

**Investigation into the circumstances surrounding the
death of a man at hospital, whilst in the custody of
HMP Hewell, in October 2008,**

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

August 2009

This is the report of an investigation into the death of a man who died in October 2008 at hospital, whilst in the custody of HMP Hewell. He had been transferred from Hewell to the hospital on 2 October. He had been diagnosed with cancer of the small intestine. He also suffered from celiac disease. (Celiac disease is an immune reaction triggered by gluten, a collective name for a type of protein found in wheat, rye and barley.)

A post mortem was held at the request of HM Coroner for Worcester. Whilst no post mortem report has been received, the examination found that the man died from natural causes. I extend my sincere condolences to his former partner, children, family and friends.

This investigation was undertaken by one of my investigators. She was accompanied for interviews by a second investigator. In addition, a review of the man's healthcare was commissioned by the Primary Care Trust (PCT). I am grateful to the appointed clinical reviewer's.

I would like to thank the Governor of Hewell and the Governor of HMP Birmingham, and their staff for their help and assistance. I am particularly grateful to Hewell's Liaison Officer. I also acknowledge the help given by the Judge and the staff at the Crown Court.

I make 12 recommendations to reflect the key issues investigated, in relation to healthcare, bed watches, diet and the role of family liaison. One recommendation is to the Chief Executive of the PCT for improved communication between prison healthcare and the wider National Health Service. Five of the recommendations are to the Head of Healthcare at Hewell in relation to record keeping, management of celiac disease, care plans and communication. The remaining recommendations are to the Governor to improve communication between the prison and the bereaved family, the provision of medical diets, and the managing of bedwatches. Lastly, one recommendation is to the Governors at Hewell and Birmingham regarding the need for sensitivity on the part of bedwatch staff.

I also endorse the recommendations made in the clinical review.

This final report acknowledges some minor factual inaccuracies as identified by the clinical reviewer. The prison service and PCT have accepted ten recommendations and partially accepted two recommendations.

The response from the man's family to the draft report raised issues, some of which were inaccuracies as identified from their re-call of certain events. Those inaccuracies have been amended into this report. The man's family felt that he was malnourished and the prison service had failed to provide the correct diet. At the time of his admittance to hospital for his cancer treatment, they felt his ability to withstand the rigours of the treatment was effected by his poor physical condition.

The man's family have been advised of the inquest procedures and their right to raise such issues at the hearing.

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Prisons and Probation Ombudsman

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CONTENTS

Summary

The Investigation Process

HMP Hewell Grange

Key Findings

Issues

Conclusions

Recommendations

SUMMARY

The man was convicted of drug related offences at the Crown Court in April 2008. The Judge agreed to the man's defence counsel's request to adjourn sentencing whilst a medical report was prepared. He was remanded to Hewell to wait for sentencing.

On reception into Hewell, healthcare staff noted that the man had celiac disease and that it was important for him to receive a gluten free diet. It was also recorded that he was underweight and frail. His community doctor was contacted for his medical history and prescription medication.

In mid April, the man was admitted to an outside hospital, as he was unwell with pain in his rib area. The following day he was discharged back to Hewell and prescribed an anti-depressant to raise his spirits. Two weeks later, he was examined by a qualified nurse prescriber after complaining of chest pain, fever and a bad cough. She prescribed an antibiotic and noted that he had lost weight. The nurse encouraged him to eat more calories and prescribed a food supplement drink. Later, the nurse asked the kitchen staff to provide gluten free cakes and biscuits.

The Assistant Disability Officer saw the man in his cell on 12 May. The Assistant Disability Officer noted that he seemed quite ill, and that he was not always receiving the correct diet from the kitchen. Later that day, he was admitted to hospital as he had become unwell with diarrhoea and vomiting. Two days later, he returned to Hewell and was monitored on the healthcare unit, returning to his houseblock three days later. The Assistant Disability Officer saw the man again and noted that he was still not receiving the correct diet. He reminded kitchen staff of his dietary needs.

The man returned to the healthcare unit on 27 May for a week as he was unwell. It was recorded in his medical notes that the kitchen was not providing enough food for him and it was not always gluten free. On 19 June, at the Crown Court, the Judge reviewed a medical report by the Chief Medical Officer at Hewell, outlining the man's celiac disease and his general ill health. He was then sentenced to four years imprisonment.

Following gastroenterology tests in another outside hospital in July and August 2008, the man was diagnosed with cancer of the small intestine. In late August, a wing officer noted that he was still receiving the incorrect diet. The officer reported this to healthcare staff who in turn made contact with the kitchen.

On 2 October, the man was admitted to the outside hospital following a surgical procedure. Two officers acted as bedwatch escort and he was restrained by an escort chain. Six days later, he started treatment for cancer. The man's treatment was stopped and he moved into the Intensive Care Unit on 22 October. At 7.40pm on 25 October, his life support machine was turned off on the advice of hospital staff. The family were at his bedside.

