



**Investigation into the circumstances surrounding  
the death of a man at hospital  
in July 2011, in the custody of HMP Forest Bank**

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

**June 2012**

This is the report of an investigation into the death of a man, a prisoner at HMP Forest Bank. He was 50 years old when he died in July 2011 of gastric carcinoma (stomach cancer). I extend my condolences to his family. I hope the report goes some way to answer any questions they may have.

The investigation was carried out by an investigator. The local Primary Care Trust commissioned a clinical reviewer to review the man's clinical care. I would like to thank the Director of Forest Bank and his staff for their co-operation during the investigation. I apologise that the report has been delayed.

The man did not enter prison with any apparent significant medical problems. However, in April and May 2011 he was seen by healthcare staff, having reported of feeling unwell. The prison doctor urgently referred him to hospital where it was confirmed, in early June, that he had inoperable stomach cancer. The severity of his illness meant that he declined very quickly and died the following morning.

The investigation concludes that the prison acted swiftly when the man brought his symptoms to their attention. The overall care was satisfactory, indeed it compared favourably with that which he might have expected in the community and there were no significant failings in the service provided to him. Nonetheless, two recommendations are made to improve arrangements for informing the next of kin when someone dies in a hospital while in prison custody and to ensure an appropriate standard of behaviour by bedwatch staff.

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.

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**June 2012**

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## SUMMARY

1. The man was received into HMP Forest Bank on 28 January 2011. No issues of concern were noted at his reception health screen conducted the same day.
2. On 27 April, the man attended healthcare, and informed the nurse that he had been suffering from abdominal pain for five days and was unable to eat due to nausea. He was referred to the prison doctor. A week later, on 4 May, he saw a doctor and explained that he had lost weight, and felt nauseous when he ate solid foods. His weight was taken, and it was discovered that he had lost 14kg since his arrival at Forest Bank in January. After the doctor found what he thought to be an “epigastric [abdominal] tenderness with? [possible] epigastric mass” (possible tumour in the abdominal area) he sent a letter to the hospital and asked that he be seen by a gastroenterologist under the two week rule (that patients must be seen within a fortnight). The letter was marked as urgent.
3. The man was seen by a consultant gastroenterologist at the hospital on 13 May. He agreed with the prison doctor’s earlier findings, and referred him for a CT scan (a three dimensional x-ray used to produce virtual images that show what a surgeon would see during an operation) of the abdomen, and a gastroscopy (an examination of the inside of the gullet, stomach and small intestine).
4. On 7 June, the man was seen by a consultant surgeon who explained that tests had revealed that he had stomach cancer and, due to the advanced nature of his cancer, palliative chemotherapy (to treat the symptoms rather than cure the cancer) was his only option. The consultant made a referral to another hospital, asking that he be seen for possible palliative chemotherapy.
5. The man was admitted to hospital on 28 June to have ascetic drainage (fluid drained from the abdomen area) with a plan to release him so he could have palliative chemotherapy as an outpatient. However, his condition deteriorated unexpectedly and he was unable to leave hospital. He collapsed in July before hospice care or compassionate release could be considered by the prison.
6. The man’s partner was informed of his death by hospital staff.
7. Two recommendations are made. The first regarding arrangements for a prison informing a family of a prisoner’s death. The second concerns expected standards of behaviour for staff whilst carrying out bedwatch duties.

