

**Investigation into the circumstances surrounding the  
death of a prisoner at HMP and YOI Doncaster  
on 5 September 2006**

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

**January 2007**

This is the report of an investigation into the death of a prisoner who died at HMP/YOI Doncaster on 5 September 2006. The post mortem indicates that the prisoner was 59, died of ischaemic heart disease caused by coronary artery atheroma, complicated by diabetes and a fatty liver.

I offer my condolences to all those who knew this man. On reception into prison, had not nominated a next of kin and, despite the best efforts of the prison and the police, no relatives of the prisoner have been identified. My investigator has therefore been unable to establish if there are any family issues or concerns surrounding the circumstances of the man's death.

I am grateful to the Director of Doncaster prison and his staff for their co-operation during this investigation. I am also indebted to the Central Doncaster Primary Care Trust for providing the clinical review into the prisoner's care and treatment whilst in custody.

When he was received at Doncaster, the man was noted to be a type 1 diabetic (insulin dependent). It was also recorded that he had a heart condition. Because of the state of his physical health, as well as concerns over his mental wellbeing, he was located in the prison's healthcare wing.

I judge that Doncaster offered the prisoner a standard of support and care that he might well not have received in the community. I concur with the clinical reviewer, that the man's diabetes was managed reasonably successfully in spite of his non-compliance. I am also content that reasonable efforts were made to assess and treat the prisoner's mental health, although I appreciate that these efforts were rebuffed by him. In view of the way in which the prisoner managed and used his diabetes, it appears that his death was almost inevitable irrespective of whether he was in prison or not.

I am aware that the Coroner has set a very tight timetable for the inquest into this man's death, and this report has been completed with that in mind. In general, I welcome more timely inquests, although the proper requirements upon my office to engage and involve bereaved relatives, and to allow both the family and the service in remit to comment on draft reports, mean that most of my investigations cannot be finalised so soon after the death itself. Had any of the prisoner's relatives been traced and had they raised matters they wished me to explore, this report would inevitably have taken longer to complete. I am also very reliant upon the timeliness of Primary Care Trusts in carrying out the clinical reviews.

I have made five recommendations in this report, three of which are operational and were identified by the prison following the prisoner's death. The clinical reviewer has

also highlighted issues in regard to maintaining medical records (a problem that is by no means unique to Doncaster).

The prisoner appears to have led a sad and solitary lifestyle that brought him into frequent contact with the criminal justice system. It seems he was the sort of petty but persistent offender whom no-one believes really needs to be in prison, but for whom no-one seems to be able to provide a satisfactory alternative. Although I am not in possession of the full details, I understand that at the time of his death the man was serving an 18 month sentence for breaching an Anti-Social Behaviour Order (ASBO) by begging in public. That very fact surely speaks for itself.

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

**January 2007**

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## SUMMARY

At about 9.25am on 5 September 2006, the prisoner was discovered by staff to be unconscious and unresponsive in his cell in the healthcare wing at HMP and YOI Doncaster. Staff began cardio pulmonary resuscitation but, despite their efforts and those of the paramedics, the man was pronounced dead at about 9.40am. He was 59 years old.

The prisoner had served in excess of 80 prison sentences of varying lengths. On 2 June 2006, he was received at Doncaster as a remand prisoner, but was later sentenced to 18 months imprisonment for the breach of an ASBO. Because of the concerns over his physical and mental health, he was located in the prison's healthcare wing. In healthcare, staff managed to establish a good and respectful rapport with him.

The gentleman entered prison as a type 1, insulin dependent diabetic. Whilst in prison he was erratic in his compliance with his diet and medication, perceiving it as a way of control and leverage. He was also known to have a heart condition. Some concerns were also raised in respect of his mental health, although he rejected efforts to assess and treat him. For the two days preceding his death, he had refused food, his medication and blood tests, acknowledging the consequences of his actions. However, on the morning of his death, he agreed to have his blood/sugar level tested and to take insulin. About 20 minutes after receiving his insulin injection, he was discovered unconscious.

The post mortem indicates that the man died of ischaemic heart disease caused by coronary artery atheroma, complicated by diabetes and a fatty liver.

The clinical review has highlighted a number of issues in regard to record keeping. The review concludes that the prisoner presented a number of challenging problems in terms of his healthcare management.

