

**Investigation into the circumstances surrounding the
death of a man,
a prisoner at HMP Durham, in October 2009**

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

April 2010

This report considers the circumstances of the death of a man at HMP Durham in October 2009. He was 61 years old when he died. A post mortem showed that he died from bronchopneumonia (infection of lungs and linked airways) and disseminated carcinoma oesophagus (cancer of the oesophagus).

I offer my sincere condolences to the man's family and friends for their loss. One the Family Liaison team had contact with the family during the investigation. I apologise for the delay issuing my report and any additional distress this may have caused.

The man's family told the investigator that they did not believe that he received good care whilst he was in prison. They believe that a terminally ill man, such as he, should not have been in custody at the end of his life. They are also concerned about communication between the prison and the hospital, the use of restraints, visiting arrangements and information provided for them. I have considered their concerns carefully in the report.

The investigation was carried out by my colleague. We would like to thank the Governor and his staff for their co-operation during the course of our enquiries.

I also thank the local Primary Care Trust for appointing a clinical reviewer. As the man died from natural causes, the findings of the clinical review play an essential part in my report. The reviewer judges that he received good care whilst he was in custody which was equitable to what he could have expected in the community.

I make one recommendation concerning prisoner's medication when they are discharged from hospital.

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.

Jane Webb
Deputy Prisons and Probation Ombudsman

April 2010

CONTENTS

Summary

The investigation process

HMP Durham

Key findings

Issues

Recommendations

SUMMARY

The man was born in May 1948 and lived in Cumbria. He was married and was 61 years old when he died. He appeared at Magistrates Court on 1 June 2009 and was remanded into custody. He was sent to HMP Durham and, because of his medical condition, he was admitted straight to the healthcare centre as an inpatient.

On 15 July, he appeared at Crown Court and was convicted of a sexual offence and remanded in custody until 27 August. Seven days later he complained of being unable to swallow. The prison doctor made a preliminary diagnosis of cancer and referred him immediately to the specialist consultant at the local hospital.

He was admitted to hospital on 27 July and the specialist confirmed the diagnosis of cancer of the oesophagus and upper spine. He was offered radiotherapy and chemotherapy but declined both. A stent (a tube to prevent constriction within the body) was fitted in his oesophagus to allow him to eat soft food. He was discharged from hospital back to the prison healthcare. The hospital's palliative care team visited him and his wife in prison to review and discuss his needs. He was offered radiotherapy and chemotherapy but declined both.

Due to throat infections, he returned to hospital on the 3 September and 24 September. On each occasion he was discharged back to the prison after being treated for the infections.

On 8 October, he was taken back to hospital as his condition had deteriorated rapidly. His family were informed of his deteriorating health before he left the prison but, due to the distance and the time for the journey, they arrived after he died.

I am satisfied that the care and attention he received at Durham was equitable to that he could have expected to receive in the community. He exercised his right to refuse palliative treatment.

I make one recommendations concerning prisoners receiving prescribed medication on discharge from hospital.

THE INVESTIGATION PROCESS

1. The investigation was opened on 9 October 2009 when an investigator issued notices 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 prisoners came forward as a result.
2. The investigator contacted HMP Durham on 10 October to obtain copies of all relevant documentation relating to the man. The investigation was reallocated to another investigator on 24 February 2010. He visited Durham on 17 and 18 March and interviewed eight members of staff.
3. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care. The Ombudsman's investigator liaised with the clinical reviewer to discuss the care the man received.
4. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my 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 the man's death.
5. One of the Family Liaison team was in contact with the man's family during the investigation. Both she and the original investigator met the family on 14 December 2009. They expressed their wish for him to be referred by his nickname in the report.
6. The family raised the following concerns which they wished the investigator to address:
 - They believe the man did not received good care whilst he was at HMP Durham, and that prison healthcare was an inappropriate setting for him to receive the necessary care that he required.
 - They believe that there was a lack of communication between the prison and the hospital.
 - They believe that the level of escort and use of restraints was inappropriate given the man's medical condition.
 - They believe that the visiting arrangements at the prison were not acceptable.
 - They can not understand why they were not informed sooner of the man's deteriorating health in the period leading up to his death in October 2009.
7. I have attempted to address the issues raised within the report. I hope that it provides a better understanding of the treatment he was given and the events leading up to the man's death.

