# Investigation into the circumstances surrounding the death of a man at HMP Dovegate, in October 2009

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

**June 2010**

This is a report into the death of a man at HMP Dovegate in October 2009. The man was 68 years old. A post mortem showed that he died from ischaemic heart disease. I offer my sincere condolences to the man's family and friends for their loss.

The investigation was carried out on my behalf by my colleague who is one of the investigators. We would like to thank the Director of HMP Dovegate and his staff, in particular Head of Operations for their co-operation during the course of our enquiries. I also thank South Staffordshire PCT for the appointment of the clinical reviewer.

As the man died from natural causes, the findings of the clinical review play a critical part in my report. The review shows that the man had a reasonable standard of care whilst he was in custody, although there were some shortcomings that should be addressed.

I endorse the recommendation made in the clinical review concerning cancellation of hospital appointments. The man missed 14 appointments, the majority cancelled by Queens Hospital. I am disappointed to repeat this recommendation and ask the Director, Head of Healthcare and PCT to urgently address this matter. I endorse the recommendations made concerning medical record keeping and the need to follow clinical instructions to undertake blood pressure checks. I draw the attention of the Director and Healthcare Manager to the other recommendations in the clinical review. I also make one recommendation concerning breaking the news of a death to the bereaved family.

**Jane Webb**
**Acting Prisons and Probation Ombudsman** **June 2010**

**CONTENTS**

## SUMMARY

The man was born in October 1941, and lived in the London area prior to his conviction on 15 June 2005 when he was remanded into custody at HMP Liverpool. On arrival it was recorded that he had experienced three heart attacks in the past and was taking medication for angina, high blood pressure and cholesterol.

The man was sentenced to 22 years in custody on 30 October 2006, and remained at Liverpool until he was transferred to HMP Dovegate on 19 March 2007. He continued to take his medication, which was regularly reviewed by one of the prison doctors.

The doctor referred the man to a consultant cardiologist on 4 April 2007. There were 14 cancelled or rescheduled appointments before he saw the consultant cardiologist on 27 February 2009, who recommended that he had an exercise tolerance test and echocardiogram to fully assess his heart condition. An appointment was arranged for 11 May but. on the day he refused to attend.

The man was admitted to healthcare by a prison doctor on 1 October, so that he could be closely monitored. Five days later on 6 October, at 5.30pm he was found not breathing in his cell. Staff started cardio pulmonary resuscitation (CPR) and an emergency ambulance was called. The paramedics arrived and took over CPR but assessed that the man had died. He was pronounced dead at 5.55pm. The post mortem showed that he died of ischaemic heart disease.

The prison records showed that the man's next of kin lived in Kent. Due to the distance and time of day, the decision was taken by Dovegate to approach Kent Constabulary to notify them of his death. The family were notified later that night by the police.

The prison family liaison officer spoke to the family the following morning and offered support and financial assistance towards the funeral costs. Dovegate abided by the family's wishes that there should not be any prison representation at the funeral. The family liaison officer did take the man's money and belongings to his daughter in person.

There are several issues arising out of this investigation. I do not consider that the care the man received was equitable with what he could have expected in the community. The clinical review highlights shortcomings that should be addressed. Specifically the medical records were not maintained to the required standard, clinical requests for blood pressure checks were not followed, and I am very concerned about the number of cancelled or rescheduled hospital appointments.

I also make a recommendation regarding breaking the news to a bereaved family. The police should only be used as a last resort.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 7 October 2009 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to discuss information relating to the man's death to make themselves known to the investigator. No prisoners came forward as a result.

2. The investigator visited HMP Dovegate on 16 October. During his visit he was also given copies of all the documentation relating to the man. The investigator returned on 19 November, 21 December and 6 January 2010 to interview eight members of staff.

3. South Staffordshire Primary Care Trust asked the clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer discussed aspects of the man's treatment and jointly interviewed staff at HMP Dovegate.

4. The investigator contacted Her Majesty's Coroner for South Staffordshire to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into Mr Johnson's death

5. One of the family liaison team contacted the man's family about the investigation. The family had no issues or concerns that they wished the investigator to explore at that time.