Nevertheless, the clinical reviewer judges that staff worked hard to ensure the prisoner's safety and improve his health, and I share that view. Sadly, the man succumbed to the cardiovascular problems that so often accompany diabetes. This was further compounded by his non-compliant behaviour and lifestyle.

## THE INVESTIGATION PROCESS

1. The investigation into the circumstances surrounding the prisoner's death was opened by one of my investigators, when he visited HMP and YOI Doncaster on 14 September 2006. Interviews with staff who had known the prisoner took place in October. Notices were issued to staff and prisoners informing them about the investigation and giving them the opportunity to speak with my investigator. In response to the notice, a prisoner wrote to my investigator to confirm that the man had refused insulin and food in the days preceding his death.
2. The Director and his staff produced the man's prison records, including his medical record for review.
3. Central Doncaster Primary Care Trust was commissioned to conduct a clinical review into the care and treatment that the man received whilst at Doncaster. Joint interviews were conducted with my investigator, and completed the clinical review which is attached in full to this report as an annex.
4. In most circumstances, one of my Family Liaison Officers would have contacted the man's next of kin or other family members to offer them the opportunity to meet with to discuss the purpose of the investigation, and to raise any concerns or questions they would like to be addressed. Sadly, the prisoner did not nominate a next of kin and attempts by the police and the prison to locate members of his family have so far been unsuccessful. I am therefore not aware of any family issues surrounding the prisoner's death.
5. My investigator contacted Her Majesty's Coroner by letter to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of the report will be sent to the Coroner to assist him with his inquiries.

## THE PRISONER

6. The man was born in 1947 in Chesterfield. It seems he did not do well at school and there is no indication that he had ever been employed. The prisoner stated that in 2001 he had lived with his sister for a short time, although since 1993 he had apparently been living rough, sleeping in shop doorways and begging for a living. He does not appear to have maintained any contact with his family (his mother died in 1999). He was not married and had no known dependants.
7. The prisoner had 286 convictions dating back to 1961 and had served in excess of 80 prison sentences of varying lengths. (His medical record indicates that the prisoner's father also served a significant number of prison sentences.) His offences were predominantly acquisitive or of a public order nature. The prisoner had long term problems with alcohol and once described himself as a "disagreeable nuisance". He came into frequent contact with the police. In early June 2006, he was remanded into custody by Rotherham Magistrates' Court for begging. That was in breach of an outstanding Anti-Social Behaviour Order (ASBO). On 30 June 2006, he was sentenced to 18 months imprisonment by the Crown Court for the breach of the ASBO. (I know nothing more about the circumstances giving rise to the prisoner's imprisonment, and am aware that other ASBOs have been imposed in respect of persistent begging. However, I must also record that begging itself is not an imprisonable offence.)
8. The prisoner's medical record indicates that he had a history of mental health problems and had been admitted to various psychiatric units on and off since 1968. However, a letter from HMP Nottingham to the Queen's Medical Centre dated 9 May 2006 says there was no evidence of any current mental illness, although the man apparently displayed some personality traits.
9. Just prior to arriving at Doncaster, the prisoner had been in HMP Bristol and HMP Nottingham. In February 2006, he had been admitted to a Bristol hospital, having fallen into a diabetic coma. His medical record notes frequent referrals to hospital as a result of his diabetes, and also includes evidence of the prisoner discharging himself against medical advice.
10. On 22 March, the man was admitted to hospital from HMP Nottingham, because of a hyperglycaemic attack. On this occasion, his blood sugar level was recorded at 30.9 mmols (the normal range for insulin dependent diabetics is between 5 and 7 mmols). He was also confused and disorientated, which I understand to be a classic indication of abnormal blood sugar levels. The man was discharged from hospital on 26 March.
11. Healthcare staff at Doncaster told my investigator that the prisoner could be cantankerous, but was not considered to be a discipline problem. They said that he was frequently non-compliant with his insulin, and often refused to eat as a protest for having to take food with other prisoners at the servery. His failure to eat properly or to comply with his medication would consequently affect his blood sugar levels and therefore his physical health. The medical records indicate that he had used his diabetes as a form of control and leverage. In an entry in his medical record made whilst at HMP Nottingham, the prisoner told staff "when I

get angry I stop altogether". The prisoner told staff that, whilst not in prison, he controlled his diabetes with alcohol and spring water. He said he also used to obtain insulin from small medical practices.