HMP DURHAM

8. HMP Durham is a Category B local prison built in the early 19th century. It serves the courts in the local area and it holds just under 1,000 prisoners. The prison comprises seven wings as well segregation and healthcare units.
9. The local PCT commissions and provides primary care health services and the NHS Trust provides specialist mental health services. There is 24 hour healthcare provision, which includes a clinical director and a general practitioner, supported by a primary care nursing team. Inpatient facilities in the prison are located on E wing.
10. Following a full announced inspection of Durham in September 2006, Her Majesty's Chief Inspector of Prisons published a report which found that the new management team was "driving forward some significant and much needed improvements," that "relationships between staff and prisoners were good," and that the prison was an "improving establishment".
11. The Inspectorate carried out an unannounced inspection of Durham in October 2009. The report of this inspection is still at draft stage but I understand that it will reflect the improvements made since 2006.
12. 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. In their report for the year 2007 to 2008, the IMB made the following comments concerning healthcare at Durham:

"Prisoners referred to specialist services in neighbouring hospitals receive treatment within target times as per the local general population.

"Over £900,000 has been spent during 2007/8 on a limited upgrade of the existing building resulting in some improvement. The Board believes the health care centre building still presents some challenges for staff in the delivery of 21st century primary care & Inpatient care.

"The Board remains of the opinion that the building is not totally suitable to the provision of modern healthcare. The Board does appreciate that with the expenditure that has taken place there is, disappointingly, little chance of a new health centre in the foreseeable future."

13. The IMB also commented that:

"Throughout the period of this report HMP Durham has retained its level 3 status in the Prison Service's performance ranking. This implies that the prison is 'meeting the majority of targets, experiencing no significant problems in doing so, delivering a reasonable and decent regime.'"

14. The Prison Service's performance ranking system referred to in the IMB report is a quarterly data driven performance assessment for each prison. The

assessment results in prisons being rated at one of four levels: rating 4 equals exceptional performance; rating 3 equals good performance; rating 2 equals development required; rating 1 equals serious concerns. Durham's rating remained at 3 following the period covered by the IMB's report and remained at 3 for the time the man was there.

15. The man's death was the 21st to occur at Durham since the Ombudsman became responsible for investigating deaths in custody in 2004, nine of which were due to natural causes. There was no link between the circumstances surrounding his death and those of other prisoners.
16. On each occasion a prisoner is escorted outside of the prison to hospital a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.
17. Prisons do not routinely inform the next of kin that their relative has been admitted to hospital. The decision is made after considering the prisoner's health and any security issues and whether the prisoner would be returned to the prison that same day.
18. Early release on compassionate grounds is subject to the instructions contained in PSO 6000 which states that:

"Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period. It is therefore essential to try to obtain a clear medical opinion on the likely life expectancy. The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison."

KEY FINDINGS

19. The man was born in May 1948 and lived in Cumbria. He was married and was 61 years old when he died.
20. He appeared at Magistrates Court on 1 June 2009 and was remanded into custody. He was sent to HMP Durham where an initial healthscreen was conducted by a nurse. The nurse recorded that he had a history of heart disease and had experienced three heart attacks in the past. He was an out patient at hospital. He also told the nurse that he suffered from vertigo and had a duodenal ulcer. The nurse further recorded that he was prescribed Ezetimibe (for treatment of cholesterol), Atrovastatin (for treatment of high cholesterol), Ramipril (for treatment of high blood pressure and heart failure), Omeprazole (for treatment of gastric conditions), Bisoprolol (for treatment of cardiac disease), Prochlorperazine (for treatment of vertigo) and aspirin. Due to his medical condition the nurse decided that he should be seen by the doctor the following day.
21. Rather than being located in the prison's first night centre with other new prisoners, the man was admitted as an inpatient in the healthcare centre where nursing and medical staff could monitor his condition.
22. The next day a Prison Doctor A saw the man and confirmed that he was a patient at hospital. The man had an implantable cardioverter-defibrillator (ICD) fitted in his chest. (An ICD is a small battery-powered electrical impulse generator which is implanted in patients who are at risk of sudden cardiac death.) The doctor confirmed his medication prescription. Healthcare staff contacted the hospital later in the day to ascertain details of the ICD and the care that he needed. It was established that he was scheduled to attend a follow up monitoring appointment at the hospital on 7 July.
23. On 3 June, healthcare staff contacted the man's doctor in the community and received a fax giving details of the treatment he had received. It was noted that he had not attended his six monthly cardiac heart disease blood tests and the prison doctor authorised that they should be carried out by the nurses. Prison Doctor B reviewed the blood test results on 12 June and all tests were normal.
24. The man went to the appointment at hospital as arranged on 7 July. A security risk assessment was completed, assessing that a two officer escort should be in place together with a long escort chain (a two metre chain with a single cuff at either end). The hospital confirmed that the ICD was working well, there was no change required in his medication and that he should have a further appointment in three months time.
25. On 15 July, the man appeared at Crown Court where he was convicted of a sexual offence and remanded in custody until 27 August for reports and sentencing.
26. He next saw Prison Doctor A on 22 July when he complained of being unable to swallow. The doctor made the preliminary diagnosis that this could be due to

