ground floor of a wing. Throughout 2004, he appeared to cope with the help of other prisoners who fetched his meals and cleaned his cell.

In May 2005, the man slipped and fell in his cell and could not get himself back on to his feet. Wing staff called healthcare for help and subsequently told healthcare that they were no longer able to meet his daily needs. His hygiene standards had fallen and his health was deteriorating. A previous request by wing staff for him to be located in the inpatient healthcare unit had been refused as he did not meet the clinical criteria for a placement in the unit.

While located on the wing, the man had missed a number of appointments to monitor his diabetes and blood pressure. The move to the inpatient healthcare unit meant that these conditions could be monitored and were well controlled. The clinical record shows detailed care plans with regular reviews. Appropriate referrals were made to specialists such as the Tissue Viability Service for help and advice. Notably, the healthcare team at Swaleside were successful in treating his leg ulcers, a condition which is acknowledged to be very difficult to control.

The man's medical care continued to the same high standard in 2007 during a temporary move to HMP Elmley while the healthcare unit at Swaleside was refurbished.

In May 2009, healthcare staff were concerned that the man had a very swollen leg and called the prison doctor to examine him. He was jaundiced and the doctor suspected that he had deep vein thrombosis. He was sent to hospital urgently. Investigations at the hospital confirmed a diagnosis of deep vein thrombosis, but also an unexpected diagnosis of pancreatic cancer. He returned to the prison.

Just over a fortnight later, a member of healthcare staff came on duty early in the morning of 7 June. She heard the man gasping for breath and hiccupping. An emergency ambulance was called and he was taken to hospital. In accordance with prison security policy, he was taken to hospital in restraints. This was a handcuff

attached to his hand with a long chain (an escort chain) attached to a prison officer. The restraints were removed the following day. Officers sent with him had asked the prison for permission to do so in accordance with prison policy and procedures regarding the use and removal of restraints.

Staff contacted the man's family when it became clear that he was fast deteriorating and likely to die imminently. The family were able to visit him.

The man's rapid decline was unexpected. The clinical reviewer suggests there is room for improvement in communication between the prison and secondary care providers as the information given to the prison was patchy and did not clearly advise of his imminent demise. I have made a recommendation regarding improving communication.

I make further recommendations regarding the training of all healthcare staff to use the electronic recording system and the use of restraints.

Throughout his sentence, the man's behaviour was testing and he did not heed dietary advice. Despite this, it was clear to my investigator that healthcare staff who tended to him on a daily basis, and those discipline staff who knew him, were fond of him and saddened by his passing.

THE INVESTIGATION PROCESS

1. I was notified of the man's death in June 2009. Terms of Reference and notices were issued to staff and prisoners at Swaleside telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of his core record, clinical record and other records relevant to his time in custody and death.

2. My investigator also contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. That report concludes that the man died of pancreatic cancer. The Coroner has requested a copy of my report upon completion and I am happy to comply.

3. A clinical review of the man's medical care was commissioned from the local Primary Care Trust. This was undertaken by the clinical reviewer who focussed on the medical care he received at Swaleside. Her review appears as an annex to this report.

4. The investigator and the clinical reviewer conducted interviews at Swaleside in early October 2009 with staff who were involved in the man's care. They also met with the Head of Healthcare and his staff. The investigator and clinical reviewer toured healthcare and saw the cell where the man was located before his death.

5. The investigator visited the prison again in November and spoke with the Governing Governor. She also talked to the Deputy Governor at the time the man was at Swaleside.

6. One of my Family Liaison Officers spoke with the man's sister. She raised a number of issues relating to his care at Swaleside and the delivery of his property to the family following his death. Some of the issues were outside my remit and the Governor has agreed to take them forward.

Property

7. The man's sister said that her brother's property was returned to her husband's workplace and in a marked prison van. My investigator spoke with her liaison officer and the Governor who were both concerned. However, they were clear that the National Offender Management Service (NOMS) does not have marked prison vans. They explained that his property would have been returned in a plain black bag supplied by the prison. Regrettably, the matter remains unexplained.