12. Staff described the man as having a passion for horseracing and drawing teddy bears. He would usually refer to staff and fellow prisoners as "my ducks". The man could be obsessive about cleaning and, when the opportunity arose, he would collect and store pots of jam in his cell that he had taken from the breakfast servery.
13. The prisoner's post sentence report indicated that he had no intention or inclination to change his habits or lifestyle. Upon release, he wanted to move to Scotland in order to carry on drinking alcohol without the risk of breaching an ASBO.

## **HMP AND YOI DONCASTER**

14. Opened 12 years ago, HMP and YOI Doncaster is a purpose-built Category B' male prison, privately managed under contract by Serco Home Affairs. The prison is made up of three houseblocks, each with four wings, with a maximum capacity of 1,120 prisoners. Its principal function is as a local prison serving the local courts, and the majority of its population are unsentenced prisoners.
15. The prison has a healthcare unit with provision for up to 29 inpatients located on the second floor. The lower level is dedicated to the delivery of primary care services. The resuscitation equipment, including the defibrillator, is kept in the pharmacy room. A local doctor provides on site cover 21 hours a week and the prison employs two other part-time doctors to provide a 24-hour service. The mental health in-reach team is from the Doncaster and South Humber Mental Health Trust. It provides a service to a cluster of prisons in the area. There are also two Registered Mental Health Nurses and a support worker based in Doncaster. A clinical psychiatrist and a forensic psychiatrist also attend the prison for regular sessions.
16. A drug strategy provides support to prisoners with substance misuse problems, including alcohol dependency. A community re-entry team provides advice about resettlement into the community upon release from prison, including housing support.
17. During the investigation, the Healthcare Manager said that many of the patients had mental health problems and had been on the healthcare wing for a long period of time. They were mainly cared for by a group of Prison Custody Officers (PCOs), but nurses attended regularly to administer medications and make entries in the care plans. Due to the time that some of the patients had been in healthcare, a good relationship had developed between staff and prisoners.
18. The most recent inspection of the prison was an announced inspection that took place in November 2005. Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, found that HMP Doncaster 'was generally well-ordered'. However, Ms Owers expressed concern that 'prison managers had allowed important areas to slip below what is safe and decent' since the Inspectorate's previous visit in April 2003.

## EVENTS LEADING UP TO THE PRISONER'S DEATH

19. On reception at Doncaster the prisoner received a medical assessment during which he told staff that he suffered with type 1 diabetes which had been diagnosed in 2001. He was noted to be prescribed Mixtard 30, a medium acting insulin. His normal dosage up until his death was 32 units in the morning and 35 units in the afternoon.
20. It was also noted that the prisoner was offered the services of a dentist and an optician, but refused these offers.
21. It was established that he had recently been in HMP Nottingham. Doncaster contacted Nottingham and requested the prisoner's previous medical record. Upon receipt, the record confirmed that he had suffered a myocardial infarction (heart attack) in July 2005 and was suffering with severe left ventricular failure and cardiomyopathy.
22. Following his reception, the man was located on the detoxification wing because of his alcohol misuse.
23. The medical record notes that, during previous periods in custody, the man would try to engineer visits to outside hospital by refusing to take his insulin or food. An entry in the medical record for 3 June indicates that the prisoner had to attend the healthcare wing before breakfast and tea time for his insulin injection. The man was not considered suitable for in cell medication and at Doncaster his injections were administered by nursing staff in an attempt to ensure compliance. Information received from Nottingham indicated that the prisoner had been engaged with numerous mental health services over a number of years. This included periods of formal sectioning under the Mental Health Act.
24. During his reception, the prisoner had denied any thoughts of self-harm, although his previous medical record from Bristol indicated that for a period of time he was subject to an F2052SH (a 'suicide and self-harm at risk' form used to monitor and support those prisoners at risk). The form had been opened because of his refusal to eat properly or take his insulin.
25. On 8 June, the prisoner refused to attend healthcare for his insulin injection as he had not received his canteen (goods from the prison shop). On 10 June, he again refused insulin, saying that he was receiving the wrong dosage. In consultation with the doctor, his dosage was changed and the man agreed to take his medication. On 16 June, he was moved to a residential house block (he was considered to be vulnerable to other prisoners because of his bizarre behaviour). The medical record notes that the prisoner was rambling in speech, suffered delusions and had an obsession for cleaning. A referral to the prison psychiatrist was made.
26. On 18 June, the man was transferred back to the healthcare wing, where further observations of his mental and physical health could be made. On 20 June, his blood glucose was described as unstable and on 21 June he was given dextrose (glucose) to compensate for this.