## THE INVESTIGATION PROCESS

8. The investigation was opened on the appointed investigator's behalf on 22 July 2011 by another of investigators. Notices were issued announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No-one came forward in response to the notices.
9. During the opening visit, the investigator collected copies of the man's prison files, including his medical records and met with the prison's Director. He visited the healthcare unit, met, with the healthcare manager and introduced himself to the staff on the unit.
10. During the opening visit, the investigator also met with a member of the Independent Monitoring Board (IMB) and asked if they knew the man and had any concerns they wished to discuss about his care. The IMB member confirmed that members of the IMB had visited him, but in the same capacity they would do with all other terminally ill prisoners. She said that he had not submitted any complaints to the IMB.
11. The appointed investigator visited to Forest Bank on 22 September 2011 to interview five members of staff. Verbal feedback was given to a governor at Forest Bank as the Director was unavailable, and written feedback was forwarded to the Director on 7 October.
12. A clinical review of the man's health care in prison was carried out by the clinical reviewer on behalf of the local Primary Care Trust. The report was delayed as the clinical review was not received in this office until 10 November, and also because of work pressures within this office.
13. One of the Ombudsman's family liaison officers contacted the man's next of kin, his partner, to inform her of the investigation and to provide her with an opportunity to raise any issues or concern. She raised a number of issues during this telephone call. The family liaison officer and the investigator met with her partner on 4 October to discuss some concerns she had. Concerns were raised regarding restraints, the behaviour of bedwatch staff, and the diagnosis of her partner's terminal cancer. The questions raised by her are discussed in the issues section of this report starting at page eight. She received a copy of the draft report as part of the consultation process. She agreed with the recommendations made by the Ombudsman and reiterated her concerns about the lack of respect shown by the bedwatch staff and hoped this would lead to an improved practice for the benefit of other prisoners and their families.
14. The investigator wrote to the Coroner at the outset of the investigation, and this report will be forwarded to the Coroner to assist in his enquiries into the man's death.

15. The investigation assessed the following aspects of the man's care and treatment:

- Whether his diagnosis was made in a timely fashion?
- Whether he was told about his condition and the treatment which followed?
- Whether he was treated properly and attended hospital appointments as necessary?
- Whether the liaison with his family was appropriate?
- Whether he was accommodated in the most appropriate part of the prison?
- Whether consideration was given to compassionate release from prison?
- Whether appropriate palliative care was provided?

## HMP FOREST BANK

16. HMP & YOI Forest Bank is a prison operated on behalf of the Ministry of Justice by a private contractor, Kalyx. It is a local prison for adult and young adult male prisoners and has the capacity to hold up to 1,424 prisoners. Forest Bank healthcare department has a 20 bed in-patient facility, incorporating two four bed wards and an observation suite. This is complemented by 24 hour nursing care. There is a healthcare manager supported by two clinical leads. The GP service is provided by Cimarron, a GP agency.
17. The most recent published report by Her Majesty's Chief Inspector of Prisons (HMCIP) was dated June 2010, and detailed a full unannounced inspection of Forest Bank. The summary of that report said:

“Forest Bank is a good local prison and a number of improvements were evident since our last inspection. For a local prison, prisoners spend a good amount of time out of their cells. The quality of education, training, employment and other activities was generally good – work in the kitchens and the employer-led employment initiatives were particularly impressive – but there was simply not enough available. Most prisoners could access an activity place but many were only part time. So although 88% of prisoners could access some form of activity our roll check found about half the prison population locked in their cells during the working day.”
18. The report further noted that “The standard of health care has improved”.
19. Members of the community are appointed to each prison's Independent Monitoring Board (IMB) by the Secretary of State for Justice. They are required to produce an annual report to the Secretary of State on the prison, highlighting good practice and flagging up areas of concern. The Independent Monitoring Board published their most recent annual report in 2009 and the report's executive summary said:

“This is the tenth anniversary of the opening of Forest Bank and is a significant milestone in the history of the establishment and represents a huge achievement by the staff and management team.”
20. This was the sixth death to occur at Forest Bank since the Ombudsman started investigating deaths in custody in April 2004 and the third due to apparent natural causes. The Ombudsman's reports into these deaths reached varied conclusions on the care provided. One investigation found that the standard of care received by the prisoner was comparable to that he would have received in the community, whilst other investigations were more critical of prisoner care.

