

**Investigation into the death of a man in June 2007
while in the custody of HMP Doncaster**

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

September 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Doncaster, who died in June 2007. A post mortem recorded his death as due to peritonitis, caused by a perforated stomach ulcer. He was 44 years old and had been in custody for less than two weeks. I offer my condolences to his family and to all those affected by his death.

This investigation was carried out by one of my investigators. A clinical review of the man's medical care at Doncaster was carried out by a clinical reviewer. The report has been greatly delayed because, after he died, South Yorkshire Police began an investigation which went on for nearly three years. In accordance with our agreement with the police, our investigation was postponed until their enquiries were complete and we had received the relevant records from the police investigation.

The man had reported stomach pain for several days before his death. He had been treated with pain relief medication, and in June was found by his cell mate, apparently dead. During the previous evening the nurse who attended him had given him additional pain relief. She had tried to persuade the out of hours doctor to come and see him but he had declined. Nor was she able to persuade the doctor that he should go to hospital. Subsequently the nurse, apparently worried that his death might have been connected with his medication, falsified the clinical record.

The clinical review concludes that the man's care was exceptionally poor and that his death was a potentially avoidable incident. I agree. Although there is no evidence that this was connected with his death, I am also concerned that emergency cell bells were not operating properly at the time. The nurse who falsified the record was subsequently investigated by her employer and action taken. A doctor concerned with the case was prosecuted by the police for an associated matter, although there were no prosecutions in relation to the man's death. Although five years have elapsed since his tragic death, the Director of Doncaster and the current health care provider need to ensure that appropriate lessons have been learned and there can be no repetition of such failures in the prison's duty of care.

The recommendations made in the draft report have been accepted by HMP Doncaster. I have included the prison's response to the recommendations at the end of this 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.

SUMMARY

1. The man was born in 1962. He was 44 years old when he died in June 2007 at HMP Doncaster. He died of natural causes as a consequence of peritonitis¹ caused by a perforated stomach ulcer.
2. He was received into custody at Doncaster on 15 June 2007 after being sentenced to two months imprisonment at Magistrates' Court for driving offences.
3. At his health screening interview, he informed staff that he had attempted self-harm when he was much younger. Subsequently a self-harm observation and support plan was opened but was closed the next day, on 16 June, when he appeared more accepting of his situation and the risk of self-harm was thought to be low. It was also noted that he had been taking prescribed pain killers (dihydrocodeine) for the past 22 years after injuring his right hip when a car fell on him. As his medication was opiate based (and can be used as currency in prison), he was prescribed alternative pain relief medication (diclofenac and co-codamol) by the prison doctor. This was reviewed on 19 June, after he complained of experiencing side effects from taking the new pain relief medication. His medication was changed back to the prescription he been receiving before he arrived in custody.
4. During the late evening of 24 June, the man complained of stomach pain. He was seen by healthcare staff throughout the following day and night. In the early hours of 26 June, staff responded to an emergency cell bell. They were told by his cellmate that he thought he had died. Staff called for medical assistance and attempts were made to resuscitate him, these were continued by paramedics. Unfortunately, the attempts were unsuccessful and he was pronounced dead at 1.59am.
5. After the man died, the prison activated its death in custody contingency plan. The police were informed and they visited Doncaster. The Coroner's officer informed the Head of Internal Affairs, who was managing the prison's response following the man's death, that he had died from natural causes.
6. The clinical review carried out by the clinical reviewer considered the care provided to the man throughout his time in prison. In his view, the care provided to him was "poor and possibly negligent". The reviewer does not make any specific recommendations. However, we make six recommendations based on the information provided in the clinical review and from our own investigation. These relate to seeking information from a prisoner's General Practitioner when they arrive in custody, ensuring information relating to prescriptions and observations

¹ Peritonitis is an inflammation (irritation) of the peritoneum, the thin tissue that lines the inner wall of the abdomen and covers most of the abdominal organs.

is clearly recorded, referral to hospital, and the maintenance of cell call bells.