27. On 21 June, whilst under the care of a multi-disciplinary team, he was noted to have a long history of refusing his insulin. He was to continue to be monitored in healthcare for his diabetes. His mental health and bizarre behaviour was attributed to his long term alcohol abuse and solitary lifestyle.
28. On 22 June, the prisoner was seen by a psychiatrist. He was described as excited in mood, but compliant with his medication. The psychiatrist noted that the man was paranoid about younger prisoners whom he said called him 'Hitler'. The prisoner also said that he would sue the prison because it was dirty and this could affect his diabetic condition. He told the psychiatrist that he used alcohol to control his chronic paranoia. Following the assessment, the psychiatrist diagnosed the prisoner as suffering with borderline psychotic features and prescribed him risperidone, an anti-psychotic drug.
29. On 25 June, the prisoner refused to take the risperidone. The following day, he was seen by a Mental Health Nurse who reported that he continued to refuse any anti-psychotic medication or accept any psychiatric intervention. However, the nurse described him as pleasant and appropriate in his presentation.
30. By 27 June, the medical record notes that the prisoner still refused his risperidone and was not compliant with his insulin. On 28 June, he was seen by the Mental Health In Reach Team (MHIT). He told the doctor that he did not consider himself to be mentally ill and that he would refuse any psychiatric intervention. It was also ascertained from the interview that the prisoner was not registered with a doctor. Whilst at liberty in the community, he obtained insulin, from small medical practices across the country.
31. Records indicate that on 28 June he was unwell and spent most of the day in bed. He was later diagnosed with a urine infection which was appropriately treated with oral antibiotics.
32. On 30 June, the day he received his sentence, the prisoner was abusive towards the judge and appeared to be responding to hallucinations. On 4 July, he refused to see anyone from the MHIT. Consideration was given to discharging him back to a residential block as he did not co-operate with his medication regime and a proper mental health diagnosis could not be made. However, he was not considered to be a discipline problem and, in any event, it was deemed prudent to continue to monitor his diabetes in healthcare.
33. On 14 July, the mental health team noted in the prisoner's medical record that his bizarre behaviour could be indicative of psychotic behaviour, and he was to be reviewed once again by the psychiatrist despite his continued refusal to engage with mental health services. The medical record notes that on the same day he experienced a hypoglycaemic (low blood sugar) episode, for which he needed glucagon (glucose) to correct his blood/sugar levels. The record notes that he could be given dextrose in an emergency, although because of his erratic compliance with insulin he could not keep this in his cell. On 18 July, the prisoner demanded to see the doctor to have his insulin dose changed. Records indicate that on 19 July, he was constantly pressing his cell buzzer demanding attention. By 22 July, the medical record says that he was compliant in taking his insulin.