## ISSUES

### The diagnosis of the man's terminal illness

21. The man was received into HMP Forest Bank on 28 January 2011. A nurse conducted his reception health screen the same day where no matters of concern were noted.
22. On 27 April, the man was seen by another nurse when he complained of abdominal pain. He told her that he had suffered with this for five days, and was unable to eat due to nausea. She made a note in his medical records: "No constipation, no difficulty passing urine ... Pain not localised, will refer to Dr for examination".
23. A week later, on 4 May, a doctor examined the man. He told the doctor that he was suffering from abdominal pain, had lost weight, and felt nauseous when he ate solid foods. His weight was taken, and it was discovered that he weighed 77kg, 14kg lighter since his arrival at Forest Bank in January. On examination, it was noted by the doctor that he had: "epigastric [abdominal] tenderness with? [possible] epigastric mass".
24. The doctor sent a letter to the hospital to ask that the man be seen under the two week rule (that a patient must be given an appointment within two weeks of the referral). He detailed in the letter that: "examination reveals a soft abdomen with epigastric tenderness and the suggestion of epigastric mass. Worryingly he complains of fullness on eating and vomiting after meals". The letter was marked as urgent. The doctor prescribed hyoscine butylbromide (used to treat pain and discomfort caused by abdominal cramps) and omeprazole (to block the production of acid in the stomach).
25. The man was seen by a consultant gastroenterologist at the hospital on 13 May. The consultant wrote in a letter to the prison that he looked "rather gaunt", confirming the doctor's earlier findings. He said that he would arrange for a two week wait CT scan (a three dimensional x-ray used to produce virtual images that show what a surgeon would see during an operation) of the abdomen, and a gastroscopy (examination of the inside of the gullet, stomach and small intestine).
26. On 25 May, the man attended the endoscopy department at the hospital for a gastroscopy. The Upper GI Specialist Nurse wrote to the doctor at Forest Bank on 31 May, explaining the findings from this procedure. She wrote:

"He [the man] was found to have an ulcerated mass in his stomach at the pylorus [the part of the stomach that connects to the small intestine]. Biopsies have demonstrated a signet ring poorly differentiated adenocarcinoma [cancer]"
27. The Specialist Nurse explained that the man was due to have a CT scan on 1 June, and the results from both procedures would be discussed when he attended the Upper Gastroenterology clinic on 7 June.

28. After undergoing a CT scan on 1 June, it was discovered that his cancer was too advanced for surgery to be of any benefit. On 7 June, the man was seen by a consultant surgeon. The consultant explained that tests had revealed that he had stomach cancer and, due to the advanced nature of his cancer, palliative chemotherapy (to treat the symptoms rather than cure the cancer) was his only option. He made a referral to another hospital to ask that the man be seen for possible palliative chemotherapy.
29. The man's partner explained to the investigator that she had visited him in March and had noticed his weight loss. She asked if the diagnosis could have been made sooner.
30. The clinical reviewer comments:

“The cancer was identified in a very timely fashion. The patient was first seen by a GP working at Forest Bank on 4 May 2011. He correctly identified an epigastric mass, he correctly assumed it was a gastric carcinoma and he referred the patient under the two week rule for an urgent assessment”.
31. The investigation endorses the conclusion reached by the clinical reviewer. Once the man was seen by the doctor, he was seen by a hospital consultant within two weeks of the referral, which was appropriate given his symptoms.

### **Informing the man about their condition and treatment**

32. On 7 June, the man was seen by a consultant surgeon, who explained to him that the tests had revealed that he had stomach cancer. He was told that due to the advanced nature of his cancer, it was inoperable, and his only option was palliative chemotherapy. The possibility of a 'stent' (artificial 'tube' or scaffolding) being fitted to help him be able to eat again was also discussed.
33. The consultant told him that, to try and lessen his nausea, he would arrange for a barium meal test (a procedure where a person swallows a drink containing barium, a substance which shows up on x-rays. An x-ray of the abdomen would then be taken to show any abnormal growths, narrowing or blockages of the stomach and intestine). It was explained that if a blockage was discovered, a 'stent' (artificial 'tube' or scaffolding) could be fitted in the pyloric area (where the small intestine joins the stomach) to help him to eat again.
34. On his return from hospital later that day, a nurse sat down with him, and he told her that he had been diagnosed with stomach cancer. The same day he spoke with the chaplain, and a note was made in his medical record to say: “... has discussed in length his condition and what he would like in terms of [his] care with [the] chaplain”.
35. On 23 June, the man attended an appointment at hospital to discuss his diagnosis and palliative chemotherapy. On his return, it was noted by