An address book entry for clinical negligence

8. My investigator spoke with the Head of Healthcare about an entry in the man's address book regarding an address to write to about clinical negligence. He was unable to say why there should be such an entry. The man had not made any complaint either formally or informally while at the prison.

9. I hope my report has answered the remaining issues the family raised regarding the use of restraints and why they were not informed earlier of the seriousness of the man’s condition.

HMP SWALESIDE

13. Swaleside is a category B prison. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous.) It is part of the Sheppey cluster of prisons that includes HMP Elmley and HMP Standford Hill, an open prison. Each prison has a governor and the cluster is managed overall by a chief executive.

14. Prisons in the cluster share services. The man spent part of his sentence located in the inpatient healthcare unit at Elmley while the healthcare unit at Swaleside was refurbished.

15. Swaleside has an operating capacity of 951. All prisoners are serving a sentence of four years or more. Around half of the population at Swaleside are life sentenced prisoners. When my investigator visited, construction of a new residential wing (H wing) was at an advanced stage.

16. The man was an inpatient in the healthcare unit for most of his sentence. The HM Inspector of Prisons commented in her most recent inspection report[1] that the healthcare inpatient unit had 10 beds, increasing to 15 following refurbishment. The Head of Healthcare confirmed in interview that this had since increased to 18.

17. The local Primary Care Trust are responsible for the commissioning of healthcare services. HM Inspector found the management of long term illnesses to be good, as was the general practitioner service. A doctor was available in the prison every weekday from 8.00am to 5.00pm, with out of hours cover provided by the local NHS. The Head of Healthcare described the services available to my investigator. They include clinics for diabetes, cardiac conditions, physiotherapy, dental health and hepatitis C.

18. An Independent Monitoring Board (IMB)[2] report for the period 1 May 2008 to 30 April 2009 reported that refurbishment of the healthcare unit was complete. Plans for telemedicine were at an advanced stage. This would allow speedier consultations via the internet, and reduce the need for bed watch escorts and the use of restraints.

19. HM Inspector reported that the EMIS electronic system of recording medical information could not be used by all staff as not all were fully trained. As a result, paper records were held as well creating a two tier system of recording. I address this matter later in my report.

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[1] HM Inspectorate of Prisons; Inspection of HMP Swaleside, 31 March 2008 to 4 April 2008.

[2] The Independent Monitoring Board monitors day-to-day life in their prison and ensures that proper standards of care and decency are maintained. Prisoners can complain to them using confidential access. IMB members visit the prison regularly and obtain responses from Governors on any points raised by prisoners. The Board is required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern.

20. HM Inspector found Swaleside to be a “safe and respectful” prison which was “impressive given the many serious offenders held”. Relationships between staff and prisoners were considered a strength, and this was clear in the man’s care while in the inpatient healthcare unit.

21. There have been 18 deaths at Swaleside since 2004 when my office was entrusted with responsibility for investigating all deaths in prison custody. My investigation has not found any common factors between the circumstances surrounding his death and previous deaths at Swaleside.

KEY FINDINGS

22. The man was 52 years old when he was sentenced to 14 years imprisonment in November 2002. This was the first prison sentence that he had served in the United Kingdom. He was aged 58 years at the time of his death at hospital. He had been granted release from prison on compassionate grounds in June. Sadly, the notification of this was received just hours after his death.

23. The Judge's remarks when sentencing the man are significant. While acknowledging the seriousness of the offence, she was aware of his poor state of health. She said: "it was a tragedy to see a man in your physical condition facing a long prison sentence … conscious that you are extremely ill and have a limited life expectancy." Court papers suggest that, as he had a previous conviction for a similar offence and did not plead guilty, the Judge was unable to find any mitigating factors to reduce the sentence.