34. By 23 July, the man's mood was changeable and he was not eating properly despite staff encouragement and support. He was again refusing to take his insulin.
35. On 25 July, the prisoner sustained an injury to his right elbow when he threw cups of water at a Prison Custody Officer (PCO). The prisoner slipped on the wet floor and was taken, under escort, by ambulance to the Royal Doncaster Hospital. He was later diagnosed with a dislocated elbow which was placed in a plaster cast. The man later removed the plaster, complaining that it made him itch. He subsequently refused to attend hospital on 27 July to have his elbow reviewed. Between 25 July and 30 July, the prisoner was erratic in compliance with his medications and food. A letter was sent from Doncaster to the Rotherham District Hospital stating that the man continued to display psychotic symptoms and suffer episodes of extreme agitation, and that healthcare staff found it increasingly difficult to manage him. Staff told my investigator that, when the prisoner was agitated or excited, he was locked behind his cell door to enable him to calm down.
36. On 1 August, the man attended hospital and his elbow was reset in plaster. At about 6pm, he claimed that he had not eaten all day and was too weak to take his insulin. He was given two glucose tablets. The man had refused to eat as he did not like the food that was on offer.
37. On the night of 2 August, the prisoner was warned by night staff because of his frequent use of his cell bell. My investigator was told that the man could be quite demanding, often activating the bell to demand cups of tea.
38. At about 12.22am on 5 August, the wing history sheet notes that healthcare staff were called to the prisoner's cell as he was suffering a hypoglycaemic episode. At about 2.20am, a PCO found the prisoner on the floor of his cell moaning and shouting. Bruising was noted to his left elbow. The prisoner informed staff that he had banged it on a metal divide in the cell. At 3.30am, healthcare staff were again called to the prisoner's cell, where he appeared to be quite agitated and thrashing around on the floor. Treatment and reassurance was given. His blood glucose level was tested and a reading of 16.8mmols was recorded. At 7.15am, his blood sugar levels were noted to be more stable and he received his insulin.
39. On 11 August, a Security Information Report indicated that, following damage to his television set, the prisoner was subject to Control and Restraint (C&R).
40. On 15 August, the man took his breakfast behind a locked cell door following an incident with a fellow prisoner. Records indicate that the prisoner experienced a restless night during which he used his cell bell to demand cups of tea from staff. On 18 August, he complained of a rash in his groin. He was seen later that day and was prescribed cream to treat the problem.
41. On 20 August, the prisoner was erratic with his diet but was still taking insulin. However, he complained that his blood sugar levels were not right and asked for dextrose to compensate for this. On 27 August, he complained of a toothache

and was diagnosed as suffering from a dental abscess for which he was prescribed oral antibiotics. The multi-disciplinary care plan on 30 August noted that he had become settled and compliant in treatment and medication. However, by the evening of 31 August it was recorded that the prisoner was in an elated mood and was shouting and talking to himself.

42. On 1 September, the man complained that he was not getting his medications when he needed them. However, it was also noted that he was refusing medications when they were offered. He was upset and agitated and threw cups of liquid outside his cell. The prisoner continued to complain of a toothache.
43. On 3 September, various records note that the prisoner was upset that he had to queue with other prisoners for breakfast. Because of his agitated behaviour, he was put behind his cell door in order to calm down. He refused to eat or have his insulin injection. Another prisoner who suffered with diabetes confirmed to my investigator that the prisoner had refused food or insulin when these were offered to him on a number of occasions. At 6.20pm on 3 September, the medical record notes that the man was still refused to have his blood tested or his insulin injection. The consequences of not taking his medications or having his blood tested were explained to him and fully acknowledged by the prisoner. At about 10.10pm, he was abusive towards staff, complaining that he was not getting his insulin. When the nurse arrived at 10.30pm to give him his insulin injection, he refused once again.
44. The prisoner continued to refuse to have his blood tested, take his insulin or accept food on 4 September. He also continued to complain of toothache and demanded to go to hospital to be treated with intravenous antibiotics. However, he refused to take a new course of oral antibiotics for the abscess.
45. At 8pm, prisoners on the healthcare wing were locked in their cells for the night. He was not subject to any formal observation regime and consequently there are no recorded observations of him during the night. My investigator also established that the prisoner had not come to the attention of staff during the night and did not activate his cell bell.
46. PCO A is a member of staff who routinely works on the healthcare wing. He told my investigator that, when he saw the prisoner at about 6.30am on 5 September, he did not look well although his presentation appeared to be consistent with previous occasions when he had refused to take insulin. The prisoner asked for and was given water by PCO A. PCO A was concerned about the man's condition and brought it to the attention of the duty healthcare staff. These concerns were then brought to the attention of the prison doctor when he arrived in the prison later that morning.
47. At about 7am on 5 September, prisoners were served breakfast on the healthcare wing. The prisoner refused breakfast and his insulin. Although he continued to refuse food, medication and blood tests, his behaviour was not considered by staff to be unusual given his previous history of non-compliance.