## HMP DOVEGATE

6. Opened in 2001, Dovegate is a category B prison for adult male prisoners sentenced to over four years and local remand prisoners. It is managed by Serco under contract to the National Offender Management Service (NOMS). It currently holds up to 1,146 prisoners. There are 946 in the main prison and 200 in the therapeutic community (TC). Healthcare services in Dovegate are provided by Serco Health.

7. Her Majesty's Chief Inspector of Prisons last reported on Dovegate following an announced inspection in October 2008. The Chief Inspector said that:

> "On our last two visits to the main prison, we noted serious weaknesses in safety and control and a lack of progress between inspections. To the credit of the Director and his staff, this full announced inspection found a safer and more controlled prison with reasonable purposeful activity, although resettlement remained weak.
>
> "The establishment was now much better ordered and considerable efforts had been made to tackle bullying. A strong emphasis had been placed on security, and this was not disproportionately affecting the regime for prisoners. Staff appeared more confident and there had been a substantial reduction in the use of force."

8. Regarding the healthcare services at Dovegate, the Chief Inspector made the following comment::

> "Primary health services were reasonable, but were compromised by shortages of staff and accommodation, which needed a substantial increase in funding for healthcare to move forward. Chronic disease management was maintained despite staff shortages, but staff needed more time to give a quality service to prisoners. Many NHS appointments were cancelled or rearranged, and pharmacy services needed further development. Nursing staff administered medications on their own, which was unsafe. Mental health services were good and developing, and prisoners were well supported by the primary and secondary services."

9. The Independent Monitoring Board (IMB) comprises lay people from the community who monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained. The IMB Annual Report, for the period 2007-08, made the following comments regarding healthcare services:

> "Serco Healthcare has a contract to provide healthcare at HMP Dovegate. Unlike Home Office prisons the local Primary Care Trust is not responsible for delivering healthcare at HMP Dovegate, but does provide support for clinical guidance.

"Any prisoners requiring more specialist treatment, or emergency treatment, are transferred to the local District Hospital. This can be costly, requiring transport, escorts and sometimes bed watches. In the future it is hoped to provide minor surgery and more specialist clinics *in situ*.

"There has always been a high turnover of staff in healthcare, nurses and GPs, as well as managers. This unit needs some stability particularly at this time. As part of the ongoing extensions to HMP Dovegate the healthcare unit is to be increased in size, extra facilities and more single rooms are to be provided."

10. This is the 11th death to have occurred at Dovegate since April 2004 when the Ombudsman began investigating deaths in custody in England and Wales. Of the ten previous cases, five were due to natural causes. In three of the previous investigations the Ombudsman recommended that the Director and Healthcare Manager ensure that medical records are to the standard required by the General Medical Council and Nursing and Midwifery Council. I have also had cause to repeat a recommendation regarding cancelled hospital appointments.

## KEY FINDINGS

11. The man was born in October 1941, and lived in the London area prior to his conviction. On 15 June 2005 he appeared at Tower Bridge Magistrates Court and was remanded into custody, initially to HMP Emley, and then to HMP Liverpool on 27 September.

12. On arrival at Liverpool the man underwent a reception health screen with a nurse. It was recorded that he had suffered a total of three heart attacks, one in 1987, 1992 and 1999 and continued to suffer from angina. He was prescribed the following medication: Atorvastatin (for treatment of cholesterol), Furosemide (for the treatment of congestive heart failure), Amiodarone (for the treatment of an irregular heart beat), Losartan (for the treatment of high blood pressure), Diltiazem (for the treatment of high blood pressure and angina), Glyceryl Trinitrate spray (for the treatment of angina), and aspirin.

13. From 30 September 2005 to 30 October 2006 the man appeared at Liverpool Crown Court on 39 occasions. On his last appearance, on 30 October, he was sentenced to 22 years in custody and remained at Liverpool

14. The man transferred to HMP Dovegate on 19 March 2007. A reception health screen was conducted by a nurse who noted both his past medical history and current medication. The nurse noted that he had no mental health issues and had no thoughts of harming himself. His blood pressure was recorded as 150/70. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.). His weight was 145kg. The man told the nurse that he experienced breathing problems when he exerted himself. The nurse made an appointment for him to see the doctor on 26 March.