cancer of the oesophagus. He made an immediate referral under the National Health Service “Two week rule” to the specialist consultant at hospital.

27. Three days later, the man saw Nurse A and complained again of being unable to swallow properly. He was anxious about his hospital appointment. The nurse examined him but did not find any swelling. He was able to swallow sips of tea and water and was encouraged to continue and to inform staff of any change in his condition.
28. The next day, the man’s wife called the prison to express her concern about her husband who had told her about his difficulty swallowing and also said that he had not had his medication. As a result of these concerns Nurse B and Prison Doctor A examined him again. They found no physical abnormalities or other apparent symptoms. He was told that his hospital appointment was the next day and that the hospital had requested that he should not eat or drink anything from that evening.
29. The man was admitted to hospital on 27 July. A bedwatch risk assessment was completed and the same arrangements were put in place. The escort chain was to be removed for treatment as directed by the hospital staff.
30. The next day a hospital consultant confirmed the diagnosis of advanced cancer of the oesophagus and upper spine, deciding that no surgical intervention was appropriate. The man was offered radiotherapy and chemotherapy but declined both. He was transferred to an Infirmary where a stent was fitted in his oesophagus to allow him to eat soft food.
31. On 3 August, healthcare staff at Durham were informed that the man was to be discharged from hospital later that day. Prison Doctor A wrote to a consultant in palliative care, to refer the man to their services. The doctor also contacted the man’s solicitors to make them aware of his diagnosis.
32. Later that evening, the man was discharged from hospital and returned to the prison’s healthcare centre. Advice was given that he should be having a soft diet, with fizzy drinks before and after food. Tramadol was prescribed for moderate to severe pain relief but it was not issued by the hospital and was not available in the prison until the following morning.
33. The next day, Prison Doctor B saw the man who said that he knew the diagnosis and had been told that there was no cure. The doctor recorded that he was in some discomfort following the stent insertion but had no bone pain. The doctor added the Tramadol to the man’s prescription and sent a memo to the kitchen regarding a soft food diet. To increase his comfort and assist the nurses look after him, he was transferred to a cell with a multi position electric hospital bed. The bed had a pressure relieving mattress designed to prevent bed sores. The nursing staff monitored his pain levels every two hours. As his medication included controlled drugs, it was administered by two nurses working together.