48. At about 8.45 am, the prison doctor accompanied by a Healthcare Assistant and a Nurse went into the prisoner's cell. The doctor was apprised of the prisoner's condition and history. On entering the cell, the man was lying on his bed, fully clothed. An entry in the medical record indicates that his breathing was shallow and he was clammy to touch. However, the prisoner was able to follow commands and agreed to have his blood tested and his insulin injection. He also asked for and was given water to drink. The medical record notes that the prisoner had vomited during the night. The prison doctor then left the man's cell to attend to his duties in the Care and Separation Unit, having asked the Nurse to test the prisoner's blood and to administer his normal dose of insulin of 32 units of Mixtard 30. In his statement following the prisoner's death, the prison doctor said he also told healthcare staff to take clinical observations and that he would check on the prisoner in about one hour.
49. The Nurse took the prisoner's blood sugar levels in his cell and these were recorded as 28.6mmols. The medical record notes that, following the man's blood test result, the Nurse contacted the Care and Separation Unit at about 9am by telephone and spoke to the prison doctor to confirm his instructions. In her statement, the Nurse said that the prisoner asked her for his injection and that she gave him his normal dosage of insulin at about 9.05am. The Nurse told my investigator that she had administered insulin injections to the prisoner on a number of occasions previously and had access to his prescription chart. The Nurse then left the man's cell to attend to other patients' medications. The cell door was left ajar.
50. At about 9.26am, PCO A entered the prisoner's cell to offer him some toast, having been told that he had been given his insulin injection. PCO A saw that the man was lying on his bed unconscious and unresponsive, and called to his colleague PCO B to ask a nurse to attend the cell immediately. PCO A also called the Nurse who had attended to the prisoner to the prisoner's cell and asked her to have a look at him. The Nurse entered the cell and examined the prisoner. She could not elicit a response from him or detect a pulse.
51. PCO C also entered the cell and, on confirming that there was no sign of a pulse, immediately commenced cardio-pulmonary resuscitation (CPR). The Nurse then called to PCO B to contact the Control Room via his radio to request medical response from other healthcare staff on duty. Nurse Nkomo then assisted PCO C with CPR.
52. At about 9.30am, the prison doctor's surgery was interrupted when he was told by a member of staff that the prisoner 'had gone'. The doctor attended the man's cell and began to assist with the efforts to resuscitate him. A number of other healthcare staff attended the prisoner's cell and who alternated with CPR. The doctor attached a defibrillator to the prisoner's chest and administered adrenaline. He requested an emergency ambulance through the Duty Operations Manager. Meanwhile, a member of staff was instructed to obtain the equipment and documentation from the Security Department that was necessary for escorting a prisoner to an outside hospital.

53. At about 9.33am, the paramedics arrived in the prisoner's cell and the prison doctor advised them of the situation. A heart monitor was attached to the man and paramedics took over the CPR efforts from prison staff. Despite their continued efforts to resuscitate the prisoner the prison doctor pronounced him dead at 9.40am.
54. The clinical review says that prison healthcare staff are to be commended for their speedy intervention and attempted resuscitation of the prisoner. It is clear that they responded quickly and appropriately to the medical emergency and did everything possible to save his life.

## EVENTS AFTER THE PRISONER'S DEATH

55. At 9.50am, the man's cell was sealed to await the arrival of the police. South Yorkshire Police confirmed with my investigator that the prisoner's death was not considered to be suspicious or the subject of any criminal proceedings.
56. At about 9.58am, the duty director and the prison chaplain arrived in healthcare to offer support to the prisoners and the staff who had discovered and treated the prisoner. Following news of his death, Doncaster implemented its contingency plan in the event of a death in custody that included informing the Prison Service's National Operations Unit and the Independent Monitoring Board. Staff were made aware of the role of the care and support team should they require it. Those prisoners in the healthcare wing who were subject to the suicide and self-harm monitoring were checked and asked if they would like to speak to a member of the chaplaincy or to a Listener (a prisoner trained by the Samaritans).
57. The prisoner had not identified any next of kin and the prison or police could not trace any members of his family. Further investigations confirmed that he had not received any domestic visits, letters or telephone calls whilst in Doncaster or any other prison. The prison contacted the man's probation officer who was unable to provide any details of relatives. Later attempts by the prison and police to find members of the man's family have to date proved unsuccessful.
58. At about 1.30pm on 5 September, a 'hot debrief' took place chaired by the Assistant Director of Operations. This included those staff who had responded to the medical emergency that morning. Staff were praised for their efforts and were reminded of the role of the care and support team. Issues arising from the prisoner's death included the need for an appropriate system to alert healthcare staff as to the severity of an incident they are being asked to attend, as well as the nomination of a staff member to collect documentation and equipment should a prisoner be required to be taken by emergency ambulance to hospital. The debrief also identified that, in the event of an ambulance attending the establishment, staff should be nominated to meet and direct the ambulance to the relevant area. These issues did not affect the treatment that was given to the prisoner and did not affect the outcome. (I should add that this appears to have been a very professionally-conducted and productive debrief.)
59. On 14 September, a memorial service took place for the prisoner at the prison. Staff told my investigator that, whilst the man was often non-compliant and could be a source of frustration to them, he was a likable man notwithstanding his bizarre behaviour. In the months that the man was in healthcare, staff managed to establish a good rapport with him.
60. The man's funeral took place on 18 September and was attended by a number of staff from the healthcare wing. The cost of the funeral was paid by Doncaster prison.