THE INVESTIGATION PROCESS

7. The investigator was formally notified of the man's death on 27 June 2007. Notices were subsequently issued to both staff and to prisoners at HMP Doncaster informing them of the investigation process and asking anyone who had relevant information to contact the investigator. No one came forward. He examined all the man's relevant prison records including his medical records.
8. A clinical reviewer was commissioned to carry out a clinical review of the medical care the man received during his time in custody. The purpose of the review was to establish whether the care which he received in prison was comparable with that he would have been offered in the community and to identify any points of learning. The reviewer's report was not received until 8 March 2012, following the conclusion of the police investigation.
9. The investigator visited Doncaster on 5 July 2007 and discussed aspects of the man's treatment with staff at the prison. He interviewed the man's cellmate. He was able to provide background information about him and the events leading up to his death.
10. The investigator returned to Doncaster on 10 August to meet with a team of detectives from South Yorkshire Police who had started an inquiry. The police officer leading the inquiry asked that the Ombudsman's investigation be suspended until their investigation, and any subsequent court proceedings, had been concluded. The police agreed to share the information they gathered, including the witness statements. The police investigation was eventually closed in July 2010 but despite a number of requests from this office, papers relevant to the Ombudsman's investigation were not received until November 2011, at which time they were shared with the clinical reviewer. We regret this considerable delay and any additional distress this may have caused the man's family.
11. The investigator contacted Her Majesty's Coroner to inform her of the nature and scope of the investigation and to request a copy of the post mortem report. This investigation report will be sent to the Coroner to assist in her enquiries.
12. One of the Ombudsman's family liaison officers contacted the man's partner and one of his sons, as his listed next of kin, at the outset of the investigation in 2007. They were told about the Ombudsman's investigation and its suspension in light of the ongoing police enquiries. Some months later, another of the man's sons instructed a solicitor. He raised the following issues for consideration as part of the investigation at such a time when the Ombudsman was able to proceed with his independent investigation. He was concerned that prison staff failed to act when his father rang his cell bell to complain about stomach pain before his death. During telephone calls home, he had said he was not

getting food, and his son was concerned this might have led to problems with his existing stomach ulcer. His son said he last saw his father five months before he died when he looked in good health and his father did not refer to any health problems in correspondence with him.

13. The man's family and their legal representative received a copy of the draft report. No further representations were made in response to the findings.

HMP DONCASTER

14. HMP Doncaster is a privately run local prison, holding remand and sentenced prisoners, operated by Serco Home Affairs. Local prisons serve magistrates and Crown Courts in their area and hold prisoners detained before trial and after conviction. The accommodation at Doncaster is arranged in three identical triangular shaped houseblocks, each with four wings. There are 95 prisoners on each wing with cells arranged on two levels. Doncaster holds up to 1,145 prisoners.
15. At the time of the man's death the healthcare provider was Serco Health. More recently, Nottinghamshire NHS Trust has become the healthcare provider at Doncaster. The healthcare centre is based on two floors. A 19 bed in-patient unit is located on the upper floor with primary healthcare services on the lower floor.
16. There were two other deaths at Doncaster in 2007 and, in one of those investigations, the issue of ensuring information is accurately recorded in medical records was also raised. Since 2007, this office has made a number of recommendations to Doncaster about the standard of clinical record keeping.

Doncaster's emergency procedures

17. Emergency codes are used at Doncaster to summon staff to deal with a prisoner who requires immediate attention cannot be taken to the healthcare centre for treatment. The codes allow the medical staff to respond with appropriate equipment:
 - Code red: Unconscious, not breathing, in collapsed state – immediate response required.
 - Code amber: Blood evident, has had medical crisis but in recovery, in recovery position/immobile, may be conscious but in a confused state.
 - Code green: Patient fully conscious, no blood evident – injured, no signs of distress can verbalise but requires assessment, non urgent, minor illness and injury.
18. The general alarms are linked to the control room. When the button on a wing landing is pressed it registers in the control room and is broadcast over the radios throughout the establishment so that staff from other areas can respond to the alarm in that location.
19. Emergency bags are located around the prison. They contain life support equipment, which includes airways, ambu bags (breathing aid), oxygen, needles and syringes. There are also 12 defibrillators. A defibrillator measures electrical activity in the heart and issues audible instructions about treating the patient including, when appropriate, delivery of an electric shock. A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the

electrical activity in the heart and gives automated instructions to the rescuer.