24. A medical report by a doctor, dated July 2002, recorded the man's known previous history of diabetes and hypertension[3]. He also noted a series of mini-strokes since 1966 affecting both speech and mobility. These had worsened over the previous two years with the result that the man had become depressed and over-ate in response to his depression. Another doctor completed a report in August 2002 in which he disputed the first doctor's findings, but agreed there was "no controversy surrounding the fact that the man has several highly significant vascular risk factors and has established small vessel disease of the brain."

25. A Specialist Registrar in Forensic Psychiatry prepared a psychiatric report dated October 2002 for the court proceedings. She described the man as physically frail, walking and speaking slowly. She assessed him as low in mood at the time due to his ill health and the forthcoming trial.

26. The man began his sentence at HMP Wandsworth. A member of healthcare staff completed the Modified First Reception Health Screen document. The man said that he had been homeless before coming in to prison. He confirmed that he had been diagnosed with diabetes and hypertension, but did not know the name or the dosage of the medication he had been prescribed. He said that he had been treated for neurological problems and depression in the past. When asked if he had any other health concerns, he said that he had suffered five myocardial infarctions[4] and was under the care of a neurologist. The interviewer noted that the man was obese, walking with the aid of a Zimmer frame, and that his speech was slurred.

27. Settling into HMP Wandsworth and its regime proved difficult for the man. He was located in a single cell on a main prison wing because of his medical problems. His wing history sheet records that he was able to shower, keep his cell clean and make telephone calls only with the help of landing cleaners who had been asked by the wing officers to assist him.

[3] Hypertension is a medical term for high blood pressure.
[4] Myocardial infarction is a medical term for a heart attack.

28. The man asked for a transfer to HMP Erlestoke, Wiltshire, on medical grounds and because of the difficulty his family encountered visiting him from Reading. His request for a transfer to Erlestoke was refused as the prison was not equipped to meet his mobility needs. (In any event, Erlestoke is a category C prison and an Initial Categorisation and Allocation (ICA) 1 form dated January 2003 assessed him as a category B prisoner.)

29. The ICA 1 form noted the man's response to a move to Swaleside as positive as he hoped it would be easier to serve his sentence at Swaleside than Wandsworth. He was allocated a place at Swaleside because the prison could locate him on the ground floor of a wing and meet his numerous medical needs.

30. In late October 2003, the man transferred to Swaleside and was immediately located in the inpatient healthcare centre. He was noted to be unhappy about this. He preferred to go straight to a residential wing because he was allowed only a very limited amount of property in his possession in the healthcare centre. At that time, staff noted his diabetes was "well-controlled".

31. The clinical record shows that in November 2003 the man went against medical advice by eating large amounts of fats and sugar. He was noted to have "no concerns or insights into complications and told medical staff 'it's my choice how I die'." Entries in the clinical record also show that he was reluctant to leave his cell to shower, telling staff he would wash in his cell. His attitude towards his hygiene and medical conditions remained unchanged throughout his sentence, and staff continued to advise him with little success.

32. A prison doctor made an entry in the clinical record in December 2003. Wing staff had asked him to see the man on the wing as he had "medical problems". The doctor assessed the problems as non-medical. The man was not washing, bathing or showering and, as a result, he had poor hygiene. He said that all he needed was help with undressing before a shower and dressing after it. Wing staff made it clear to the doctor that, while they agreed his needs had been correctly identified, they did not have the capacity to do these tasks and he should be placed in inpatient healthcare. The doctor disagreed on the grounds that the man did not fulfil the criteria for inpatient healthcare. As the doctor refused to admit him, it was agreed that staff would find ways to cope and approach managers for help if necessary.

33. The prison doctor wrote to a hospital doctor in February 2004. He explained that the man was diagnosed with diabetes mellitus[5], high blood pressure, hypercholesterolemia[6], morbid obesity (body mass index of 49.5), and had a history of myocardial infarction and impaired mobility. The prison doctor set out the medication the man was currently taking and asked the hospital doctor for his advice before making any changes. The clinical reviewer has noted that the man's medication remained almost unaltered throughout his sentence.

[5] Diabetes mellitus is a long term (chronic) condition caused by too much sugar in the blood.
[6] Hypercholesterolemia is an excess of cholesterol in the blood.