The man seems to have been well cared for by wing staff in Hewell. However, I am concerned by difficulties he faced in respect of receiving the correct diet. My report also considers security measures for prisoners taken to outside hospital, risk

assessments on the use of restraints, communication, family liaison and the recording of information in medical records.

THE INVESTIGATION PROCESS

1. My investigator visited Hewell on 3 November 2008 to open the investigation into the man's death. The Ombudsman's terms of reference and notices of investigation had been sent to the prison in advance of her visit. The Independent Monitoring Board and the Prison Officers' Association did not ask to meet her.
2. My investigator did meet the Liaison Officer and reviewed the man's prison file. My investigator asked that copies of documents from the file and the man's medical notes be sent to her. There was no response to the notice of investigation from staff or prisoners.
3. A review of the man's medical care was commissioned by the PCT and two clinical reviewer's were appointed.
4. On 10 December, my investigator and one of my family liaison officers visited the man's former partner, his next of kin, at her home. His former partner raised concerns over his medical care whilst in Hewell. Those concerns included the management of his diet and celiac disease, communication with the prison, and the sensitivity of bedwatch staff. I will deal with those points in the issues section of this report.
5. My investigator and her colleague carried out interviews with prison staff at Hewell on 6 and 7 January 2009. My investigator returned to Hewell on 18 February to interview the catering manager, with the clinical reviewers.
6. On 3 March, my investigator and her colleague interviewed an officer at Hewell, then travelled to HMP Birmingham to interview two officers who had acted as bedwatch escorts whilst the man was in hospital.

On 12 March, my investigator visited the Crown Court to review documents from the man's trial in April 2008. My investigator searched his court file to find any information relating to reports requested by the trial judge into the man's medical condition.

HMP HEWELL

7. HMP Hewell was created on 24 June 2008 by the merger of three former prisons located on the same site: Blakenhurst, Brockhill and Hewell Grange. The new prison caters for category B, C, and D prisoners. There are a total of eight houseblocks on the site. One has dormitory accommodation with the remainder having single or double cell occupancy.
8. Hewell primarily serves the Worcestershire, West Midlands, and Warwickshire areas.
9. Healthcare is provided by the Primary Care Trust. There is 24 hour nursing care with an inpatient unit. The unit is staffed by qualified general and mental health nurses.
10. The last inspection by HM Chief Inspector of Prisons, of HMP Blakenhurst (the site which is now the category B prison and where the man was located) was in 2006. The Chief Inspector found:

“Health services were good quality and safe, with adequate cover out of hours. The prison and the primary care trust were working well together to develop clinical governance and a whole-prison approach to health.”
11. There has not been an Annual Report by the Independent Monitoring Board since the clustering of the three prisons in June 2008.
12. This is the second death that has occurred since the merger of the three former establishments. The previous death did not have any similarities to the circumstances of the man who is the subject of this report.

KEY FINDINGS

13. In April 2008, the man was remanded to Hewell following a court appearance at the Crown Court. His defence counsel asked for an adjournment for a detailed medical report owing to his poor state of health. The Judge agreed to the adjournment and arranged for the man to be examined by a doctor who would provide the court with a history of his medical condition.
14. On his reception into prison, the man was seen by a member of the healthcare staff. A first reception health screen document was completed and noted that he suffered from celiac disease. He was taking vitamin and mineral supplements and required a gluten free diet. The document further noted that he walked with a stick due to lower back pain, appeared to be underweight, and was having problems sleeping.
15. A general health assessment was completed and the man's weight was recorded at 52 kgs for his height of 1.75 metres. (This meant that he was clinically underweight.) The doctor deemed that he was unfit for work. A fax was sent to his community doctor for further information about his medical condition, and blood tests were ordered.
16. On 14 April, the man's medical notes recorded that information received from his community doctor confirmed that he suffered from celiac disease. Recent blood tests indicated liver disease. An appointment was made for him to see the doctor the following day. The doctor prescribed vitamin and mineral supplements along with paracetamol and Fortisips (a food supplement drink). The doctor asked that the man's community doctor be contacted again so that a full list of his medications could be reviewed.
17. The man was seen by a nurse on houseblock six on 20 April. The nurse noted he looked pale and was complaining of pain in his right rib area. An appointment was made for him to see the doctor. The next day he was examined by the doctor. His observations were noted as temperature 36.7 degrees (within normal range 36.5), blood pressure 104/76, (lower than normal range of 120/80) and pulse rate of 75 beats per minute (within normal range of 60-100). He was pale and short of breath and the doctor arranged for him to be admitted to an outside hospital.
18. The man stayed in the hospital overnight until he was discharged back to Hewell. His medical notes recorded his gluten free diet and he was prescribed Fluoxetine (an anti-depressant) as he was feeling low. On 1 May, he did not attend a doctor's appointment, but no reason was given.
19. On 8 May, the man was seen in his cell by a nurse as he had not gone to the treatment hatch for his medication. The nurse noted he was pale, and he told her that he had not eaten for a few days and had a bad cough. The nurse referred him to see the triage nurse. At 11.00am, he was seen in his cell by a nurse. The nurse, a qualified nurse prescriber, noted that he was unwell with chest pain, a cough and fever, and prescribed an antibiotic, Amoxicillin. The nurse discussed the man's diet with him as his weight had dropped to 48kgs.