Police investigations of deaths in custody

1. With all deaths in prison custody, the police are notified by the prison as soon as the death is discovered. It is only when the police are satisfied that the death is not suspicious, or complete their own enquiries, that the Ombudsman's investigators can conclude their investigation.

KEY EVENTS

2. The man was born in 1962 in Yorkshire. He was father to five children with whom he had regular contact. He had previously been married but this relationship had ended. He had suffered poor health for a number of years. He had been crushed when a car fell on his right hip, over twenty years previously, and he also had a history of arthritis.
3. The man was convicted on 15 June 2007 and sentenced to two months imprisonment at Magistrates' Crown Court. He arrived at HMP Doncaster on the same day. He had a long history of offending going back to his early teenage years, but this was his first time in prison.
4. During his first reception health screening interview (this interview highlights any immediate mental or physical health problems requiring referral to the doctor or other specialist service) it was recorded that he had been taking prescribed pain killers (dihydrocodeine - an opiate based pain relief medication) for the past 22 years. One of the prison doctors changed his pain relief medication and prescribed diclofenac (a non steroidal anti-inflammatory drug used to treat pain and inflammation associated with arthritis) and co-codamol (a combination of codeine and paracetamol which is prescribed for moderate pain). The doctor prescribed alternative pain relief medication as a substitute because of the security concerns surrounding prescribed drugs in prison, the risk of medication being stolen or traded and the addiction and abuse potential of his previous pain relief medication which was opiate based. Staff at Doncaster did not attempt to contact his doctor in the community to confirm what medication his General Practitioner (GP) had prescribed.
5. During his health screening interview, it was noted that the man appeared shocked at being sent to prison. He was very tearful, was concerned about his partner and was unable to confirm whether he would harm himself. He told staff that he had previously attempted to harm himself, but this was over 20 years before. Because staff were concerned that he might be at risk of suicide and self harm, monitoring procedures were started. These were closed the next day when it was decided, after observation and discussion, that he was a low risk. The following day, 17 June, he moved to double cell (3:22) on Houseblock 3B which he shared with another prisoner.
6. On 19 June, the man completed an application for a healthcare appointment. When he was seen by a nurse, he complained that he was experiencing stomach pains which he felt were being caused by the diclofenac tablets (a side effect of the medication can be problems affecting the gut such as abdominal discomfort, gastric and peptic ulceration). The nurse noted in his medical record that he had not been taking his morning and afternoon medication for three days and that she referred him to the prison doctor for a medication review. The following day, he was seen by a doctor who noted that his medication was

causing side effects, and changed his pain relief medication back to dihydrocodeine.