34. When located on the residential wings, the man missed a number of appointments to attend clinics in the prison. The clinical reviewer has commented that this might have been due to a combination of his forgetting the appointments and his lack of mobility to go to healthcare. An entry dated February 2004 in the clinical record shows that healthcare staff recognised this, but there was no plan as to how this was to be managed.

35. The clinical record entry of May 2005 shows that healthcare staff were called to help the man as he had fallen and could not get himself back up. He told staff he had just slipped over. He was admitted to inpatient healthcare that day. He had very poor mobility and his obesity had caused areas under his stomach roll to break down. In the short term, these needed dressing with foam and pads for comfort while healthcare considered long term measures. His limited mobility and obesity led to constraints on some nursing care.

36. A Physical Needs Care Plan dated May 2005 was completed following the man's admission to healthcare to manage his deteriorating condition. The nursing action was to monitor the pressure areas, monitor his diet and fluid intake, maintain personal hygiene, and give medication as prescribed. This care was given throughout his sentence.

37. The man returned to the wing in June. Records show that healthcare staff asked wing officers to tell them if there were any changes or concerns regarding his day to day management. It was agreed that wing staff would bring him to healthcare for personal and medical care on "recommended days".

38. A later Physical Needs Plan dated August 2005 identified that the man suffered from ulcers on his leg. The clinical reviewer has observed that his ulcers became inflamed and infected at times, and he was prescribed antibiotics. He was then found to be doubly incontinent at night, and he was re-admitted to healthcare for management. Attempts by specialist continence professionals to address the problem were unsuccessful and this condition continued throughout his sentence. The planned outcome of the care plans was for him to be free from infection and the wounds to heal. This was difficult to achieve because of his incontinence which impaired leg dressings. Throughout 2005, he was appropriately referred to optical, physiotherapy, chiropody and diabetic clinics.

39. In May 2006, healthcare staff sought advice from the specialist Tissue Viability Advice Service as the man's wounds had not healed and there had been a general deterioration. Staff from the advice service visited the prison to make an assessment and the appropriate dressings were ordered. This pattern continued throughout 2006 and regular care plans were put in place and followed. Staff carried out personal care and sometimes bedding had to be changed twice a day.

40. The man's physical health needs were reviewed in July 2006. A care plan identified that he should be encouraged to walk daily using his frame to help his circulation. Standing every few hours and moving to use the toilet was encouraged. The care plan was reviewed again in early August as healthcare staff considered it unrealistic due to his very painful leg ulcers and lack of

mobility.

41. On a morning in July 2006, a nurse went into the man's cell and found him covered in dark vomit. He was taken to the hospital as an emergency at 9.25am but nothing abnormal was found. Later that day, the man said he wanted to review and improve his diet as he wished to stop eating chocolate biscuits and drinking diet coke. A referral to a dietician was suggested.

42. In November 2006, the man replied to a security category review that he wished to be re-categorised from B to D status. This would allow him to move from the closed conditions of Swaleside to an open prison. His reasons were that he had been located in Swaleside inpatient healthcare for the past two years, there was no work available to him at the prison, he was aged 56 years and he "didn't expect to live much longer". Despite falls and a reluctance to accept dietary advice, he was noted to be improving in December 2006. (Later in his sentence in 2008, he was encouraged at HMP Elmley to improve his mobility in order to move to a category D prison. His response was that he was not interested and did not want the conversation to continue.)

43. The man transferred to HMP Elmley in June 2007. The Head of Healthcare at Swaleside told my investigator this was because the Swaleside healthcare unit was undergoing refurbishment following a critical inspection by HM Chief Inspector of Prisons.

44. Throughout the man's stay at Elmley healthcare staff encouraged mobility, assisted in personal care, gave dietary advice to try to reduce his weight, and addressed his medical needs. This assistance was given despite his reluctance to help himself and on a number of occasions his standard of behaviour fell below acceptable levels. However, there were positive entries in the clinical record when he socialised with other prisoners and tried to improve his mobility with encouragement from staff. For example, an entry in April 2008 said that he had managed to walk the length of the healthcare unit and back again with the help of his walking aid. He was noted to be happy with his progress and cheerful in mood. Staff encouraged him to use his wheelchair to wheel himself along the corridors to collect his medication.