She encouraged him to increase his calorie intake and take his Fortisips twice a day. Later, the nurse spoke to kitchen staff to ask them to provide gluten free cakes and biscuits as well as increasing his food intake.

20. Four days later, a member of wing staff and an Assistant Disability Officer made an entry in the man's personal file:

"I have spoken to [the man] in my role as the ADLO which is the Assistant Disability Liaison Officer, and he does appear to be quite ill. He is currently on medication for a chest infection and pain killers for a lower back problem. He states that his diet is gluten free but he is not eating all the food and he does have a gaunt look on his face and quite pale. Medical staff have been notified and I have also requested that they check his weight. Can all staff monitor this prisoner during the day and it would be advisable to keep his door open when occupied so he can increase his mobility and aid his circulation."

21. Later, the man was seen by a nurse who noted that he was suffering with diarrhoea and vomiting. He had a poor appetite and his observations were recorded as low blood pressure (88/59) and a high pulse rate (110 beats per minute). The nurse referred him to the doctor. The doctor examined him and started to make arrangements for him to be transferred to hospital. The assistant disability officer spoke to him and re-assured him that he could return to houseblock six when his health improved. The officer told the man that he would find a specially designed disabled cell for him with more space. In the meantime, he was admitted to the healthcare unit so that staff could monitor his condition. At 4.30pm, he was transferred to an outside hospital.

22. On 14 May, the man returned to Hewell and stayed in the healthcare unit for observation. He was monitored on the unit and a care plan was opened. The next day, his medical notes record that he was extremely thin and that his dietary needs should be observed and checked regularly. He was encouraged to take supplementary food drinks.

23. Two days later, the man asked to return to houseblock six to be with his friends as he felt unsettled in the healthcare unit. Following discussion with wing staff, he returned to the houseblock. He was told that if he felt unable to cope on normal location he should tell healthcare staff, and arrangements would be made for him to transfer back to the healthcare unit. A care plan was formulated and sent to houseblock six for the attention of nursing staff.

24. The following day, the man was seen in his cell by nursing staff. Although he was feeling better and eating more, it was noted that he was still being sent inappropriate meals from the kitchen. The assistant disability officer emailed the kitchen staff, reminding them to send a gluten free diet. On 25 May, it was recorded that a prescription was also requested for Build Up, a supplementary food drink.

25. On 27 May, the man became unwell again with diarrhoea and was transferred to the healthcare unit. His blood pressure was low at 104/78 and pulse rate

normal at 88 beats per minute. His weight had risen to 53kgs and his medical notes record that the kitchen was providing salad for him. Whilst appropriate for his diet it did not provide enough calories to address his weight loss. An appointment was 'put back' for him to attend the Gastroenterology Department at an outside hospital, due to a security problem.

26. The following day, a nurse noted that the man was due a vitamin B injection and his care plan was updated. He had the injection on 30 May, and his notes record he was eating and taking fluids, although his blood pressure remained lower than the normal range. Three days later, his weight had increased by several kilos although his medical notes record that he was not eating enough and was fussy about his food. He was seen by a doctor who noted that he should take 2,000 calories daily, have a monthly weight chart, record his daily intake of food, and receive a dietician's advice leaflet.
27. The man transferred back to houseblock six on 2 June. A revised care plan was formulated and regular monitoring was arranged by healthcare staff. On 7 June, a wing officer asked healthcare staff to visit the man in his cell as he was complaining of diarrhoea. The nurse visited him and, following his medication, he felt better. Two days later, his medical notes record that he had again been given an inappropriate diet from the kitchens. This was followed up by healthcare staff who contacted kitchen staff to remind them that the man must receive the correct diet for his medical needs. An outpatient appointment was cancelled for security reasons on 12 June.
28. On 14 June, it was recorded in his medical notes that the kitchen had sent a pie for the man. This is inappropriate for celiac disease, and healthcare staff again spoke to kitchen staff about his dietary requirements and that salads did not provide enough calories.
29. Five days later, the man went to the Crown Court for sentencing. A medical report from the Medical Director of Hewell outlined the medical interventions that the man had received in Hewell, including inpatient admissions and described his current medical condition. Later that day, he was sentenced to four years imprisonment and returned to Hewell. On 4 July, he weighed 53kgs, his blood pressure remained low and he complained of swollen feet.
30. In response to the draft report the man's former partner felt that the prison misrepresented their ability to provide for his special dietary needs and this was overlooked in the report from the Medical Director.
31. The man went to the outside hospital on 10 July for gastroenterology tests which had previously been cancelled. The following day he was seen by a nurse. His weight had dropped to 52kgs. The nurse asked the kitchen staff to increase the amount of food allocated to him within the confines of his special diet.
32. The man was examined by the doctor on 30 July and his weight had increased by a kilo. The doctor noted that the man had problems sleeping and complained of leg and joint pain. Pain relief medication, Tramadol, was

prescribed and he was advised to try to eat more. It was noted that he was waiting for a computerised tomography (CT) scan. (A CT scan takes x-ray images of the whole body.) However, the appointment for the scan was cancelled on 5 August for security reasons.