34. Later that afternoon the man's wife contacted healthcare because she was concerned about her husband's care. Prison Doctor A spoke to her at length to explain his condition and the care that he was being given. At the same time, the man's brother-in-law sent a letter of complaint to the Primary Care Trust concerning his care and treatment in prison. The family believed that his care fell below what was required for a terminally ill person needing palliative care. They did not believe that the prison environment was the appropriate location for him.
35. On 5 August, Prison Doctor B prescribed further pain relief in the form of morphine sulphate granules (a long acting pain relief used to control severe pain) and Oramorph (an opioid pain relief used to control severe pain). Later that day, the man's sister rang the prison to enquire how he was and arrange to visit him.
36. Prison Doctor B reviewed the man's pain relief medication the following day and decided to stop the Tramadol. He did not complain of discomfort in the following days with the exception of 9 August when he complained of pain but said that he did not want any additional pain relief medication.
37. The consultant in palliative care and Nurse C from the palliative care team at the hospice came to see the man and his wife in the prison on 10 August. They discussed his illness and that the cancer was inoperable. The consultant advised an increase in the dose of morphine sulphate and also prescribed Temazepam (to treat sleeplessness and anxiety). The doctor also agreed to explore end of life care options including palliative chemotherapy. The man and his wife were given the telephone number to access the palliative care team directly.
38. On 12 August, Nurse D talked to the man about the complaint received from his brother-in-law. Because the complaint had been sent by a relative rather than his next of kin, he had to provide his written consent for it to proceed. It was recorded that he was shocked and upset when he read the content of the complaint, and so he was allowed to speak to his wife about it. Nurse D spoke with the man's wife and sister to inform them that he had to decide whether to proceed with the complaint was his and that he had not given his consent. The nurse also recorded that the family said that the complaint was no reflection on the prison's healthcare services and staff.
39. The same day, the man saw Nurse E. He had two visits that day and told the nurse that he had enjoyed the exercise going from healthcare to the visits area and wanted the arrangement to continue. Nurse E explained that consideration would be given to visits within healthcare if the exertion became too much for him. The nurse also recorded that the man had tried different diets over the past few days and said that he was happy with the variety.
40. The consultant in palliative care contacted healthcare on 13 August to say that the man's sister had been in touch about her concerns that he was not receiving appropriate palliative care. The consultant was assured that the treatment was in place and the doctor said she would inform his sister accordingly. Prison

Doctor A saw the man the same day and noted that his overall level of comfort was good although he did get a burning sensation in the throat. The next day, the consultant contacted healthcare again to say that she intended to visit on 18 August and would like the man's wife to be present for the consultation.

41. On 15 August, Nurse F recorded that the man had taken all his medication and accepted all his food and drinks. Two days later, Prison Doctor A saw him. The doctor thought that he looked and sounded better, and there were no problems with his pain management. The man had not reported any problems or concerns, had eaten well and said he was comfortable in his bed.
42. The consultant in palliative care and Nurse G visited the man and his wife as arranged on 18 August. The hospice doctor found that his pain relief had improved but he complained of having stiff joints. Ibuprofen (used to control pain associated with inflammation) was prescribed and some changes to his pain relief were recommended. The wife and sister expressed their concerns about his healthcare. They stated that they were not concerned about the services provided by the prison, but complained about the handover process that occurred when he was discharged from hospital back to the prison.
43. Following the visit, Nurse D recorded in the medical records:

“I witnessed significant pressure being applied by his visitors for him to reconsider this decision and sign the consent form, despite the man being in tears and clearly upset. There was also a verbal outburst from his sister at the end of the visit when they were informed that future visits would not be facilitated in HCC but in normal visits.”
44. On 20 August, Prison Doctor A saw the man to review his medication for pain relief and recorded that he experienced pain around the lower right rib area. He told the doctor that he was able to swallow and found most of the food palatable. The doctor encouraged him to go outside for some exercise as it was a pleasant day.
45. The following day, Nurse H recorded that the man appeared confused. On one occasion he informed a member of staff that he needed the door opening as he had some worktops to pick up. Later that day the consultant in palliative care contacted healthcare to say that the man's family had contacted her. The family said that he had called them in tears, saying that he had asked for pain relief the day before but had to wait four hours for it. The clinical record was checked which showed that his pain levels were reviewed every two hours and he had not asked for any extra pain relief medication. The consultant recommended that he should be prescribed Haloperidol to relieve his confusion. The doctor also said that he could be referred for palliative chemotherapy, as his “mental cloudiness” might indicate the possibility of secondary tumours in the brain.
46. On 24 August, Prison Doctor A reviewed the man's pain relief again. The doctor explained the benefit of additional pain relief but the man refused any increase in dosage. The night healthcare staff recorded an improvement in his confusion from the preceding days as a result of the prescription of Haloperidol.