15. The man did not attend the doctor's appointment on 26 March. There is no evidence in the medical records to say why this was or what follow up action was taken, if any.

16. On 4 April a prison doctor, sent a referral letter to the cardiologist at Queen's Hospital, Burton on Trent. The doctor wrote that the man was obese, had experienced three heart attacks in the past and had problems walking and breathing. The doctor added that he had fluid on both his lungs and legs. There is no entry in the medical record to show whether the doctor actually saw the man before making the referral.

17. Queen's Hospital replied by letter 24 April, received by Dovegate on 30 April, giving an appointment for the man to see a doctor on 16 May. The letter said that this was the first available appointment "within the clinical priority of the consultant". On examination of the medical records, the investigator saw there was a handwritten note on the letter with the words "fully booked - reschedule". When interviewed the Healthcare Manager, explained that the system at Dovegate allowed four prisoners each day to go out for hospital

appointments. This is because uniformed staff were needed to escort the prisoners. If there were more appointments than places on any given day, priority was based on clinical need. Healthcare would contact the hospital to re-arrange the necessary appointments. Any emergency admissions to hospital were in addition to the four planned appointment visits. The Healthcare Manger went on to say that, as in the community, the hospital also cancelled and/or rescheduled appointments.

18. The table below shows the sequence of appointments made for the man between April 2007 and April 2008, at the Queens Hospital, detailing the instigator of the cancellation or rearrangement.

| Date | Appointment | Reason |
|---|---|---|
| 24/07/07 | Appointment arranged for 16 May | Cancelled by Dovegate |
| 03/05/07 | Appointment changed to 27 June | Changed by hospital |
| 13/06/07 | Appointment for 27 June changed to 25 July | Changed by hospital |
| 24/07/07 | Appointment for 25 July changed to 1 August | Changed by hospital |
| 25/07/07 | Appointment for 1 August changed to 2 August | Changed by hospital |
| 05/09/07 | Appointment for 24 September | Cancelled by Dovegate |
| 06/09/07 | Appointment for 24 September changed to 21 November | Changed by hospital |
| 20/11/07 | Appointment for 21 November changed to 27 February 2008 | Changed by hospital |
| 18/01/08 | Appointment for 27 February time changed from 9.30am to 2.00pm | Changed by hospital |
| 21/01/08 | Appointment for 27 February changed to 23 April | Cancelled by Dovegate |
| 24/01/08 | Appointment for 23 April changed to 28 May | Changed by hospital |
| 11/02/08 | Appointment for 28 May changed to 27 May | Changed by hospital |
| 22/04/08 | Appointment for 27 May changed to 18 July | Changed by hospital |

19. Between 24 July 2007 and 22 April 2008 the man had his medication reviewed by the prison doctor on 12 separate occasions. Each review was recorded in the medical records, however it was not possible to identify which doctor made the entry, and some of the notes were illegible. The notes do not make it clear whether he was actually seen by the doctor or the review was undertaken in his absence. There were no changes to his medication during this period.

20. On 27 May the man's medication was reviewed again by an unidentified prison doctor. The doctor recorded a request for the man's blood sample and pressure to be taken. This was carried out by an unidentified nurse on 10 June, but the entry in the notes only stated that a blood sample was taken. There is no entry concerning his blood pressure.

21. The next letter from the Queen's Hospital was received at Dovegate on 12 June. It gave details of an appointment for the man on 18 July. A handwritten note on this letter stated that his appointment was to be moved to accommodate the needs of another prisoner, and a further letter was then received changing the appointment to 26 September.

22. Between 20 June and 14 August, there were three further reviews of the man's medication. Again, on each occasion, the doctor could not be identified from the entry made and there were no changes to the prescription.

23. The Queen's Hospital next sent a letter on 29 August to Dovegate to cancel his appointment for the 26 September, and reschedule it for 28 November. Two weeks later there was another medication review conducted, by an unidentified doctor, and no changes were made to the man's medication.