33. On 12 August, the man attended an outpatient appointment for his CT scan and his care plan was updated the next day. He was still receiving daily visits by nursing staff and his clinical observations monitored. A letter from a Consultant Physician and Gastroenterologist at the outside hospital to the Chief Medical Officer at Hewell, written on 14 August, confirmed suspicions that the man had an intestinal lymphoma (cancer of the lymph glands in the small intestine).

34. The man's medical notes recorded on 18 August that his weight had fallen to 51kgs and the nurse intended to discuss re-commencing high calorie drinks with the doctor. On 23 August, an officer noted in the man's personal file that he had been sent inappropriate food. At interview the officer said:

“He had to be on a special diet and the main diet that the kitchen used to send him up more or less every day was pasta which was the one thing that he couldn't eat. On the odd occasion when we (the kitchen) did sort of get it right, they would send him a salad.”

35. The officer said he spoke to a nurse as the problem with the man's diet had not been resolved. He hoped that, as a nurse, she could speak to the kitchen staff to rectify the problem. The officer went on to tell my investigators that the servery staff (prisoners who serve up meals on the houseblock) would help the man if he had not received an appropriate meal. They would plate up food for him to boost his diet and provide a suitable meal. The officer also spoke to the nurse about the man's continued frailty and deteriorating health. He told the nurse that he might benefit from more supplementary food drinks, as he had told the officer he found them beneficial. The nurse told the officer she would see that the man was prescribed further liquid food drinks.

36. On 29 August, the man's medical notes record that the officer told healthcare staff that the man had been informed, at an outpatient appointment two days earlier, that he would require surgery, to confirm his diagnosis of cancer. Healthcare staff were unaware and asked the healthcare administration to confirm with the hospital. His medical notes further noted that gluten free products were to be ordered from a pharmaceutical shop, that he should be seen daily, and that his weight would be checked weekly.

37. It was recorded on 11 September that the man was still losing weight and more food supplement drinks were prescribed. Three days later, he was seen by a member of healthcare staff who noted that the kitchen were still not consistently providing an appropriate diet, although he did have gluten free foods in his cell. An appointment was made for him to attend hospital for a pre-operative assessment.

38. On 2 October, the man went to an outpatient appointment at the outside hospital. A risk assessment was completed and he was placed on an escort chain (an escort chain is a 1.8 metre length of chain with a cuff attached to the prisoner and the second cuff attached to a prison officer). Following the surgical procedure, he was admitted to the hospital and two officers commenced a bedwatch. On 6 October, he was fitted with a feeding tube.
39. The man was told by hospital staff that chemotherapy (a treatment for cancer related disease) would commence on 8 October. On 9 October, the bedwatch notes record that he would remain in hospital for up to three weeks. Officers from HMP Birmingham and HMP Long Lartin provided bedwatch staff to support Hewell.
40. On 10 October, a hospital doctor spoke to the bedwatch officers about restraints being removed as the man was immobile and his medical condition was deteriorating. A principal officer (PO) was at the hospital completing a management check. The PO told my investigators he spoke to the doctor who said that, if the man's condition continued to deteriorate, restraints would seem inappropriate. The PO passed this information onto the security department on his return to Hewell.
41. Five days later, the bedwatch notes record that the man was in pain and very unwell. Hospital staff asked for details of his next of kin as they were worried about his health. His former partner arrived no later than a half hour after being told of the deterioration. At 4.15pm the bedwatch officers spoke to the duty governor and permission was given to remove the restraints. Family members were allowed to visit and spend time with him.
42. Two officers were carrying out bedwatch duties on 16 October and were sitting away from the man's bedside. His children visited him around 2.00pm with their mother, his former partner and one of the bedwatch officers was in the room on their arrival. The second bedwatch officer told my investigators that the family were unhappy about the officers being present in the room. The officer reminded the family that the man still needed officers to be present and, if his condition improved, there was a possibility that restraints could be re-applied. The second bedwatch officer told my investigators that this upset the family and caused some distress. Later, the bedwatch notes record that the man was receiving a number of visitors and they had to be reminded that only two people were allowed in his room at a time, as per the hospital rules.
43. It was noted the following day that the man was still receiving more than two visitors and there was some tension between them. The doctors reiterated the hospital rules of two visitors to the prison staff. On 18 October, a new risk assessment was completed and the bed escort was reduced to one officer. The bedwatch officer made contact with the duty governor and it was agreed, with hospital permission, that the man could have three visitors by his bedside. Later that day, one of the visitors refused to give his name to the bedwatch officer and swore at him. The next day another visitor also refused to give his name. (For security reasons all visitors to a prisoner on a bedwatch escort must give the escorting officers their names.)