## **CLINICAL REVIEW AND POST MORTEM**

61. The Central Doncaster Primary Care Trust was asked to undertake a clinical review into the care that the prisoner received whilst at HMP/YOI Doncaster. The review concludes that the man presented a number of challenging problems in terms of his healthcare management, but that staff worked very hard to ensure his safety and improve his health. He succumbed to the cardiovascular problems that can accompany diabetes, and this was compounded by his non-compliant behaviour and lifestyle. The clinical reviewer says that staff are to be commended for their work in caring for the prisoner.
62. The clinical reviewer has also made a number of recommendations in regard to maintaining full, clear, consistent and continuous medical records in compliance with required standards.
63. A post mortem indicated that the prisoner died of ischaemic heart disease, caused by coronary artery atheroma complicated by diabetes and a fatty liver.

## ISSUES CONSIDERED DURING THE INVESTIGATION

### *Management of diabetes*

64. Despite his sad and chaotic lifestyle, I am convinced that the prisoner clearly understood the implications of not taking food or insulin. Although he was somehow able to control his diabetes in the community by obtaining insulin from small GP practices and through use of alcohol, there was evidence to suggest that on occasions his diabetes got the better of him and consequently he required some periods as a hospital inpatient. It also seems apparent that this man contrived to use his condition as a form of leverage whilst in prison, making conscious and determined decisions not to comply with his diet or treatment. In view of this, I believe that Doncaster took every reasonable step to manage the prisoner's condition. He most likely received a greater level of clinical monitoring and care than he would have had in the wider community. But the prisoner was not a well man, and his frequent non-compliance with regard to his diabetes probably made the outcome inevitable, irrespective of whether he was in prison.
65. I judge that healthcare staff worked very hard to protect and assist this man and they are to be commended for their dedication. However, the clinical review has highlighted a number of issues in regard to record keeping.

**The Healthcare Manager must ensure that good standards of record keeping in the medical record are maintained, in compliance with the Nursing and Midwifery Council (2005) Guidelines for Records and Record Keeping, and Department of Health (2006) NHS Code of Practice Records Management.**

**The Healthcare Manager should remind staff that all actions stated within the medical record must include a rationale for action, followed up with a review to confirm the action was undertaken and to state the outcome of that action.**

66. The prisoner appears to have been a solitary character, intransigent in nature and prone to mood swings. He consciously elected on numerous occasions to refuse treatment for his chronic condition, despite staff establishing a good, supportive and respectful rapport with him. Under the circumstances, staff had little option but to monitor, encourage and support the prisoner, emphasising the importance of self-management and compliance with his medication and diet.
67. Staff reported that on 5 September 2006 the man did not look well, although his presentation was similar to previous occasions when he had refused food and insulin. Staff also said that, on receiving insulin and food, the prisoner's condition would normally improve. Further clinical observations of the man following his dose of insulin at 9.05am did not take place, although he was due to be reviewed by the doctor within the hour. However, he was discovered unresponsive and unconscious about 20 minutes later.