Events from 24 to 26 June 2007

7. Four days later on 24 June at around 11.00pm, Prison Custody Officer (PCO) A was in the wing office in Houseblock 3 when she saw a cell call light monitor in the office for the B wing landing (the audible alarm was not working, although a light also illuminated outside the cell). It is not clear how long the light had been illuminated. She responded immediately she saw it and was informed by the cellmate that the man was in pain and had been for a while.
8. The officer thought that the man, who complained of stomach pain, looked in agony and appeared pale. He asked another colleague, PCO B, to come to the cell and they radioed for medical assistance. Two nurses arrived quickly and entered the cell. They recorded: "No nausea or vomiting reported. Stated bowels are regular and has also not been eating well lately". His blood pressure was recorded as 110/70 (this is quite low as most adults in the UK have blood pressure readings in the range from 120/80 to 140/90) and his pulse was recorded as 62 (normal pulse rate is between 60 and 100 beats per minute). He was given his medication (60mg of dihydrocodeine) and the nurses then left his cell.
9. Both officers were still concerned about the man so they looked in on him throughout the night. Officer A went to see him when he pressed his cell bell at around 2.00am. He said his pain was getting worse. She informed the healthcare staff and Nurse A immediately responded. He administered (via an injection) further pain relief medication. After approximately 30 minutes, Officer B returned to the cell to check how he was and he said it was easing off, but not getting a lot better. Observations were taken at this point by the nurse and his blood pressure was still low (110/65) and his pulse (85) was still within normal range. According to staff, during the rest of the night he seemed a lot more relaxed, but he was in and out of bed all night.
10. On the morning of 25 June, a doctor saw and assessed the man after a referral from Nurse B. It was documented in his medical record that he was suffering from abdominal pain due to the side effects of his previous medication (diclofenac). The doctor decided that he was suffering from a peptic² ulceration as a result of his medication. He prescribed 60mg of lansoprazole to suppress stomach acid production and 10mg of metoclopramide (medication used to suppress nausea and to treat heart burn). The doctor did not document his blood pressure or his pulse readings.

² A peptic ulcer is an area of damage to the inner lining (the mucosa) of the stomach or the upper part of the intestine (duodenum).

11. When interviewed as part of this investigation, the cellmate recalled that when the man woke up that morning (25 June) he did not want to get up. He lay on his bed for most of the day and did not eat anything all day. He told him that he could not feel his legs, although he could wriggle his toes. As he was feeling too unwell to collect his medication Nurse C, took it (60mg dihydrocodeine) to his cell at around noon.
12. At about 5.00pm, during the evening houseblock medication rounds, Nurse C visited the man in his cell and again gave him 60mg of dihydrocodeine. The nurse reported that he was still experiencing abdominal pain, but he said the pain had not got any worse since he had seen the prison doctor earlier in the day. The nurse noted that he appeared to be sweaty and clammy, and was also very pale. He did not document his blood pressure or his pulse readings.
13. Around 5.30pm, Nurse C went to see the duty nurse and said that, because of his concerns about the man, he was going to refer him back to the doctor's clinic in the morning. At 7.45pm, the duty nurse was called to the wing to see him and went there immediately. She recorded that he looked slightly sweaty but his colour appeared normal. He told her that the pain in his stomach was still bad but no worse than earlier. He said he had not had any nausea and had not vomited. She told him that she was going to telephone the duty doctor for advice and that she would return shortly.
14. The duty nurse rang the doctor's mobile three times but did not get a response. She then rang his home phone and also did not get a response. She decided to refer to the British National Formulary to clarify what additional medication she could administer. (This is a medical and pharmaceutical reference book used by doctors and by other healthcare professionals to help them use drugs optimally to care for patients as appropriately as possible.)
15. At around 7.50pm, the duty nurse decided to administer 120mg of slow release dihydrocodeine. After she administered the medication she informed the man that she would contact the prison doctor and get back to him. She did not document his blood pressure or his pulse readings. She noted in his medical record that he had abdominal pain and she wrongly formed the opinion that he appeared to be displaying symptoms of opiate withdrawal. She also noted that he appeared to have been taking large amounts of his medication (dihydrocodeine) before he came into custody.
16. When the duty nurse returned to healthcare the telephone was ringing and it was the doctor. She told him about the man and informed him about what medication she had given him and her opinion that his symptoms were as a result of his withdrawal. The doctor accepted her opinion and was satisfied with the medication she had prescribed, but told her if the pain continued to administer a further dose of 60mg of dihydrocodeine. She tried to explain to the doctor how much pain the

man was experiencing, but she was unable to convince him to attend the prison. She wanted to send him to hospital, but the doctor did not agree.