44. In response to the draft report, the man's former partner is clear that the hospital never specified to the family the number of visitors allowed. She can only assume that this was only ever communicated to the bedwatch staff. Her view is that the hospital staff were happy throughout.
45. On 20 October, following a risk assessment, it was noted that the bedwatch officer would now be located outside of the man's hospital room. At 5.00pm, the officer raised concerns about the number of visitors coming and going out of the man's room. The following day, the bedwatch was increased to two officers who were to remain outside his room. A risk assessment noted that hospital staff hoped to improve his mobility. At 1.00am on 22 October, he moved to the high dependency unit (HDU). Five hours later he was transferred to the intensive care unit (ITU).
46. At about 5.40pm, one of the visitors asked the bedwatch officers why they were still providing an escort for the man. The officers explained the rules to the visitor who then said that another person would be visiting and he would not give his name. The officer explained that the man was still in custody and that all visitors must give details to the bedwatch officers, as they do when visiting at a prison. The officers remained on duty outside the ITU.
47. According to the bedwatch notes at 9.20am on 24 October, the bedwatch officers refused entry to a visitor who would not give his name. By now, the man was on a life support machine. In response to the draft report his family cannot re-call that any visitor being refused entry.
48. The man's former partner spoke to the bedwatch officers at 4.00pm on 25 October. She telephoned a governor and the officers left the ITU area as his life support machine was going to be switched off. The officers moved to the foyer area of the hospital thereby allowing the family privacy with the man. At 7.40pm, his life support machine was switched off and he died with his family at his bedside. At the time of writing, a post mortem report has not been received.
49. The chaplain at Hewell held a short prayer service for the man in the prison's chapel. Patrick's family were offered financial assistance towards his funeral expenses as required by Prison Service Order 2100.

ISSUES

Clinical Care

50. A clinical review of the man's medical care was commissioned by the PCT. The reviewers, a retired Director of Public Health, and a retired NHS Director of Corporate Affairs, conducted a wide ranging and comprehensive review for which I am grateful.

51. The reviewers interviewed clinical staff from the NHS Trusts, a doctor from the man's community practice, the Head of Catering Services at Hewell, and a prison liaison officer. The reviewers comment on five specific areas of his care:

- The reception process.
- The management of the man's illness, including day to day healthcare and care planning.
- The identification of dietary needs and the provision of food.
- Record keeping.
- Security arrangements for sick prisoners in external NHS settings and communication between prison healthcare and the NHS outside the prison.

Reception process

52. The clinical reviewer's note that the man's previous medical history and celiac disease was correctly identified and his medication recorded. Healthcare staff noted that he was underweight, with lower back pain. A senior staff nurse undertook a general health assessment and confirmed his dietary needs of a gluten free diet. A doctor ordered blood tests and requested his previous medical notes from his community doctor. The clinical reviewer's comment that:

"The first reception health screen and the subsequent general health assessment appear to have been through and well documented. They followed national guidelines."

Communication between healthcare and external National Health Services

53. The clinical reviewer's reviewed the man's outpatient appointments and the cancellation of some of those appointments.

54. Before the man had been received into Hewell, his community doctor had referred him for a gastroenterology outpatient appointment. The date of that appointment had to be changed on three occasions and a final date of 10 July was agreed. The reason for the cancelled appointments was because hospital booking clerks and medical staff informed him of the dates. The NHS staff involved were not aware that prisoners should not know the date of their appointments. For security reasons appointments for prisoners should be only made with prison healthcare staff. Similarly, a CT scan appointment had to be altered from 5 to 12 August.

55. The Acute Hospitals Trust and Hewell have a joint policy on prisoner visits to hospital, although that policy did not cover Hewell with the outside hospital. (the outside hospital was not one of Hewell's normal places of referral for prisoners requiring hospital treatment.) Medical staff at the hospital did not always know who to make contact with at Hewell and found it difficult to telephone. Likewise, healthcare staff found it hard to contact hospital staff as the telephones were not always answered. Ward staff seemed reluctant to offer information to prison staff with whom they were unfamiliar. Therefore, it would seem the policy was not always adhered to. The clinical reviewers comment that:

“There was a lack of clarity about the aspects of communication between healthcare staff in the prison and those in an NHS Trust that did not have established links with the prison. This led to delays in the timing of the out patient appointments.”

They make the following recommendation which I endorse:

The PCT should develop protocols covering healthcare provision in prison, security, booking of appointments and communication for use when prisoners visit a NHS Trust. A copy should be taken by the prison escort officers to hand over to hospital staff at the first attendance.

Management of the man's illness and day to day healthcare and care planning

56. Healthcare staff were aware of the man's celiac disease. He was encouraged to eat more and prescribed vitamin and food supplements. However, some weight changes were not always noted and a doctor asked that his weight should be monitored using the same scales. There were problems with his malabsorption of food, which a better diet might have helped to resolve.

57. The man's repeated bouts of diarrhoea were noted, however there was no clear plan for treating his symptoms. His symptoms were monitored and it was thought that some diarrhoea was due to his inappropriate diet and, on one occasion, related to taking an antibiotic.