45. In August 2008, the man complained of feeling dizzy, with headache, nausea and blurred vision. He was assessed by a prison doctor and sent to hospital. Staff found it difficult to contact the hospital ward to check on his progress. He had a computerised tomography (CT) scan (a specialist x-ray which can show detailed images of structures within the body). He returned to the prison with a diagnosis of a "benign headache" and with no changes recommended in his medication.

46. The man returned to Swaleside in January 2009. The clinical record says his care plan was "re-entered". He appeared to settle back well into the regime in inpatient healthcare. In interview, the Head of Healthcare at Swaleside said that the man was very reluctant to make efforts to be more mobile and he considered that he had not made progress while at Elmley.

47. The man's pressure sores were regularly examined and the Tissue Viability Nurse gave detailed instructions. It was assessed that he might benefit from an air mattress as he was able to move very little while in bed. However, he did not feel confident in using this and a normal foam mattress was used instead.

48. Throughout his sentence, the man spent most of his time in his cell watching television. When he returned to Swaleside, the nurse discovered that he liked playing chess. The nurse knew of another prisoner who also liked to play, and he was asked to play with the man to help him to socialise with others.

49. One of the prison doctors told my investigator and the clinical reviewer that in May 2009 he was called to see the man in healthcare as staff were concerned. The doctor saw that his calf was extremely swollen. He also noticed that he was jaundiced. The doctor arranged for urgent blood tests as he suspected that the man had a deep vein thrombosis. The results arrived the following day and showed that his "dimer"[7] level was high. At interview, the doctor commented that this was the highest level he had ever seen. The clinical reviewer has explained that this suggests thrombosis[8]. The man was admitted to hospital as an emergency. The doctor said that staff made him aware that, at that stage, the man did not wish to be resuscitated. An ultrasound scan performed at the hospital did not give a result and therefore a CT scan was to be carried out.

50. In May, a member of healthcare staff telephoned the hospital to ask about the man's condition. He was told that he still had a thrombosis in his leg and had also been diagnosed with pancreatic cancer. The hospital advised that he should lie as flat as possible and would therefore need to be nursed in bed upon his return to prison. Healthcare had been granted permission by prison managers to allow the man's cell to remain unlocked during the night. It was noted that he appeared not to be aware of his diagnosis and was not to be told at that time.

[7] Dimer levels identify those patients at risk from a stroke.
[8] Thrombosis is a condition where a blood clot forms in a deep vein, usually the leg.

51. While the man was in hospital, a Bed Watch Log[9] entry made at 3.50pm by a prison escort officer,[10] and dated May, says that doctors visited the man. They told him that they believed he had pancreatic cancer and that they would be discussing the best course of treatment for him. Swaleside were "updated" and the details of the man's next of kin (his parents) were given to the escort officers to pass to the doctors. It was noted that he took the news well. (Therefore, contrary to the belief of the prison healthcare staff, he was aware of his situation.) Following a scan to his legs, he was discharged from hospital back to prison.

52. A multi-disciplinary meeting was held at the hospital in June 2009 to discuss the CT scan. A note of the meeting records an initial action plan created by a specialist team of consultants, including a cancer specialist and palliative care nurse, to manage the man's care. The scan had shown "multiple liver metastases,[11] celiac axis nodes[12] and a pancreatic mass". Chemotherapy was considered but assessed as unrealistic as the man had poor kidney function. In the circumstances, he was referred to a hospice in Rochester.

53. In June, the Medical Director of a hospice wrote to the prison doctor. He confirmed that he had visited the man the day before and acknowledged his medical conditions and existing medication. He had completed a Resuscitation Status Form assessing that any resuscitation would be very difficult and inappropriate because of his many illnesses. In his view, the man should have medication available by injection in case of sudden deterioration. He commented that he felt the care at Swaleside to be excellent but, should the man deteriorate, he would look at a transfer to the hospice.