17. Further checks throughout that evening by residential staff appeared to suggest that the man, while still feeling unwell, had been able to get some sleep. The officers assumed that, because he had been seen by healthcare staff, he was recovering. There was nothing in his medical records to suggest that there was any plan for further observation throughout the night by healthcare staff.
18. At around 10.45pm, the Unit Manager was assisting in escorting newly arrived prisoners to Houseblock 3B. While he was on the upper landing he noticed that the man's cell call light was on. It is not clear how long it had been illuminated. He opened the cell door observation flap and he cellmate told him that the man was feeling unwell. The Unit Manager asked the man if he had been seen someone from the healthcare, but he could not understand his reply. He then went to the wing office and confirmed with an officer that he had already seen a nurse.
19. At around 11.30pm, due to his concerns about the man's health, an officer went to check on him. He noted that both the man and his cellmate appeared to be asleep. The officer assumed that the medication given to the man by the nurse had now taken effect and settled his stomach. He checked on the other prisoners on the houseblock before returning to the wing officer to continue with his duties.
20. When interviewed, the cellmate recalled that he rang the cell bell on at least three occasions on 25 June and the response to this only resulted in the man being given more medication. He remembered that as the day progressed the man's condition deteriorated. His eyes were rolling back in his head and his speech was slurred. After they had been locked in for the night he lay on the top bunk and watched television. The last thing he heard before going to sleep was the man's breathing.
21. The cellmate recalled waking up a few hours later and the television was still on. He checked on the man and could not see his stomach moving or whether he was breathing. He called out his name a couple of times but got no response. He then jumped out of bed and switched the cell light on. He shook the man's arm, which was cold and limp, and called his name again but could not rouse him. He was concerned something was seriously wrong and immediately pressed the cell bell, banged on the cell door and called for assistance.
22. At approximately 1.20am an officer noticed that a cell indicator light was lit; he went to the wing and saw the light was lit outside the man's cell. When he got to the cell the cellmate said, "He's dead". The officer

radioed for a medical response (Code red). He then opened his sealed key pouch³ and, as the response team arrived, he entered the cell.

23. The officer was unable to rouse him and could not find a pulse or evidence that he was breathing, so began cardio-pulmonary-resuscitation (CPR)⁴, assisted by the Unit Manager. They were joined by the officer in charge of the prison at that time and two nurses, who brought a defibrillator with them. The medical staff then took over the man's care and continued CPR, as the defibrillator did not advise giving an electrical shock.
24. The cellmate was initially asked to wait outside the cell on the landing and he was then taken downstairs to the ground floor of the wing while attempts to resuscitate the man continued. He was given some tobacco to smoke and moved to another cell for the night.
25. A Night Patrol Officer requested an ambulance via the prison communication system. The records show that the ambulance was requested at 1.24am and a follow up call was made at 1.44am when they were informed it was on the way but delayed because of flooding. An officer went to meet the ambulance and escort the paramedics to the cell. When paramedics arrived, at 1.51am, they took over his care. Attempts to resuscitate him were unsuccessful and he was pronounced dead at 1.59am.
26. Due to the extreme weather and flooding in South Yorkshire at the time of the man's death, the prison chaplaincy asked a parish pastoral worker to inform his family of his death, which they did. A prison chaplain was appointed as the prison's family liaison officer. He maintained contact with the family and assisted with the arrangements for the funeral. The prison provided financial assistance towards the funeral costs in accordance with national guidance. A memorial service was later held by the chaplain at the prison. The funeral took place on 23 July 2007.
27. Prisoners were informed of the man's death during the morning and asked whether they required any additional support. All the prisoners who were subject to self-harm and suicide monitoring were reviewed. Prison managers also held a 'hot debrief' for staff immediately involved to share information and provide reassurance and support.

³ After the evening roll call to confirm prisoners are all accounted for, the prison enters what is called patrol state. The main role of the small number of staff on duty at this time is to maintain the security and safety of the prison. Officers on wings carry cell keys in a sealed packet for emergencies.