58. It was noted that the intestinal lymphoma could have been present in his system for some time. The lymphoma might also have been the cause of some of the symptoms that the man suffered, and not just his celiac disease and inappropriate diet. The clinical reviewer's comment on the diagnosis of his lymphoma by saying:

“Even after July, whilst the diagnosis was being progressively firmed up, there were no new insights into how to manage [the man's] treatment, largely because there was little more that could be done in the prison setting.”

In response to the draft report, the man's family believes that the sentencing judge was misled about the ability of the prison to meet his medical needs.

59. A CT scan appointment on 12 August confirmed that the man had an intestinal lymphoma. He was then referred to a consultant at the outside hospital. During August, the man lost more weight and was prescribed further food supplement drinks. The man was seen by a consultant haematologist on 27 August who hoped that a tissue biopsy would follow in two weeks time. This biopsy did not take place for five weeks but there is no indication as to the reason for the delay.

60. The clinical reviewer's comment:

"Without these delays, [the man] would have had a diagnosis earlier, and chemotherapy treatment may have started earlier. However, he would not have been any stronger than he was when he was finally admitted to the outside hospital, and the consultants told us that the outcome would not necessarily have been any different. There was only a 25 per cent chance of survival at three years, and an overall ten to fifteen per cent likelihood of being cured."

61. The man continued to be monitored by healthcare staff until he was admitted to hospital for the biopsy on 2 October. He remained in hospital afterwards and chemotherapy was started as the only hope to control the lymphoma. It is noted in the clinical review that the bowel collapses for about one third of patients receiving chemotherapy for this type of lymphoma.

62. The clinical reviewer's conclude that:

"The delay in securing a biopsy caused [the man] more pain and an earlier diagnosis would have meant earlier treatment. Unfortunately, the outcome would have been the same even with an early diagnosis. [His] deterioration was unexpected with low white cell blood count and he was suffering from fever and shivers all associated with the side effects of chemotherapy. He then developed acute respiratory failure that could have been a reaction to the chemotherapy or acute respiratory distress syndrome."

63. In response to the draft report, the man's former partner's main point is that the man did not survive because he was malnourished and was not strong enough to handle chemotherapy. She insists that the oncologist at the hospital told her that he would not survive because he had malnutrition not because he had cancer. The oncologist is attributed as saying that the cancer was normally survivable.

I endorse the recommendations made by the clinical reviewers:

Prison healthcare staff should improve their awareness of the management of celiac disease. In particular, consideration should be given to the clear and consistent recording of significant indicators such as weight and the results of blood and other tests; the use of referral to a

dietician and to nurse specialists; and the use of gastrointestinal review when the disease is not under control.

Scales use to weigh prisoners should be calibrated regularly to ensure consistent and accurate readings.

Diet and the provision of appropriate meals

64. The man's former partner told my colleagues that his condition was well known to both medical and prison staff in Hewell. Indeed, the judge who had remanded him into custody on 11 April 2008 ordered that the Prison Service should provide a medical report to the court outlining how the prison could provide and monitor an appropriate diet during any sentence of imprisonment. Hewell had stated that they could provide such a service. When he was sentenced, the judge said in open court that the man's dietary needs "must be catered for".
65. My investigator visited the Crown Court offices where the Judge had given permission for her to review the man's court files. Although she could not take away copies of the files, she reviewed a medical report provided by the chief medical officer at Hewell outlining the man's medical condition and inpatient admissions to hospital. From the court records available to my investigator there was only one reference to the judge's comments about his dietary needs. This was at the court hearing in April when the Judge said, "His [the man's] physical condition would be taken care of."
66. The man saw the doctor four days after he arrived in prison and the doctor noted his celiac disease and his prescribed medication, which included vitamins and food supplement drinks. This suggested that the catering services had already been contacted to ask for an appropriate diet.
67. A nurse made contact with the kitchen staff on 8 May, and recorded:
- "... they will provide gluten free cakes and biscuits and increase the amount of food he [the man] receives."
68. Nevertheless, the man complained to his former partner and his brother that he was not getting the right food. He also said that no one would listen to him when he complained. He told his former partner that he would often be unable to have any breakfast or midday meal because he was offered things he did not like, and he frequently only ate one meal a day.
69. The man was sent the wrong type of food for his medical condition on many occasions. Often he would get pasta dishes, and on one occasion, he was sent a pie. Neither is gluten free. The serving staff looked after him and, once it became apparent that he was experiencing difficulty receiving appropriate food, they would ensure that he was given something that he could eat.