47. Three days later, the man appeared at Crown Court via video link and was sentenced to two years in custody.
48. He was re-admitted to hospital on 3 September following Prison Doctor B's assessment that he had a chest infection and needed hospital treatment. A bedwatch risk assessment was completed and he was accompanied by two escort officers using a long escort chain, which was to be removed for treatment as directed by the hospital staff.
49. The same day a meeting took place between the man's family and the Healthcare Manager at Durham and a Principal Officer (PO) as a result of the complaint made on 3 August.
50. On 8 September, the man was discharged from hospital back to healthcare at Durham. The Healthcare Manager recorded the actions that staff were to take to assist with his care and comfort. They were:
- He would use the telephone nearest his cell and be provided with a chair to sit on whilst he was doing so.
 - Medication would be provided in a form that is easy to swallow, i.e. crushed or in liquid form.
 - Medication information be given.
 - He would be assisted with eating, drinking and maintaining his personal hygiene as required.
 - A wheelchair would be provided for him to use should he need to go to other areas of the prison.
 - A review would take place prior to every visit from his family and a decision made as to where it should take place.
 - He would be given the correct diet.
 - He was to be encouraged to express his own needs.
51. The following day, the Healthcare Manager spoke to the man's sister to reassure her that he had received his pain relief medication and that her concerns about his healthcare had been documented. Prison Doctor B also saw him the same day and noted that he lacked the confidence to move around the healthcare centre and agreed to use a walking stick.
52. Prison Doctor B next saw the man on 10 September and reviewed his pain relief. He told the doctor that he had been in pain for most of the night but had not vomited or felt sick. The doctor contacted the consultant in palliative care and they agreed that the dose of morphine sulphate should be increased.
53. Nurse G visited the man the next day, and then discussed the changes in his pain relief with Prison Doctor B. The level of morphine sulphate was to be

increased every two to three days and Diclofenac added to his prescription (for treatment of pain and inflammation of the joints).

54. On 14 September, Nurse G visited the man at the same time as his family were present. He was unsure whether to commence palliative chemotherapy treatment and wished to discuss it with his wife over the next seven days.
55. Prison Doctor B saw the man the following morning as he complained of severe pain. The doctor increased the level of morphine sulphate. Later that morning, he told Nurse F that the pain had eased after about an hour of taking his medication. The nurse recorded that he had ate his breakfast and was encouraged to drink fluids.
56. A Healthcare Support Worker (HCSW) A recorded on 15 September that the man had had a settled day and ate all his meals and fluids. He told the HCSW that he was in very little pain and asked to have his hair cut before his next family visit. The nurse organised the wing barber to trim his hair.
57. The next day, Prison Doctor B saw the man to discuss his pain control. He told the doctor that he felt it was adequate at that time and he had no other concerns other than that he no longer liked the milk based drinks. The doctor arranged for him to have fruit based drinks instead.
58. Prison Doctor B reviewed the man again on 18 September. He told the doctor that the pain relief was working although he felt uncomfortable first thing in the morning. He told the doctor that he preferred the new juice flavoured drinks. The doctor prescribed an increase in morphine sulphate.
59. On 21 September, the Acting Deputy Governor wrote to the man's wife regarding visits to her husband whilst in Durham. He confirmed that weekly visits were allowed and were to be booked in the usual way through the prison. The letter specifically stated:

“Healthcare staff will make an assessment before each visit of which is the most suitable venue for the visit, i.e., main visits room or the healthcare centre.

“It is my expectation that visits will normally be held in the main visiting room and when this is the case we will endeavour to hold the visit in a quieter part of the room.

“This arrangement will be reviewed as necessary in collaboration with Senior Managers in the healthcare department.”
60. The same day, Prison Doctor A talked to the consultant in palliative care and the saw the man again. The doctors agreed to add Metoclopramide (for treatment of nausea and vomiting) and Dexamethasone (an anti-inflammatory medication) to his prescription.