54. The clinical reviewer has noted that in June the man returned to the hospital for a procedure to investigate the spread of the cancer and to help relieve his jaundice. He did not wish to have the procedure and was discharged back to the prison.

55. The prison doctor told my investigator and the clinical reviewer that he knew the man well and was familiar with his medical problems. In respect of his final illness, the doctor thought that the man was surprised to find that he was ill. He said that he was not involved in the decision whether or not he should be resuscitated following a collapse.

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[9] A Bed Watch Log is the written history of time and events while the prisoner is out of prison in hospital.

[10] A prison escort officer is an officer who accompanies prisoners when they go to hospital and remains with them at all times. The officer is responsible for recording details in the Bed Watch Log.

[11] Liver metastases is liver cancer that has formed from cells spreading from an original cancer site elsewhere in the body.

[12] Celiac axis nodes are the lymph nodes.

Events in June

55. A staff nurse arrived on duty early on a morning in June. During interview, she said that she knew the man well. When she arrived, she took responsibility for the healthcare unit. She said that she relieved the member of night staff who was on duty and let them out of the unit because they did not have keys. She recalled returning to the healthcare unit office and sitting down. The staff nurse said she heard loud gasping and hiccupping from his cell as he was experiencing breathing difficulties. She called two prison officers to the cell to observe the situation for themselves. She told them she was sending the man to hospital immediately and they agreed. An emergency ambulance was called and he was taken to hospital. Restraints (a handcuff applied to the man with an escort chain attached to a prisoner officer) were applied in accordance with a risk assessment and the Swaleside restraints protocol document.

56. At around 6.20pm, the Senior Officer (SO), one of the escort officers at the hospital, completed a Review of Hospital Assessment. This is completed when there is a change in either medical or security circumstances. The hospital Medical Assessment Unit had told the escort staff that the man would not be returning to prison as his life expectancy was estimated to be a "few more days". The Duty Governor had been informed, and at 6.40 permission was granted by the Governor for the restraints to be removed.

57. My investigator spoke with the SO who recalled that the man was always very polite and "grateful to you for anything you did". She felt quite sad, but said that she "had a good experience with him." It was very clear to her that he was extremely ill. She had been out to the hospital with him on a number of occasions in the past and she knew him very well. She described his eyes and skin as "really yellow" and said he was unable to move. She took the initiative to ask for the restraints to be removed as it was her understanding that restraints can be removed if they "hinder medical care". In her assessment, removal was appropriate because he had cannulas[13] for different medications.

58. My investigator was impressed with an entry in the Bed Watch Log made by the SO which expanded upon her entry in the Review of Hospital Assessment. She had asked the prison for permission to remove the handcuffs "for the patient's dignity" as he did not pose an escape risk.

59. The doctor from the hospice and the palliative care nurse visited the man in hospital. An entry in the Bed Watch Log confirms that later the same day the Principal Officer (PO) told the officer who was on escort duty at that time that the Duty Governor had instructed that the restraints should be reapplied, pending confirmation of the man's medical condition.

60. A further entry at 4.36pm makes it clear that there was some confusion between the prison's understanding of the man's condition and that of the escort staff. The Log records that Swaleside, "… are of the belief that the man is not terminal

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[13] A cannula is a tubular flexible surgical instrument that is inserted into a cavity of the body to put in or take out fluid.

whilst the medical team on Keates Ward are consistent in the assertion that he is terminally ill and hence will be transferred to hospice care …" This meant that restraints were re-applied while the situation was investigated by the prison.

61. My investigator discussed with one of Swaleside's governors the confusion between the prison and the hospital. He remembered a conversation with escort staff at the time. He said they needed clear instructions. He spoke with the prison doctor who told him that the man was not terminally ill, would not be sent to a hospice, and would be returning to the prison. The doctor's understanding was that his jaundice was caused by a blocked bile duct. Once this had been treated, he would be returning to the prison. The escort staff had told the governor that the man was dying. The governor rang the hospital and spoke to a doctor who "left him in no doubt" that the man was terminally ill. An entry in the Bed Watch Log timed at 6.10pm confirms this. The governor said the restraints were to be removed if he deteriorated further.