24. On 13 October prison doctor reviewed the man's medication and again made no changes. A week later the lead nurse for the chronic heart disease clinic, saw the man. The nurse recorded that his blood pressure was 162/89 and referred him to the doctor. A prison doctor saw the man on 12 November, and prescribed Simvastatin (for treatment of high cholesterol) in place of Atorvastatin.

25. Dovegate received a letter from the Queen's Hospital on 21 November, which cancelled the man's appointment on 20 February 2009 and rescheduled for 27 February 2009. (The investigator found no evidence that the man's scheduled appointment for 28 November had been cancelled, nor was there any letter from the Queen's Hospital found in the documentation that rescheduled this appointment to 20 February 2009). On the same day the man had an appointment with the lead nurse for chronic heart disease but wing staff said that he was not well enough to attend. The nurse re-booked the appointment for 4 December and advised that the man was to contact healthcare immediately if he needed any assistance.

26. The man did not attend the appointment arranged on 4 December and there is no evidence of any follow-up action being taken. Four days later a prison doctor reviewed the man's medication and there were no changes made to the prescription.

27. On 2 January 2009 the man had another appointment with the nurse but again failed to attend. Five days later the prison doctor repeated the man's prescription.

28. The nurse saw the man in the nurse clinic on 26 January. The nurse recorded his blood pressure as 188/96 and set a review for four weeks time. The nurse also noted that blood tests were required for both glucose and cholesterol.

29. The blood samples were taken on 10 February but there is no record of the results, nor a review by either a nurse or doctor. The following day the prison

doctor reviewed the man's prescribed medication and no changes were made.

30. On 27 February the man saw a doctor at the cardiology department of Queen's Hospital. The doctor sent a letter to a prison doctor that outlined the findings of his assessment. The doctor wrote that the man complained of exertion angina, which had become worse over the past few months, and he had an exercise tolerance of about 50 metres. The man's blood pressure was recorded as 138/83 with a regular pulse of 82 per minute. In addition his heart sounds were normal and the results of a chest x-ray were clear. The hospital doctor recommended that the man had an exercise tolerance test and echocardiogram (creates two-dimensional pictures of the cardiovascular system) in order to evaluate his coronary artery disease, and prescribed Nicorandil (for treatment of angina).

31. The prison doctor reviewed the man's medication on 10 March and no changes were made. Two days later Dovegate received two separate letters from the Queen's Hospital. The first was for an appointment for an exercise tolerance test on 6 April. This had a handwritten note on it which stated "reschedule". The second was for an appointment for an echocardiogram on 7 April.

32. Queen's Hospital sent a letter on 17 March with a rearranged appointment for the exercise tolerance test on 11 May. Six days later he had an appointment with the lead nurse but he failed to attend. There is no record of any follow up action taken. The prison doctor next reviewed, and repeated the man's prescribed medication on 6 April. The man also failed to attend two further appointments with the lead nurse on 10 and 22 April, and the prison doctor conducted a further medication review on 6 May.

33. On 11 May, an unidentified nurse recorded that the man was fit to attend an outpatient appointment that day. However a Consultant Cardiologist at Queen's Hospital, sent a letter to the prison doctor dated 22 May, stating that the man had refused to attend his appointment for the exercise tolerance test and echocardiogram. The Consultant Cardiologist suggested that the man required a coronary angiogram (procedure to access the blood filled chambers of the heart for both diagnostic and treatment purposes).

34. The Consultant Cardiologist wrote directly to the man at the same time to explain his recommendation for the angiogram, which would be carried out at Glenfield Hospital. The Consultant Cardiologist asked the man to provide his written consent to have the procedure. There is no entry in the medical record that the reason for the procedure was explained to the man by any member of the healthcare team, nor that he refused to have it done.

35. There were then four further reviews of his medication on 3 June, 29 June, 27 July and 25 August. The first three were conducted by the prison doctor, the last by an unidentified doctor. No changes were made at any of the reviews.