⁴ Cardio-pulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

28. The post mortem report records the man's death as being due to natural causes, as a consequence of peritonitis, caused by a perforated duodenal ulcer. The report says:

“The dihydrocodeine was at levels higher than may be expected with therapeutic use, but not at fatal levels. The diclofenac is at levels likely to represent therapeutic range use. This person was on pain killers for a hip problem. He had been complaining of abdominal pain in the days before his death. Post mortem examination showed his death was due to a perforated duodenal ulcer. All the symptoms he complained of can be accounted for by the presence of the duodenal ulcers with subsequent perforation. Toxicology showed use of diclofenac and dihydrocodeine. The concentration of dihydrocodeine probably reflects long term use with levels possibly altered by post mortem redistribution. The presence of high dihydrocodeine would prevent opiate withdrawal symptoms.”

ISSUES

Clinical care

29. A review of the man's medical care was undertaken by a clinical reviewer. He reviewed the medical notes and the interventions of healthcare staff.
30. In his review, he recorded that although the man had informed staff when he first arrived at the prison that he was taking medication for pain relief, this was not checked or collaborated with his own doctor. The prison doctor prescribed alternative medication as a substitute because of the potential for abuse of his own pain relief medication. The prison should have made an effort to obtain his community GP records to help ensure continuity of care. We make the following recommendation:

The Head of Healthcare should ensure that previous General Practitioner records are routinely requested when a prisoner arrives in custody so that a full history is available to prison healthcare staff.

31. The man complained that the new medication gave him abdominal pain. The clinical reviewer recorded that this would be possible as a side effect of anti-inflammatory medications. When he was seen by the prison doctor he reinstated his previous pain relief medication. However, the clinical reviewer could find no evidence that routine observations (blood pressure and pulse rate) were taken.
32. The man continued to complain to healthcare and prison staff that his abdominal pain was not improving. On the night before he died, he complained of increasing stomach pain, and was given an intra-muscular injection of diclofenac by the nurse on duty. This is recorded in his medical records as being upon a verbal order from an on-call doctor. Neither the clinical reviewer nor the investigator could find any evidence of this drug administration being recorded on a prescription chart at the time, or at any other time. There was also no evidence that the nurse on duty had informed, or indeed been asked by the doctor on call, for any pertinent history relating to his condition. His pain eased off following this injection, but he was obviously still in a great deal of discomfort throughout the night.
33. The following morning, the man was reviewed by the prison doctor, who recorded that he was suffering from abdominal pain as a side-effect of his previous diclofenac medication. The doctor diagnosed peptic ulceration and prescribed lansoprazole and metoclopramide. There is no evidence in the notes that his blood pressure or pulse rate was checked. There was also no evidence that the prison doctor had arranged for further review of him to check on his progress.

34. The man's cellmate reported that he was uncomfortable for most of the day, could not eat anything and remained on his bed. That evening he was visited by a member of the healthcare staff, whom he told that he was still having abdominal pain. The nurse noted that he was sweaty and clammy, and also very pale, but there is no record that the nurse measured his blood pressure or pulse rate. The nurse informed a colleague about her concerns regarding him, and that she intended to refer him back to see the prison doctor the next morning. Later that evening prison staff informed the nurse that he continued to be unwell. The nurse examined him and found that the pain in his stomach had persisted but that it was no worse than before. It was recorded that he looked sweaty but appeared to be normal in colour.
35. In his review, the clinical reviewer records that he was unsure whether the nurse actually examined the man or whether she simply viewed him through the observation hatch in his cell door, the records do not make this clear.
36. The nurse phoned the on-call doctor for advice but even after several attempts she received no response. She decided to administer 120mg of slow-release dihydrocodeine to the man. It is not clear whether the nurse actually administered his medication or whether she gave it to him through the observation hatch in his cell door. When the nurse returned to the healthcare centre the telephone was ringing and it was the on-call doctor. She told him about the man's condition and what medication she had given. Neither the clinical reviewer nor the investigator could find any evidence on a prescription chart that this dose of medication was recorded. The on-call doctor informed the nurse that, if the pain continued, she should administer a further dose of dihydrocodeine. We make the following recommendation:

The Head of Healthcare should ensure that full information relating to prescriptions and clinical observations are clearly recorded in a prisoner's medical record so that ongoing monitoring is effective.