70. My investigators spoke to a senior officer (SO) from houseblock six where the man had lived. The SO remembered a long period trying to arrange a gluten free, high protein diet. The man lived on the houseblock for six months and staff knew of his dietary requirements as soon as he was located there. From then until he left the prison, continued efforts were made to communicate with the kitchen about his medical condition. The SO said he understood the difficulties of providing so many meals, but felt that mistakes were made too many times.
71. In interview, the catering manager told my investigator that prisoners with specific dietary needs are notified to the kitchen by healthcare. (All meals are prepared on site including those prisoners needing a special diet.) The kitchen has a display board which indicates the prisoners with special dietary needs. Special dietary foods are prepared in individual containers and sent to the wing servery. The catering manager said that all diets can be catered for and he had previous experience of catering for a celiac diet. However, baked goods that are gluten free are not available through the normal procurement process (contractual ordering of food). Instead, the catering manager went outside the prison to purchase gluten free bread, cakes and biscuits in a local supermarket when it became apparent that the man required a high carbohydrate diet.
72. My investigator saw packets of gluten free biscuits and cakes in the man's property during her visit to Hewell on 3 November 2008. She also noted that there were packets of ginger biscuits which are not gluten free. The catering manager told my investigator the biscuits could have been ordered by the man through the canteen. (The canteen is a service for prisoners who can order goods and foodstuffs using their private money.)
73. Not only did the man need gluten free food, he also required a high carbohydrate diet. This could have been facilitated by using other foods that would give him a high calorie intake. Salad type meals did not have sufficient calories to boost his calorie intake. It is of great concern that the catering service at Hewell seem to have consistently failed to ensure that he was offered the correct diet for his medical condition.
74. The clinical review notes that eating non-gluten free food is inadvisable for people with celiac disease, as it can cause inflammation of the digestive system. Over a long period of time it can also increase the risk of lymphoma. However, the reviewers were told by hospital doctors that, in the few months of the man's imprisonment, eating these foods would not have caused his lymphoma, and it would not have been aggravated by his prison diet. His lymphoma would have been developed over a much longer period.
75. In response to the draft report, the man's family have commented that he did not refuse food because he did not like what was offered, it was the fact that he was unable to eat the food as it was not commensurate to his gluten free diet. The prison had told the Judge at the man's trial that his dietary needs would be catered for however this was obviously not the case. The bouts of diarrhoea may well have been caused by the inadequate diet he was offered.

76. The clinical reviewer's comment:

"It has not been possible to establish how many times [the man] actually ate inappropriate food. Sometimes the initial lack of appropriate provision by the kitchen was corrected following the intervention of other staff. Sometimes he was given extra supplies of food to build him up, by servery and other staff. [The man] did not like all the food that was provided for him, such as fish, which was a gluten free part of the prison diet. He refused to eat this. He did not always find specifically gluten free products to be palatable. He was recorded as being picky at times. On other occasions he did not eat or drink because he was feeling unwell, not because the food provided was inappropriate."

77. In conclusion the clinical reviewer's say:

"Prison Service Order (PSO) 5000 (Prison Catering Services) sets out a responsibility on the Prison Service to ensure that appropriate diets are provided to prisoner with celiac disease. There was a lack of clarity as to who was responsible for [the man's] diet, and no co-ordinated approach between healthcare staff and the catering department, despite the efforts of individual members of staff. There was no consistent system in place to ensure that [he], as a person authorised to receive special diets, actually received them from the kitchen."

78. PSO 5000 annexe 25 says:

"Beware of adults who have celiac disease, also known as gluten intolerance, who need to avoid all cereals containing gluten (wheat, oats, barley or rye). Alternative foods made from maize (i.e. polenta), rice, rice flour, potatoes, buckwheat, sago, tapioca, soya, soya flour are available. Seek expert advice from a dietician where necessary. Some gluten foods are available on prescription."

79. The provision of appropriate diets for prisoners with a medical condition is essential for their health and well being. It would seem that the man did not receive a suitable diet and, despite the interventions of healthcare and wing staff, mistakes were made repeatedly.

80. I note the two recommendations made by the clinical reviewer's in relation to the dietary needs of prisoners and specifically the adherence to PSO 5000.

The Governor should ensure that all prisoners who require a special diet for medical conditions should receive appropriate meals. Steps should be taken to make sure that all special and medical diets are provided to the required standard as set out in PSO 5000.

A record should be made in the medical record if a special diet has been requested by a healthcare professional. Any modifications to such a request should also be recorded. There should be an ongoing

accessible and up to date record in the kitchen of any such request for as long as the prisoner remains in the prison and requires the special diet.

Record keeping

81. The clinical reviewer's comment on the standard of record keeping in the man's medical notes. They note that most entries were in sequence, legible, dated and signed. However, identification of the staff making the entries was not always easy to follow and some entries were not signed.
82. There were some gaps in the medical records and documents, which included:
- The medical report provided by the Chief Medical Officer to the Crown Court Judge.
 - No formal medical request to the kitchen for the provision of the man's gluten free diet.
 - Results of blood test and other tests undertaken by healthcare staff.
 - Copies of signed care plans. Only two signed plans were found (which were dated 14 and 27 May) and an unsigned plan dated 24 September.
 - A gap in the continuous medical record between 29 September and 5 October, when the man attended hospital for an overnight stay and did not return.
83. Discharge care plans were formulated when the man left the healthcare unit and returned to the houseblock. The plans were kept on the wing and not copied into the medical records. Those plans should provide information for all healthcare staff and not just those carrying out wing duties.