62. Although there was a clear prognosis that the man was terminally ill, the restraints were not removed until early June. An escort officer on duty that day spoke with the SO at the prison, who in turn had spoken to the governor. The Bed Watch Log records that the governor said that he did not want the man to pass away in restraints and the officer was instructed to remove the restraints at his discretion. This was done at 9.00am.

63. Having confirmed the prognosis from the hospital, the governor told the escort staff that the necessary administration would be completed for release on compassionate grounds.

64. Staff at the prison had told the man's family he was gravely ill. They also told escort staff that the family would be arriving at around 1.00pm. Nursing staff tried to find a side room for him so he could have privacy with his family.

Compassionate Release

65. The man was granted release on a Special Purpose Temporary Licence from 1.30pm. The following day, the prison faxed an application for Immediate Early Release on Compassionate Grounds to the National Offender Management Service (NOMS). At the request of NOMS, an up to date medical report was completed by the prison doctor. He confirmed that the man was expected to die within hours. An email from the Head of the Public Protection Casework Section, sent at 6.20pm two days later, confirmed that the application had just been approved by the Secretary of State for Justice. Unfortunately, the man had died shortly before.

ISSUES

Clinical review

66. As noted, the clinical review of the man's clinical care was undertaken by the clinical reviewer, General Practitioner and Clinical Adviser to the local Primary Care Trust. She acknowledges that the man was a patient with a number of longstanding medical conditions including diabetes, cerebrovascular disease, kidney problems, high blood pressure and lack of mobility due to his obesity. She observes that, while living in the community, he had a pattern of poor attendance at clinics to monitor his conditions and obtain medication. As a result, his blood pressure was poorly controlled before he went into prison.

67. The clinical reviewer judges that, in general terms, the man's care while in healthcare at Swaleside was exemplary. She notes that the Palliative Care Physician commented specifically on the excellent care he was receiving. The clinical reviewer makes particular mention that:

    "… after years of patient attention to his leg ulcers, staff successfully managed to heal these lesions, which is a significant achievement for such a difficult condition especially in the presence of diabetes and very poor mobility."

68. The man's behaviour was challenging at times and he did not follow medical advice. The clinical reviewer has commented that his poor mobility, incontinence, and reluctance to accept dietary advice provided challenges to the staff. They responded sympathetically as evidenced in the extensive clinical record. I agree with her judgement.

Compassionate release

69. The clinical reviewer has observed that the man's rapid deterioration took prison and healthcare staff by surprise. The Bed Watch Log confirms that the prison knew he was terminally ill and that the paperwork for Immediate Early Release on Compassionate Grounds would be started the following day. It was completed and faxed to NOMS. Further medical opinion was requested and valuable time was lost while this was obtained. The consent for release was signed on the evening the man died.

70. I judge that in all the circumstances the prison acted quickly to obtain release for the man when the prognosis was clear. It is clear that his deterioration was rapid. For those reasons, I do not make a recommendation in this instance.

Communication between the prison and the hospital

71. Poor communication between the prison and healthcare staff was apparent. This was evidenced in the confusion at the prison regarding whether or not the man was terminally ill. The prison doctor was expecting his return; whereas escort staff were in no doubt that he was dying. This affected decisions by senior staff at the prison regarding restraints and delayed the application for compassionate

release. In these circumstances, I am impressed with the SO's decency and sensitivity in assessing the situation and taking the initiative to ask prison managers for permission to remove the restraints.

72. The clinical reviewer has identified that, in the last days of the man's life, information received by the prison was "patchy" and did not clearly inform staff of his imminent death. She has judged that there is room for improvement in communication between the prison and secondary care providers. She has suggested that it would be helpful to have a named member of medical staff at the hospital to provide more continuity in this respect. I have no remit in respect of hospital staff but I consider there is scope for the prison and PCT to initiate improved communications. I therefore make the following recommendation.