37. The nurse attempted to explain to the doctor how much pain the man was in, but she was unable to convince him to attend the prison and examine him, or to agree that he should be taken to hospital. While we understand why the nurse might have believed she had to defer to the doctor's opinion, we consider that if she had sufficient concerns then she should have arranged for him to be taken to hospital rather than relying on the views of a doctor who had not examined him at that time. It is likely that if he had been in the community he would have gone to a local hospital's Accident and Emergency department. We make the following recommendation:

The Head of Healthcare should ensure that nurses understand they should use their own professional judgement, in the patient's best interests, when deciding whether a prisoner needs to attend hospital.

38. When the duty nurse was interviewed by the Head of Internal Affairs at Doncaster, she admitted that she altered the man's "Prescription and Administration Record Chart", indicating that he had refused his medication on three occasions on 25 June (AM - Refused, Noon - Refused and PM - Refused) whereas he had actually received the medication. As she had altered the original entry she was suspended from duty on 29 June pending the outcome of both internal and external investigations (she returned to duty in December 2008).
39. It is not clear why the nurse altered the chart although it was surmised that she may have thought that the man's death has been caused by an overdose of the medication she had administered.
40. The clinical reviewer concludes that the man's death from a perforated duodenal ulcer was "a potentially avoidable incident". In the clinical reviewer's opinion the evidence "points to a systemic failure in the quality of healthcare provision to this patient during this extremely unfortunate incident". He finds examination recordings do not include any evidence of blood pressure nor pulse reading being taken.
41. In the post mortem report is recorded that the level of dihydrocodeine in his blood stream was at a level high enough to preclude that he was suffering from opiate withdrawal. There was also no evidence that the man had taken any illicit medication. The clinical reviewer writes:

"Intra-muscular diclofenac should not have been administered, in my opinion, given the history of the patient's presenting complaint. Throughout all of this incident there is a general paucity of clear recording of prescriptions, and in some cases a complete absence of such at all. There is an absence of a clear management plan in the notes regarding review of this patient, more especially when his condition was deteriorating. The presumption that his on-going symptoms were entirely due to opiate withdrawal is not backed by any visibly recorded observation. An acute abdomen presentation in opiate users can be difficult to diagnose, but the possibility of such should have been considered, given the nature of the patient's presentation."
42. The man had been ill for a number of days and was clearly in a lot of discomfort. Neither the reviewer or the investigator can find evidence that the option of sending him to outside hospital was considered in the days leading up to his death, although it is something the duty nurse discussed with the on-call doctor on the night before the man died. Admission to hospital could possibly have led to his underlying condition being diagnosed and treated. In summary, the clinical reviewer concludes:

“The on-call doctor should have visited the prison to examine the patient when requested by the duty nurse. The fact that her diagnosis lacked any evidence of physical findings should have alerted the doctor that a visit was essential to confirm or refute the diagnosis. The alteration of the patient’s prescription chart is obviously unprofessional and illegal. In summary, I find the level of care provided to be poor and possibly negligent.”

We make the following recommendations:

The Head of Healthcare should ensure that patients are considered for referral for hospital treatment whenever there is ongoing pain, the reasons for which are not fully diagnosed.

The Head of Healthcare should ensure that the out of hours doctor attends the prison whenever a nurse requests this, unless the doctor decides that immediate referral to hospital is necessary

Emergency Cell Bell

43. The cell bells at Doncaster should provide an audible alert in the wing office in addition to a light illuminating outside the cell. The audible alert on the man’s cell bell was not working, although the light was. We are concerned that there was too much reliance on staff to notice the light in order to respond to the bell. We do not know whether this caused any delays in responding to bells but clearly this is a risk. While these events occurred some time ago it is important that emergency cell bells function properly at all times. We make the following recommendation:

The Governor should ensure that cell bells are in good working order at all times, so that there is a timely response in the event of an emergency.