## ***Mental Health***

68. On reception at Doncaster, it was established that the prisoner had engaged with mental health services across the country over a long period of time although a firm diagnosis could not be made. His long term alcohol abuse and his solitary lifestyle may have contributed to his bizarre behaviour. Because of staff concerns in regard to his behaviour, the prisoner was referred to the Mental Health In Reach Team and assessed by a psychiatrist who believed that he was borderline psychotic. This diagnosis could be treated with appropriate anti-psychotic drug therapy. However, the man refused to believe that he was mentally ill and declined any psychiatric intervention. Overall, whilst the prisoner's behaviour was considered by staff to be bizarre, it was not considered to be inappropriate and certainly did not warrant a more intrusive programme of intervention. In this respect, I am convinced that reasonable attempts were made to assess and to treat the man's mental health. The prisoner's mental status did not inhibit his judgement or decision to refuse to have his blood tested or to take insulin or food.

## ***Issues emerging from the 'hot debrief'***

69. A timely debrief of staff who had been involved in the treatment of the prisoner took place in compliance with Prison Service Order 2710. A critical appraisal of events that had taken place raised several issues, but none of which would have affected the outcome. However, it did emerge that, when a medical response was requested through the Control Room, healthcare staff were not always sure of the type of incident that they were being called to attend or the equipment that they would need to bring with them.

**The Director, in conjunction with the Healthcare Manager, should introduce a code system that allows staff to immediately identify what type of medical emergency they are attending and to prepare for it accordingly.**

70. An emergency ambulance was called for the prisoner and arrived at Doncaster within five minutes. In the event that the man needed to be taken to hospital, an escort bag containing appropriate equipment and documentation would be needed in compliance with Prison Service Regulations. At the time, there was some confusion over the escort bag, even though an officer was instructed to collect it from the Security Department.

**The Director must ensure that a member of staff is nominated to collect the escort bag and briefings from the Security Department in the event of a medical emergency where a prisoner requires hospital treatment.**

**The Director must ensure that a member of staff is nominated to meet and direct an ambulance to an appropriate, secure and convenient location.**

## RECOMMENDATIONS

The Prison and Healthcare provider have accepted in full the recommendations identified in the report and developed an action plan to address them in a timely manner. Additionally they have considered the five specific areas of learning in the clinical review and taken steps to address them, thus improving the provision of clinical services for prisoners at Doncaster.

- 1. The Healthcare Manager must ensure that good standards of record keeping in the medical record are maintained, in compliance with the Nursing and Midwifery Council (2005) Guidelines for Records and Record Keeping, and Department of Health (2006) NHS Code of Practice Records Management.**

The prison responded to the draft report stating that a record keeping audit has been undertaken and will be periodically (6 monthly initially) reviewed. These audits will formulate on-going training for healthcare professionals. Liaison with local PCT to utilise a package of training on record keeping.

- 2. The Healthcare Manager should remind staff that all actions stated within the medical record must include a rationale for action, followed up with a review to confirm the action was undertaken and to state the outcome of that action.**

In response to the draft report the prison stated that they will be working with Senior Clinicians, to introduce a clinical recording pathway. In-house training will also be instigated to reinforce the need for inclusion of a rationale.

- 3. The Director, in conjunction with the Healthcare Manager, should introduce a code system that allows staff to immediately identify what type of medical emergency they are attending and to prepare for it accordingly.**

In response to the draft report the prison stated that the Senior Nurse Team Leader has been tasked with clinical evaluation of current response system, and consideration of developing a "traffic light" system.

- 4. The Director must ensure that a member of staff is nominated to collect the escort bag and briefings from the Security Department in the event of a medical emergency where a prisoner requires hospital treatment.**

The prison responded to the draft report stating that a member of staff is nominated by the senior manger in charge of the prison. Briefings are given by the Security manager in normal hours and by the Duty manager out of hours.

- 5. The Director must ensure that a member of staff is nominated to meet and direct an ambulance to an appropriate, secure and convenient location.**

In response to the draft report the prison stated that a member of staff will be nominated as an escort, to direct the ambulance, that member of staff will then

remain with the ambulance to ensure security is maintained and for the purpose of escorting out the ambulance out of the establishment.

## **ANNEXES**

Documents considered during the investigation

1. The prisoner's medical record
2. Statements taken from staff on discovering and treating the prisoner.
3. Interviews with key staff
4. Clinical review from Central Doncaster Primary Care Trust