61. The consultant in palliative care and a physiotherapist saw the man the following day. The consultant changed the order of the medication so that Oramorph was taken with the morning dose of morphine sulphate and the man was to wait 20 minutes before moving around. The doctor also prescribed 4mg Dexamethasone each morning for a week followed by 2mg each morning for three weeks and 10mls Metoclopramide three times a day. The physiotherapist assessed that the man was able to walk and negotiate stairs without difficulty. He should be encouraged to exercise twice a day to maintain his mobility.
62. On 23 September, Nurse I saw the man at 11.20am as he was complaining of pain around his neck and found it difficult to swallow. The nurse gave him the prescribed Oramorph and encouraged him to spend time walking around. He would be seen by the doctor later that afternoon.
63. At 1.00pm, the man's wife contacted healthcare staff to express her concern that her husband might be depressed. She sought reassurance that he was seeing a doctor regularly. She also said that when they spoke on the telephone, she was unable to hear him due to a rattling sound in his throat. Nurse I returned the call to the man's wife and made the following entry in the prison medical records:
- "I contacted the man's wife as she had spoken to HCSW B and requested I call her. She was very upset as she had just received a telephone call from the man and found it difficult to hear him due to a rattling sound. I reassured her that I had just been in to him to give him some pain relief and that neither myself or the nurse with me were aware of a rattling noise. I also informed her that I had seen him earlier today and that he had a rattle in his throat when he coughed and it was not his chest rattling. I also reassured her that should we become at all concerned about him that we would ask the doctors to see him immediately."
64. Later that afternoon, as arranged, Prison Doctor A saw the man noting that he experienced pain in the neck and the back of the head, had difficulty in swallowing and a rattle in his throat. The doctor decided that, because of the previous chest infection, it was appropriate to prescribe Amoxicillin oral suspension (an antibiotic). As well the doctor changed the morphine sulphate to Fentanyl patches (used for severe pain requiring round the clock, ongoing relief) in case he was not getting enough of the former.
65. The next day, Prison Doctor B assessed the man and decided to admit him to hospital as his ability to swallow had reduced further. Another bedwatch risk assessment was completed, again confirming that he was to be accompanied by two escort officers using a long escort chain, which was to be removed for treatment on the direction of hospital staff. He was discharged from hospital back to healthcare at Durham on 26 September and had been prescribed Nyastatin (an antifungal medication) for oral thrush.
66. Later that day the man's wife and sister arrived for a visit. They were told that the visit would take place in the main visits room, rather than in healthcare. They were described as abusive to Nurse D on the telephone and then to have

confronted two healthcare support workers in the prison car park, returning from lunch. They complained about the visiting arrangements.

67. In interview, the Governor A said that she had a telephone call from Nurse D to say that the man's family were angry that the visit would be in healthcare and were abusive on the telephone. The governor explained that there were insufficient staff in the establishment, either in the healthcare or the prison, to facilitate a visit taking place in healthcare. The man had been asked if he was happy for the visit to take place in the visits hall and said that it was fine. However the governor said that his visitors demanded that the visit took place in healthcare.
68. Governor A said that she received a further telephone call about the contact between the healthcare support workers and the man's family in the car park. The governor decided to speak to the family personally to explain that the prison was doing everything possible to facilitate the visit in the most comfortable surroundings, but that if their behaviour continued they would not be allowed into the prison at all. The family were not satisfied and showed the letter stating that, where possible, the prison would facilitate visits in healthcare. She said that she stressed to the family that, on this occasion, it was impossible for the visit to be in healthcare. Although the family were unhappy with the situation, the visit took place and lasted the duration of the visits period.
69. Prison Doctor B saw the man on 29 September to review his pain relief. He told the doctor that he experienced difficulty swallowing at times. His wife rang later that morning to ask to speak to Prison Doctor A. The doctor returned the call and had a lengthy conversation with the man's wife, at the end of which she told him that the nursing staff in the prison had been kind and helpful. The doctor also spoke to the Governor B regarding the man's condition and they agreed to call a multidisciplinary meeting when the consultant in palliative care returned from leave. The man's condition did not fall within the guidelines for compassionate release as there was no indication of his life expectancy.
70. Two days later, on 31 September, Prison Doctor B saw the man to review his medication. He told the doctor that he felt uncomfortable in the mornings for about two hours but his pain control was fine for the rest of the time and he was able to eat more than previously. Later that day the man's wife contacted healthcare staff to say that she and her husband had discussed palliative chemotherapy treatment, but had decided together that he did not want to have the treatment.
71. The man had a comfortable day the next day. He was independent and able to see to his personal hygiene needs himself. He was mobile around the healthcare unit and used the telephone to speak to his family.
72. On 5 October, Prison Doctor B saw the man as he complained he could not swallow. The doctor asked him to drink some water which seemed to pass easily, but he needed to bring up a small amount of saliva afterwards. The doctor discussed this with Prison Doctor A and they decided to prescribe a small dose of Diazepam (for treatment of seizures and muscle spasms).