CONCLUSION

44. The man arrived at Doncaster on 15 June 2007 and died of peritonitis just under two weeks later. He had a long history of taking prescribed pain relief medication following an injury to his hip. Following his death, the police carried out an investigation at the prison. The investigation by the Ombudsman's office was suspended for a considerable time while the police carried out their enquiries. The police investigation concluded in July 2010 and a doctor was prosecuted for offences uncovered during the investigation but not related to the man's death. A member of healthcare staff was suspended after he died but she returned to duty at Doncaster in December 2008 after an investigation by her employers.
45. In light of the findings of our investigation, and the clinical review, we conclude that the standard of the man's medical care was very poor and did not reflect the standard of care he could have expected to have received in the community.
46. Although the events described here happened five years ago, we make six recommendations which will need to be addressed by the Director of Doncaster and the current healthcare provider, these aim to ensure there can be no repetition of such circumstances and that lessons from the man's tragic death have been learned.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendation. That response is included in italics below the recommendation.

1. The Head of Healthcare should ensure that previous General Practitioner records are routinely requested when a prisoner arrives in custody so that a full history is available to prison healthcare staff.

Partially accepted - Current practice; when prisoners present with any medical problems or on current prescriptions a request is made with their GP for any information that is pertinent to their care, they are then booked in to see the GP within 48 hours. Following consultation should the GP require it a full medical history is requested. Obtaining a full medical history for all new arrivals would be beyond the capacity of our current team.

2. The Head of Healthcare should ensure that full information relating to prescriptions and clinical observations are clearly recorded in a prisoner's medical record so that ongoing monitoring is effective.

Accepted - All staff have completed an e-learning module on clinical observations. All staff to be given a copy of the NMC record keeping guidance – a record of staff signatures to be kept as evidence they have received the guidance and that they agree to adhere to it. All staff will complete the IG and record keeping e-learning modules – a training record will be kept and progress monitored through the OH Yorkshire Business Meeting. All supervisors as part of clinical supervision will review the standard of record keeping in at least two sets of clinical notes of the supervisee, supervision records to be audited on a six monthly basis to ensure compliance. An annual record keeping audit will be undertaken by the Forensic Audit Team.

3. The Head of Healthcare should ensure that nurses understand that they should use their own professional judgement, in the patient's best interests, when deciding whether a prisoner needs to attend hospital

Accepted - Improved clinical supervision provision and training for staff is progressively improving the confidence of front line staff. An on-call manager system is also now in place made up of senior clinical staff to provide additional support where necessary. Message to be reinforced at team meetings and documented in meeting minutes

4. The Head of Healthcare should ensure that patients are considered for referral for hospital treatment whenever there is ongoing pain, the reasons for which are not fully diagnosed.

Accepted - The Head of Healthcare to review the observations standard operating procedure providing clear guidance on when patients should be sent out to hospital for further investigations were a complete diagnosis is not available to nursing staff.

5. The Head of Healthcare should ensure that out of hours doctor attends the prison whenever a nurse requests this, unless the doctor decides that immediate referral to hospital is necessary

Accepted - A change of GP provider has taken place since this incident and no problems have been encountered when GPs have been asked to attend. Should such an occasion arise now there is an on-call managers rota which includes an escalation process should there be a need for intervention by a Senior Manager.

6. The Governor should ensure that cell bells are in good working order at all times, so that there is a timely response in the event of an emergency.

Accepted - The Local Security Strategy at 3-01 has been further amended at paragraph 5 to show the following: "The cell call light must be checked daily and reported immediately if not working correctly and the prisoners moved from the cell if it can not be repaired. The check must confirm that the cell call lights up and is visible on the wing and audible in the bubble. At paragraph 8 it states the following: The Unit Manager must ensure daily that these examinations have been carried out."