healthcare staff that he was a bit tearful. A note was made in his medical records later that day that said: "Settled down and [he] expressed gratitude to the escort for being supportive and helping him following the bad news".

36. The clinical reviewer comments in his review that:

"The man was given full information by the hospital of his diagnosis and likely prognosis. He was also given this information by the prison medical staff. The information was clearly documented in an appropriate fashion within the notes and indeed the doctor's care at this point was faultless and he should be commended for this".

37. It is clear that the man was fully informed about his diagnosis, prognosis and options for treatment. There is evidence that staff spoke to him about this and he understood what he was told.

### **The man's medical appointments and treatment of the prisoner**

38. The man attended a gastroenterology appointment at hospital on 13 May. The consultant wrote to the prison on 23 May. He noted that he looked gaunt and his abdomen was soft and tender. A scan of the abdomen and gastroscopy was arranged for two weeks later.

39. The results of these tests were confirmed by letter to the prison on 6 June. It was noted that the man had "a signet ring poorly differentiated adenocarcinoma" (stomach cancer).

40. On 24 June, a nurse contacted a specialist nurse at the hospital to arrange for the man to have ascitic drainage (a drain inserted into the abdomen to remove fluid) and a stent fitted. This was to be carried out on 29 June and he was admitted to hospital two days before. On 1 July, an update in his medical records recorded that he did not have the stent fitted as the consultant at the hospital did not think it would be of benefit. It was also noted that "drainage of ascities carried out yesterday, but has returned". He continued this procedure and had two and a half litres drained each day as required.

41. On 4 July, prison records note that a prison doctor spoke with a palliative care nurse specialist at the hospital. She said that the man was near death, was not eating, on an intravenous drip and oral morphine for pain relief.

42. There was a note made in the prison records on 6 July: "Seen on ward. Remains on active treatment, still having drains as required. Awaiting scan to ascertain if stent can be done".

43. On 15 July, it was noted that the man's condition had stabilised and he no longer required an acute hospital bed. It was planned that he would stay at the hospital until he was transferred to another hospital as a day case on 20 July when the stent procedure was planned.

44. The man's condition deteriorated rapidly. His escort chain was removed and nursing staff contacted his next of kin. He collapsed in a toilet at approximately 11.00pm. He was taken back to his bed cubicle and resuscitation began. However, this was unsuccessful and he was pronounced dead by a hospital doctor at 11.25pm.
45. With regards to the man's medical care the clinical reviewer comments that:

"He [the man] was reviewed in an appropriate and timely manner at the hospital. His case was discussed and actioned by a multi-disciplinary team meeting on 3 June 2011 at which point it was decided that no curative treatment could be undertaken as he had advanced spread of an aggressive stomach cancer. It was suggested that he might have benefited from Palliative Chemotherapy, however, this did not occur as his condition deteriorated rapidly."
46. The man's hospital appointments came through in the allocated time and from the initial appointment, his follow up care was carried out in a timely manner. Forest Bank ensured that he was able to attend hospital and no appointments were rescheduled due to operational difficulties.