36. On 24 September a nurse responded to a call for medical assistance to attend to the man. He complained of shortness of breath and said this had happened several times over the past two weeks, but he had not told anyone. He told the nurse that he had experienced three heart attacks in the past and had refused to attend recent reviews with the nurse. The nurse made an emergency appointment with the doctor for the next morning. The man told the nurse that he would attend.

37. The nurse further recorded that the emergency bag did not contain an oxygen saturation testing (SATs) machine or a stethoscope and so no details could be recorded. The Healthcare Manager said, at interview, that there are five emergency bags each containing a list of the equipment and consumables in the bag, including a SATs machine and stethoscope. There was no explanation as to why these items were missing. She said that it was the nurse's responsibility to ensure that anything used from the emergency bag was replaced.

38. There is no record whether the man was seen by a doctor the following day as requested by the nurse. Five days later an unidentified nurse responded to a request from wing staff to see him as he was complaining of breathlessness. The nurse recorded that he refused to be examined.

39. The prison doctor saw the man on 1 October and recorded that he was grossly obese, was short of breath on undressing and his ankles were swollen. The doctor increased the prescription of Simvastatin to 40mg and Furosemide to 40mg. Later that afternoon, after reviewing the case the prison doctor took the decision to admit him as an in-patient in healthcare for close monitoring, although the man wanted to remain on his wing.

40. On admission to healthcare, a care plan was produced by the Deputy Healthcare Manager. This detailed the care interventions required for the man. They included monitoring his blood pressure daily, monitoring and recording the episodes of shortness of breath and identifying any aids or assistance to reduce his breathlessness. The Healthcare Assistant (HCA) checked the man at 4.10pm, 6.05pm, 6.50pm and 7.45pm. On each occasion it was recorded that there were no concerns and he said that he was breathing more easily.

41. The next day the man was seen by the HCA at 8.00am, 11.40am, 5.10pm and 5.35pm. It was recorded that he had lunch but refused his tea, however there were no other concerns. During the day the prison doctor saw the man noting that there had been an excellent response and that he had a good nights sleep for the first time in days. The prison doctor recommended that the man should remain in healthcare, continue with the same medication and have blood tests. There is no record in either the clinical record or care plan that the man's blood pressure was taken as detailed in the care plan, or that blood samples were taken as requested by the prison doctor.

42. The following day a HCA saw the man at 8.30am, 12.00pm, 3.30pm, 4.00pm and 5.55pm. It was recorded that he had lunch and again refused tea and there were no other concerns.

43. The HCA saw him the next day at 8.00am, 2.00pm, 4.30pm and 5.00pm. Again the man had lunch but refused tea, and spent most of the day in his cell asleep. No other concerns were recorded.

44. The following day the man was seen by two HCA at 9.15am and 1.45pm. He told of them that he wanted to go back to his own houseblock and asked to see the doctor. The prison doctor saw him at 4.00pm and recorded that his ankles were less swollen, he still felt tired and his pulse was 100 after a short walk. The doctor increased the level of Furosemide to 80mg. In the time he was in the healthcare centre, there is no record in either the clinical record or care plan that the man's blood pressure was taken.

**Events of 6 October**

45. At 7.40am a HCA checked on the man who was asleep. No problems overnight were recorded. Later at 9.40am a HCA saw him and again no problems were noted.

46. The prison doctor saw the man at 2.00pm. The man said that he felt much better; and in fact he said that he felt "great". The doctor recorded that had a good normal colour, his chest was clear and requested that blood samples were to be taken that day.

47. In accordance with the regime at Dovegate all prisoners are locked in their cells at 4.30pm for the evening roll count (a security check to ensure all prisoners are accounted for). The man was seen at 5.00pm, sitting on his bed watching the television.

48. At 5.30pm prisoners are unlocked to collect their evening meal. Prison Custody Officer (PCO) unlocked the man's cell and called to him that it was meal time. The man was lying on his bed and did not respond. The PCO went into the cell to see if he was alright. On approaching him, PCO Edwards could see that his face was discoloured. He immediately called for urgent medical assistance and started cardio pulmonary resuscitation (CPR). A HCA ran into the cell and assisted with CPR and the 999 emergency call was made.