73. Nurse G came to the prison on 6 October and saw the man to review his medication. He reiterated that he did not want to commence chemotherapy treatment. The nurse recommended the use of a saline nebuliser (which converts liquid medication into an aerosol that the patient breathes).

Events of 8 October

74. Prison Doctor A saw the man in the morning and noticed that he was sweaty and clammy, had been sick, and his throat rattled. The doctor took his temperature which was normal and said that he would review him later in the day after he had used the saline nebuliser.
75. The doctor next reviewed the man's condition at approximately 2.40pm. As he was still sweaty and clammy, the doctor decided to admit him to hospital as his condition had not improved. Arrangements were made for him to be taken to hospital. The bedwatch risk assessment reduced the restraints to two escort officers without any restraints in place.
76. Prison Doctor A discussed the man's condition with the Acting Governor and they explored the possibility of release from custody on medical grounds. He also spoke to the consultant for palliative care about transferring him to a hospice.
77. Nurse I contacted the man's wife, recording in the prison medical records:
- "I contacted the man's wife and made her aware of his imminent admission to hospital. She is aware of how seriously ill her husband is and she obviously became very upset. She asked me to inform her sister-in-law. Attempted to contact her but no reply. I left a message for her to contact us."
78. The man's sister returned Nurse I's call after the ambulance had left the prison. The nurse prison recorded in the medical records:
- [The man's sister] returned my call and I have made her fully aware of the situation. She informed me that they are coming over to see him in hospital. I have informed Governor C and he confirmed that the escorting staff have been informed of this."
79. Healthcare staff were told by the hospital that the man had died at 5.45pm. The Mental Health Nursing Manager at Durham went to the hospital to meet the man's family who, due to the long journey, had not yet arrived at the hospital. When he arrived at the hospital, two officers from Durham Constabulary were present in addition to the two prison escort officers. (The local police are called following the death of any prisoner.) When the man's family arrived they were met by the Manager and two prison family liaison officers.
80. The prison complied with the requirements of Prison Service Order 2710 "Follow up to death in custody" and offered financial assistance towards the cost

of the funeral. In the days that followed, the prison family liaison officers maintained contact with the man's family who expressed their thanks for their sensitive and professional manner.

ISSUES

Clinical care

81. The clinical review considered the treatment and care that the man received whilst he was in custody. The report made the following comments:

“The clinical records show that the man was referred to secondary services for investigations into a potential diagnosis of cancer on the same day that his symptoms came to the attention of prison healthcare staff. He was subsequently assessed and a diagnosis made within a few days. This is in line with the requirements of the ‘two week wait’ standard in place nationally for people with suspected cancers and constitutes very good practice.

“He had good access to specialist services within secondary care and was visited within the prison by McMillan nurses and the Consultant from the palliative care service.

“There is good evidence of consistent communication and joint working between prison health care professionals and colleagues from secondary care services and that advice from specialist clinicians was appropriately followed.

“There is good evidence that prison healthcare staff and the palliative care team had regular contact with the man’s wife and that she was involved, as far as possible, in decisions about his care.

“The clinical notes demonstrate that his level of pain was appropriately and regularly assessed and that changes were made to his prescription when pain increased and it appeared that the prescription was insufficient.”

82. The clinical review did raise about the medication prescribed when the man was discharged from hospital. The clinical reviewer said:

“The man was discharged from hospital on 3 August 2009 with discharge medication including painkillers. However, due to security restrictions and a possible breakdown in communication, he was not given any pain relief until the following day after his wife called to complain. The need for security precautions is understood but such a delay is nonetheless unacceptable.”

I recommend that the Head of Healthcare ensures that a robust process is in place so that prisoners receive their prescribed medication as soon as possible after they are discharged from hospital.