### **The man's pain relief and medication**

47. On 7 June, following his return to prison, the man was seen by a nurse. She was told that he had been unable to eat for five days due to vomiting. He also complained of having severe back pain when lying down, and said he spent hours walking round his cell during the night trying to ease the pain. He was referred to the prison doctor for an urgent appointment. The next day he saw a doctor and was prescribed codeine (a painkiller) for his back pain and metoclopramide to treat his nausea and acid reflux.
48. He found it difficult to manage solid food and, to try and prevent further weight loss, he was prescribed fortisip drinks (high calorie 'build-up' drinks) and a memo was sent to the prison kitchen asking that he be provided with a soft diet.
49. In the addition to the above listed medication, he was prescribed cyclizine (to help treat nausea), hyoscine butylbromide (to treat pain and discomfort caused by abdominal cramps) and omeprazole for acid reflux. After a nurse visited him in hospital on 8 July, it was noted that his condition had deteriorated and to help make him as comfortable as possible, morphine was administered via an intrathecal pump (a medical device used to deliver small quantities of medication for a long period of time).
50. The man's medical records show that he was seen by healthcare every day after his complaint and diagnosis, and his medication was prescribed and reviewed appropriately.

## **Liaison with the man's family**

51. Contact with the man's family was initiated early on, nine days after he received his diagnosis. A chaplain contacted the man's partner on 17 June, to introduce himself as the chaplain and the prison's family liaison officer. He explained that he had just been informed of the seriousness of the man's condition and offered to meet with her the next time she was to visit the prison.
52. On 19 June, the chaplain met with the man's partner. He discussed the man and his condition, and assured her that he would keep her updated with any developments. He maintained contact with the man and his partner until his death.
53. When the man died in the hospital a nurse from the hospital contacted his family to inform them of this. PSO (Prison Service Order) 2710 (Follow-up to deaths in custody) describes the action to be taken following a death in custody. While the PSO does not give definite instructions as to how the news should be broken to next of kin, it does advise of the need to: "... arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened". Despite not giving specific instructions, it does say that the preferred method would be face to face. However, in his case, the hospital made contact with the family ahead of any prison contact.
54. It is reassuring to see that the chaplain contacted the man's partner early the next morning to offer his condolences and support. However, it is disappointing that next of kin notification was made by the hospital over the telephone, and not in person by prison staff. It is unfortunate that his partner found out in this way. This issue has been discussed in a previous prison report published by the Ombudsman, and the recommendation from that report is repeated here:

**The Director should ensure that the prison and the local health authority agree a policy that the notification of the next of kin is undertaken by the Director or their nominated representative.**

## **The man's location**

55. At his hospital appointment on 7 June, the man was informed that he had inoperable stomach cancer. On his return to prison, a nurse spoke to him to discuss the advantages of him moving to healthcare. She explained that if he moved to healthcare permanently they would be able to offer nursing care as and when required. However, he explained that he would rather return to the wing to be with his friends, and felt that he would become depressed in the healthcare environment. He signed a medical disclaimer form confirming that he did not want to stay in healthcare as an inpatient. Before returning to the wing he spoke to a doctor and the chaplain. He discussed his condition at

length and what he would like in terms of his care. He agreed to return to healthcare if his pain increased.

56. The following day, a nurse visited him on the wing. He was again offered the opportunity to move to healthcare, but declined. He was advised that if his condition deteriorated any further, he would have no choice but to move.

57. Later that day, a doctor met with the Head of Healthcare. The Head advised that the Deputy Director had said that he wanted the man to be moved to healthcare. The doctor made a note in his medical record to say,

“Whilst we respect that the Director has the right to decide where an inmate is located with the prison we have expressed our concerns that this is not what the patient wants. The most appropriate place of location is where the patient feels most comfortable and at the present time he expresses the wish to remain on the wing which has been his home for 4/12 [four months]. As healthcare professionals we have experience in managing pts [patients] such as him whose prognosis is poor and except that at some stage he will need to be admitted to healthcare as and when condition deteriorates”.

58. The doctor advised the Head that he would speak to the man that evening to try and help facilitate his move to healthcare. When he spoke to him, he explained that he had been referred for palliative chemotherapy, and, due to the number of hospital escorts that would be required for this, this would be better achieved if he were to remain for the time being in healthcare. He agreed to the move, but requested that he be allowed to speak with his friends first.