49. Duty Manager and a HCA arrived at the cell and continued with CPR until the paramedics arrived at 5.50pm. The paramedics took over CPR but assessed that the man had died. He was pronounced dead at 5.55pm.

50. The prison records showed that the man's next of kin lived in Kent. Due to the distance and time of day, the decision was taken by Dovegate to approach Kent Constabulary to notify them of his death. They were notified later that night by the police.

51. The prison family liaison officer and a Governor spoke to the family the following morning and made the offer of support and financial assistance towards funeral costs. Dovegate abided by the family's wishes that there should be no prison representation at the funeral, but the Governor took the man's money and belongings to his daughter in person.

52. A hot debrief for all staff involved in the emergency response was held and full care and support was offered to staff affected. The post mortem showed that he died of ischaemic heart disease.

## ISSUES

### Clinical care

Cancelled appointments

53. The clinical review into the care that the man received made the following comments:

> "The care that the man received at Dovegate was not fully up to the standard that he could have expected in the community. On arrival his medical history and medication were correctly assessed and recorded. However during the period 24 April 2007 and 27 February 2009 there was a total of 14 cancelled or rescheduled hospital appointments at Queen's Hospital, four of which were instigated by Dovegate, before the man saw the consultant cardiologist on 27 February 2009."

54. This is not the first occasion that an investigation of a death in custody at Dovegate has highlighted the issue of cancelled or rearranged hospital appointments at the Queen's Hospital. It should be noted that cancellation of appointments made by the hospital impacts on Dovegate's ability to effectively manage clinical need and patient care. I endorse the following recommendation:

**The Director and Healthcare Manager should review the process for managing outside hospital appointments, by engaging with the PCT as commissioners, to ensure that the waiting time for prisoners to see hospital specialists meets the time that could be expected in the community. Consideration has to be given to the "choose and book" approach and fixed timeframes for access to services for all prisoners to be equitable as those of people in the community.**

55. A copy of this report will be sent to the Chief Executive of the PCT and I draw their attention to this recommendation.

Monitoring blood pressure

56. There were several occasions in the man medical records where clinical requests had been made for blood pressure checks to be undertaken but no recorded action was taken. In addition, when he was admitted into healthcare on 1 October, the care plan included daily blood pressure monitoring. The clinical reviewer commented:

> "Both the prison doctor and the Deputy Healthcare Manager had requested the man's blood pressure to be regularly monitored due to his medical condition in his stay in healthcare. However no record could be found, in either his main clinical record or the care plan drawn up on 1 October, of regular blood pressure checks."

57. I endorse the following recommendation:

**The Healthcare Manager should review the process for taking blood pressure levels and to ensure that all healthcare staff follow appropriate clinical requests and documented treatment plans. All results must be promptly acted upon and documented, so that prison doctors can make timely documented clinical decisions.**

Medical record keeping and missed appointments

58. There were a number of illegible entries made in the man's medical records made by unidentified staff. There were also no entries made to explain why he failed to attend various appointments in healthcare, whether any follow up action was taken and no evidence of when test results were received and action taken. It is unclear therefore what action healthcare staff did or did not take.

59. The clinical review makes the following comment regarding clinical records at Dovegate:

> "Clinical record keeping is below the standards expected of the Nursing & Midwifery Council (NMC) and the General Medical Council (GMC). There are specific guidelines from the GMC and NMC for doctors and nurses to complete medical records in a contemporaneous way. It is essential that facts are recorded accurately and chronologically to ensure there is record and continuous history of a prisoner's needs and treatments."

60. I endorse the following recommendation:

**The Director and Healthcare Manager should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.**

61. The clinical review concludes that:

> "The death of the man was a shock to many of the healthcare and prison staff at Dovegate. The man had a history of obesity and poor lifestyle that will have contributed to his subsequent death. He suffered with heart problems and breathing difficulties before he was admitted to the prison system and continued to suffer while carrying out his custodial sentence. There may have been other medical interventions that may have prolonged his life but it is impossible to say for how long it may have done so, nor is it possible to say if the man would have consented and complied with them. Ultimately he was an independent adult able to deal with his health and personal needs.
>
> "I could find nothing to suggest that the healthcare staff or department intentionally or accidentally failed in their duty of care to the man,

however I do feel that there can be improvements made at all levels with appropriate processes established and monitored, to minimise the inequity between prison healthcare services and those available within the community setting."