83. The overall assessment by the clinical reviewer is that the treatment and care given to the man whilst he was in custody was equitable to that which he could have expected in the community.

Use of restraints

84. Unfortunately there have been too many reports in which the Ombudsman has criticised the level of restraints used when prisoners are taken to outside hospital. I have evaluated the restraints used each time the man went to hospital. The prison has to balance the prisoner's need for privacy and dignity with their own duty to protect the public. He was recently sentenced for a sexual offence and as such was assessed as a risk. Even though he was terminally ill, he was mobile and independent.
85. I judge that the bedwatch risk assessments were appropriate each time that the man was admitted to hospital on 27 July, 3 September and 24 September. I am also satisfied that on 8 October, for what was to be his last admission, no physical restraints were used and he was just accompanied by two staff. It is pleasing to recognise the good practice adopted by Durham to ensure that he was treated with dignity and respect on his final admission to hospital on the day of his death.

Complaints procedure

86. The clinical reviewer also considered the handling of the complaint made by the man's family to the Primary Care Trust and made the following comment:
- “There was not a policy in place that outlined the requirements of the health and social care complaints legislation that came into force in April 2009 at the time of this incident. However, a policy has since been developed by the Primary Care Trust.”
87. Complaints about prisoners' healthcare are properly directed to the Primary Care Trust's internal complaints procedure. From the evidence I have seen and heard, I am also satisfied that the healthcare staff, prison doctors and the Governor took steps to ensure that his needs were met. I recognise that families of prisoners can be remote from decisions about sick relatives. However, on this occasion, I believe that the prison made every effort to involve him and his next of kin, his wife, in decisions about his treatment. It is unfortunate that his illness was unpredictable. A clear life expectancy was not given and so consideration of compassionate release was impossible. His sentence was a matter for the court and so he had to remain a prisoner until his death. Regrettably he deteriorated quickly on 8 October and his family could not be at his bedside when he died.

Visiting arrangements

88. The man's family felt that the visiting arrangements to see him were unreasonable and had caused upset, although he himself did not express any concerns. I appreciate that families may find it difficult to understand the requirements of running a prison safely and securely. The family had been given written assurance that an assessment would be made for the location of each visit. He was mobile and a wheelchair was available, and on 26

September there were insufficient staff for a visit in healthcare. I find that, given the circumstances, staff at Durham acted reasonably in facilitating his visits.

CONCLUSION

89. I judge that attention was paid to the man's health needs and appropriate treatment and care was provided. I am satisfied that the standard of care he received in Durham prison was equitable to that which he could have expected to receive in the community. Except when in hospital, he remained in the inpatient's wing where he had special equipment and frequent consultations with doctors and nurses. As well he was referred to the community palliative care specialists who saw him several times. The prison doctors regularly consulted the palliative care specialists about how best to look after him. He exercised his right to refuse to accept palliative radiotherapy and chemotherapy.
90. I acknowledge the frustration families may feel in understanding the care that their loved ones receive whilst in prison. However, I do believe that Durham responded both to his changing needs and to the concerns raised by his family. Ultimately he was an independent adult able to deal with his health and personal needs without his family's involvement. I have found that he was treated with dignity and respect both at Durham and when he was in hospital. Following his death Durham appropriately followed the guidance given in PSO 2710, "Follow up to death in custody".

At the consultation stage of the report the man's sister and brother-in-law wished it noted within the report that they disagree with certain points as outlined in individuals' transcripts of interview. Specifically the fact it has been stated his sister was abusive towards healthcare staff in person and over the telephone. She found this information very distressing and upsetting. They also wished it noted that a huge amount of their frustration was with staff at Durham due to an apparent lack of communication between them and the staff and that this ultimately resulted in additional upset and distress being caused to the family in relation to their understanding of processes in regard to his care, and their ability to visit him at regular occasions.

RECOMMENDATIONS

1. I recommend that the Head of Healthcare ensures that a robust process is in place so that prisoners receive their prescribed medication after they are discharge from hospital.

Accepted - Healthcare members of staff are aware of and adhere to SOP 20 Procedure for the re-use of patients own drugs (PODs) after prescribing in prison.