59. It is understandable that the Deputy Director had concerns about the man’s location, and wished for him to be cared for as an inpatient in the healthcare department. Although he was initially reluctant, it is clear that the healthcare staff took his wishes into account when staff began to discuss the matter. Furthermore, once the doctor spoke to him he agreed to move to healthcare.

### **Compassionate release**

60. The man attended hospital on 27 June, to have ascetic drainage and a possible stent fitted. After his condition deteriorated on 4 July, while still in hospital, a palliative care specialist visited him. A note was made in his prison medical records to say that the nurse thought his prognosis to be very poor, that he was no longer eating believing that he did not have long to live. He expressed a wish not to die in prison, and the nurse commented that he was “suitable for hospice, [but] may not be manageable at home”.

61. On 6 July, the Director asked a member of the administration department to start to collate the required paperwork for the man’s compassionate release application. In an email to the investigator, a member of the Administration team at the prison explained that, after speaking with the Director, she called a member of the Public Protection Casework Team to discuss his application.

She said that she was advised that she could apply at any point in his sentence. However, the member of the Casework Team advised that due to the nature of his offence, his application might not be successful. He advised her to collate all the relevant documentation, such as medical and probation reports, and submit the application when he became physically incapacitated.

62. On 8 July, the man's offender manager completed the required section of the early release paper work. The offender manager commented that, having had sight of the most recent OASys report (a tool used for assessing risk of offenders) "... it has been calculated that he is a low risk of re-offending. However, the concerning and aggravating factor is that he denies the offence outright and refuses to take any responsibility for his offending behaviour".
63. The same day, hospital consultant completed his section and confirmed the man's prognosis: "... incurable disease, [with a] life expectancy limited to some weeks only".
64. The man signed the required consent form on 13 July, which allowed the information to be sent to the Early Release and Recall Section. On 15 July, a note was made in the control room log to say that, as his condition had stabilised, he may be able to return to prison on 21 July. The admin team member advised that the early release paperwork was ready to be passed to the Director to complete his section. However as he was not "physically incapacitated" at this time (the member of the Casework Team asked that all paperwork be submitted when he became so).
65. The man's health declined rapidly and he died unexpectedly, before the paperwork could be finalised. This is, unfortunately, not uncommon given the difficulty in judging life expectancy, and no criticism is made of the prison in this regard.

## **Palliative care plans**

66. The man was diagnosed with stomach cancer on 7 June. It was explained by the consultant surgeon that, due to the advanced nature of his cancer, palliative chemotherapy was his only option. The consultant made a referral to another hospital, and asked that he be seen for possible palliative chemotherapy.
67. A prison doctor saw the man the next day making a note in his medical file to say, "Lost some more weight since [I] last saw him... Will start care plan with head of healthcare to include memo to kitchens for soft diet".
68. Another prison doctor spoke with the palliative care nurse specialist on 4 July. She explained to the doctor that the man's prognosis was very poor. She commented that he would be suitable for hospice care but, due to his current state of health, he may not be manageable at home. It was suggested by the consultant that he may have benefited from palliative chemotherapy; however, this did not occur as his condition deteriorated rapidly.
69. The man was seen by a specialist palliative care nurse and plans were made for palliative treatment for him, although he died before this was possible.