    The Primary Care Trust, the Head of Healthcare and the Governor should establish a joint protocol to ensure that, while a prisoner is in secondary healthcare, timely and accurate information is provided to both prison discipline and prison healthcare staff by nominated staff within the secondary care services.

Record keeping

73. In her inspection report, HM Prison Inspectorate commented that a two tier system of recording clinical information existed at Swaleside. She considered that this was because not all staff were fully trained. Paper records were held alongside electronic records. My investigator found this to be the case. The electronic record started in 2006, but a paper clinical record was held alongside that of the electronic system. This creates a confusing mass of information held in two separate locations. There is potential for vital information to be overlooked by healthcare staff who use the electronic system if they do not also access the paper records. This is particularly relevant as the Head of Healthcare has indicated that the healthcare unit employs a high number of agency staff.

    The Head of Healthcare should ensure that all staff are trained in the use of the EMIS electronic system and use this method of clinical record keeping at all times.

Restraints

74. The man had serious mobility problems and was unable to care for himself. In these particular circumstances, I question whether the continuing use of restraints at the hospital was appropriate. I am pleased to note that one of the escort officers initiated the process for removal of the restraints on the day of his admission to hospital. However, they were subsequently re-applied. In spite of some initial confusion about his diagnosis, it was clear to prison managers that his condition was terminal and that he was a dying man. I am conscious that protection of the public is uppermost. Nevertheless, I judge that when his prognosis was in no doubt and the application for release on compassionate grounds was made, the restraints should have been removed from him. This was not done until later. As I have recorded in all too many other investigation

reports, a prisoner who was incapable of movement was unnecessarily denied a measure of dignity in his last days.

The Governor should ensure that restraints are removed at the earliest possibly opportunity, particularly when there is clear evidence that a patient is immobile and/or following a diagnosis of terminal illness with a very short life expectancy.

CONCLUSION

75. As a result of various ailments, the man required a high level of personal and medical care throughout his time at Swaleside. In spite of his challenging behaviour and his failure to adhere to dietary advice, staff dealt with him professionally and sympathetically. Indeed, they successfully treated his leg ulcers, a condition that is very difficult to heal. It was clear to my investigator that healthcare staff who tended to him on a daily basis, and those discipline staff who knew him, were fond of him.

76. The discovery and diagnosis of the man's pancreatic cancer was made only two weeks before his death. His deterioration just over a week later was rapid. This left staff in some confusion about his life expectancy and this, in turn, affected the prison's timeliness in removing restraints and obtaining his release on compassionate grounds.

77. I agree with the clinical reviewer that the care given by staff at Swaleside was exemplary, and judge that it exceeded that which he would have received in the community. Nevertheless, I draw attention to those areas which could be improved: namely communication with secondary care services, recordkeeping and the use of restraints. I make recommendations accordingly.

RECOMMENDATIONS

1. **The Primary Care Trust, the Head of Healthcare and the Governor should establish a joint protocol. This is to ensure that, while a prisoner is in secondary healthcare, timely and accurate information is provided to both prison discipline and prison healthcare staff by nominated staff within the secondary care services.**

   Accepted. A member of Prison Healthcare will liaise with the ward manager or the deputy ward manager on a frequent basis to ensure that information on the welfare of the patient is accurate and timely.

2. **The Head of Healthcare should ensure that all staff are trained in the use of the EMIS electronic system and use this method of clinical record keeping at all times.**

   Accepted. All staff in healthcare are now trained and using the EMIS electronic system.

3. **The Governor should ensure that restraints are removed at the earliest possible opportunity, particularly when there is clear evidence that a patient is immobile and/or following a diagnosis of terminal illness with a very short life expectancy.**

   Accepted. A new policy is in place where a prisoner is assessed in the morning senior management team meeting to evaluate their risk and circumstance of an individual who is out on a bed watch and whether there is a need to remove the cuffs from that individual.