**Family liaison**

62. Prison Service Order 2710, Follow up to deaths in custody, requires that the next of kin should normally be contacted face to face as soon as possible after a death occurs. If the family live too far from the prison, best practice is to ask a prison closer to the family home to break the news. The police should only be asked to break the news if there is a safety risk to staff going to the family home, or for some other pressing reason.

63. In the man's case, Dovegate asked Kent Constabulary to break the news to his family. This was carried out later in the same evening that he died. Whilst I appreciate the demands on prison staffing during the night, using the police in this circumstance is at odds with the spirit of PSO 2710 and does not, in my view, demonstrate the highest level of care and consideration. Subsequent contact by the prison's family liaison officer was by telephone and a visit to return his money and belongings.

64. Dovegate may have considered there was a need to balance the need to deliver the news personally to his family with the need for timeliness. Due to the time and the distance in which his next of kin lived from the establishment the latter seemed to be important. However, in contacting another prison in the vicinity of the family home would still have provided the opportunity for a Prison Service official to break the news in accordance with Prison Service policy. Indeed, this has been my experience elsewhere in the Prison Service.

**The Director should ensure that the family liaison officer from Dovegate, or another prison, is used to inform the family of a death in custody.**

## CONCLUSION

65. I recognise the issues highlighted in the clinical review and judge that the standard of care that the man received whilst at Dovegate was not fully equitable to what he could receive in the community. The standard of record keeping was below what is expected and there was no follow up of clinical requests. There were a considerable number of cancelled or amended hospital appointments, many outside the control of Dovegate, which the prison and PCT need to address. However, I also recognise that ultimately he was an independent adult able to deal with his health and personal needs.

66. Prison Service Order 2710, Follow up to deaths in custody, requires that next of kin should normally be contacted face to face as soon as possible after a death has occurred. Whilst I appreciate that his family lived a considerable distance from the prison, all possible attempts should have been made to deliver the news to the family face to face by the Prison Service rather than by the police.

## RECOMMENDATIONS

1. The Director and Healthcare Manager should review the process for managing outside hospital appointments, by engaging with the PCT as commissioners, to ensure that the waiting time for prisoners to see hospital specialists meets the time that could be expected in the community. Consideration has to be given to the "choose and book" approach and fixed timeframes for access to services for all prisoners to be equitable as those of people in the community.

   *Partially Accepted - The HCC will be conducting a full review of the referrals to hospital. All referrals to hospital are seen within 18 weeks, which is the same as that of the NHS. Choose and Book can not be considered as individual patient passwords/ and electronic referrals could lead to a security breach*.

2. The Healthcare Manager should review the process for taking blood pressure levels and to ensure that all healthcare staff follow appropriate clinical requests and documented treatment plans. All results must be promptly acted upon and documented, so that prison doctors can make timely documented clinical decisions.

   *Accepted - The HCC has gone through a major change in the last two months. New staff, policies and procedures are now in place to stop this happening. Nurse Team Leaders and management checks are being implemented to audit and confirm adherence to policies. Detailed training plans in place to support the recording of clinical information. IMRs recorded for and monitored daily. Completed June 2010 and on going processes.*

3. The Director and Healthcare Manager should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   *Accepted - New staff now recruited; as part of the recruitment and induction process all new clinical staff have received policies on clinical recording of data. This is an on going issue, and as the staff develops, we should see a vast improvement in data quality. Team Leaders and the Deputy health care manager are now tasked to do random checks. Recruitment of a new full time GP has assisted in record keeping. Completed June 2010 and on going processes.*

4. The Director should ensure that the family liaison officer from Dovegate, or another prison is used to inform the family of a death in custody.

   *Accepted - Contingency Plans revised to reflect this.*