## **Restraints, security and bed watch**

70. The man attended appointments at outside hospital on 13 and 25 May, and on 7 and 15 June. However, the escort risk assessments (detailing the reason for and location of escort, the risk of escape or to others during the escort) or person escort record (a form that accompanies prisoners on all journeys from and between prisons, providing a chronological record of the escort) were only available to the investigator from 24 June. During the visits to hospital from 24 June onwards restraints were used. Therefore it is reasonable to assume that during the earlier visits restraints were also used.
71. In preparation for a visit to hospital on 28 June, a risk assessment was conducted by two prison officers. The risk assessment confirmed that there were "no medical reasons why restraints can't be used" and that the man was "cooperative with staff and would not pose a risk to escort staff or public given the opportunity". However, despite this, instructions were given to escorting staff that he should be double cuffed (double cuffing refers to two sets of handcuffs being used, with one set being applied to the prisoner's wrists, and the second set is attached to the prisoner and the other to one of the escorting officers) due to the nature of his offence. They were advised that, if permission was sought, an escorting chain may be used during medical treatment with restraints to be removed only in an emergency.
72. After a management review on 1 July, it was decided that the man posed a low risk of escape whilst in hospital, and the bedwatch officers were instructed to remove the handcuffs. However, on 14 July, after he spent most of the day in the day room watching TV, the duty manager advised that, after observing his increased mobility, the escort chain was to be re-applied. The bedwatch

officers were advised that the escort chain was to remain on day and night, and should only be removed in an emergency.

73. The man's condition deteriorated rapidly when he collapsed in the toilet cubicle. Bedwatch officers called for assistance from hospital staff and restraints were removed to allow for resuscitation attempts. This was appropriate.
74. During a family visit the man's partner asked if he was still attached to the escorting chain when he collapsed. She said that, when she went to identify his body, she noticed marks down the side of his face that looked like they had been caused by a fall. The investigator confirmed that he had fallen in the toilet when he collapsed, and that could have caused the marks on his face. After reading statements made by the bedwatch officers, it is clear that when he collapsed in the toilet he was still on the escorting chain which was removed to allow the nurses to tend to him during the emergency response. It is also clear that his health deteriorated very quickly, before the decision to remove the cuffs could be considered. At this time the bedwatch officers were under the instruction that he should remain on the escorting chain, this only being removed for medical intervention. The action taken by bedwatch staff was appropriate.
75. It appears that consideration was given to when and how the man should be restrained and when these should be removed and this was applied appropriately and in line with prison procedure.

#### *Concerns raised by the man's family*

76. During the investigation, the man's partner raised a concern regarding the treatment he received whilst in hospital. She explained that, when he was first admitted to hospital, he was given a private room away from other patients, and was not handcuffed. However, later on he was moved onto a ward and placed back into restraints. She commented that his being on a ward was awkward for both staff and other patients on the ward. The investigator explained that as he became more mobile it was prison policy to place him back on an escorting chain. In addition to this, the investigator explained that his location whilst in hospital was a hospital decision and not in the Ombudsman's remit for investigation.
77. The man's partner raised a further concern regarding the behaviour of bedwatch staff. She explained that the escorting officers were not very considerate. She said that one officer "put her feet on the bed and they [the escorting officers] said that he [the man] was lucky to be on a long chain". The investigator explained that she had interviewed the bedwatch officers, and would look through the bedwatch logs to see if she could find anything of concern. After examining the bedwatch logs and the man's medical records, and speaking to bedwatch staff, the investigator found no evidence to prove or disprove the family's concerns. However, clearly the family were upset and distressed by some events at the hospital. With this in mind and without

attributing fault, it would be prudent for the Director to issue guidance for staff conducting bedwatches, and the standards of expected behaviour.

**The Director should issue guidance to staff regarding the expected standard of behaviour for staff when carrying out bedwatch duties.**

## **CONCLUSION**

78. The man was promptly diagnosed with stomach cancer but unfortunately died very quickly after diagnosis. He had an aggressive form of stomach cancer which had spread to other organs which made the cancer inoperable. The clinical reviewer comments in his review that: "His care was entirely appropriate indeed it would compare very favourably with a patient with a similar problem in the community". He concludes his review by saying that he appeared to have been treated promptly, appropriately and with compassion. The investigation concurs with this overall assessment.

## RECOMMENDATIONS

1. The Director should ensure that the prison and the local health authority agree a policy that the notification of the next of kin is undertaken by the Director or their nominated representative.  
**The prison accepted this recommendation.**
2. The Director should issue guidance to staff regarding the expected standard of behaviour for staff when carrying out bedwatch duties.  
**The prison accepted this recommendation.**