The clinical reviewer's make the following recommendations which I endorse:

The Healthcare Unit should remind all staff, of the importance of signing entries in the medical record, and writing or stamping their names legibly so that they can be identified.

Discharge care plans should be documented in the medical records when prisoners move from the healthcare unit to houseblocks.

Security Arrangements

84. The family has raised questions as to why the number of escorts was increased from one to two and why two officers remained when the man was unconscious towards the end of his life.
85. The deputy governor told my investigators that it is standard security policy to assign two officers to carry out a bedwatch in hospital. One of the officers is normally cuffed to the prisoner. The deputy governor was involved in the decision to reduce the bedwatch to a single officer on 18 October. She was

satisfied that the room where the man was located was suitable. Also there was less risk of infection if only one officer was present.

86. Although it would have been difficult for the man to escape, the intention was always to increase the number of officers to two officers if he regained his strength.
87. On 21 October, the deputy governor was told that the man was eating and drinking again. She said that she understood that he was likely to be mobile as his condition was improving and hospital staff were working to increase his mobility. In addition, he received many visitors. At times the officers felt that security could have become compromised by the number of visitors when one officer was on duty.
88. The man's family have commented on receipt of the draft report, that the man was not eating and drinking at this stage and his condition was not improving. From bed watch notes it was indicated that hospital staff had informed bed watch staff that his condition was improving. This information was given to the deputy governor.
89. I understand the family's frustration about the number of officers on bedwatch when it was obvious the man was too ill to be an escape threat. Nevertheless, security must always be fully considered and I accept the reasons for increasing the bedwatch to two officers.

Restraints

90. An escort risk assessment was completed on 8 October to determine the level of bedwatch staff and the use of restraints. Two days afterwards, a hospital doctor spoke to bedwatch staff about the man's deteriorating condition and the use of restraints. By then, he was immobile and very weak.
91. Later that day, the PO and the doctor spoke about the man's condition and agreed that restraints would be inappropriate should his condition continue to decline. The doctor did not ask the restraints to be removed immediately.
92. A risk assessment was not completed by senior managers when the information was passed to the security department by the PO. Five days elapsed between the conversation between the PO and the doctor and the removal of restraints. By this time, the man's wrists were so thin that a bandage had been placed under the cuff to protect any injury.
93. A risk assessment should have been completed once the security department became aware of the doctor's comments on the use of restraints. Whilst it may not have been appropriate to have removed the restraints immediately, an assessment would have given clearer instructions as to why they were to remain in place. Using a bandage to prevent injury indicated the poor physical state the man was in, and I believe the use of restraints was an extreme reaction when he was so frail and immobile.

94. The man's family found it very upsetting to learn that the restraints could be re-applied if he got better. The man's former partner, meanwhile, had been telling both her children that their father was deteriorating and this remark raised unnecessary hope.
95. The bedwatch officer concerned told my investigators that he merely reminded the family that restraints could be re-applied at any time, should the man's condition improve. The application of restraints would be risk assessed before they were used.
96. It is customary for a risk assessment to include a contingency in the event of the prisoner's medical condition improving and that restraints may be re-applied. It would not be normal or good practice to discuss risk assessments with a family. However, if a family liaison officer had been appointed the matter might have been explained more sensitively.
97. The clinical reviewer's review the use of restraints within their report. From their investigation at the outside hospital and interviews with hospital staff, it is noted that there were mixed feelings about the use of restraints. Some hospital staff found them undignified and an intrusion into patient confidentiality. However, the presence of the escorts was not generally regarded as intrusive by hospital staff. The clinical reviewer's comment:

"Bedwatch and escort requirements for seriously ill prisoners sometimes appear to be inappropriate. There is a balance to be found between necessary security arrangements and the dignity and care of very ill people."

I agree with the following recommendation made by the clinical reviewers.

The Governor should ensure risk assessments are completed when hospital staff raise the use of restraints. Escorting seriously ill prisoners can be within acceptable boundaries and the use of physical restraints can take into account the risk of physical injury to a frail person.

Good Practice

98. I find that the general standard of care offered to the man during his time in Hewell was good. There was evidence of detailed history taking and appropriate prescribing. Regular weighing to monitor his health should be commended, though this would have been more useful if the weighing scales had been regularly calibrated and the results consistently charted rather than simply recorded at irregular intervals in the medical record.
99. Healthcare staff and prison officers on houseblock six appear to have been genuinely concerned about the man's welfare, and many people went out of their way to help him. The assistant disability officer was especially supportive. For example, he asked all staff to monitor the man during the day and said that his cell door should be kept open to assist his mobility. Healthcare and prison staff dealing with him were aware of the importance of

a proper diet, and numerous attempts were made to resolve the problems although not always successfully. There were attempts to improve liaison between the hospital and the prison as time went by, and especially towards the end of his life.

Further family issues

Prison healthcare unit

100. The man told his former partner that he was afraid about returning to the prison healthcare unit because it was 'filthy'. My investigator visited the healthcare unit and found it to be of a good standard of cleanliness. It was difficult to understand what he meant by 'filthy'. He did not like being located in the healthcare unit and preferred to be on the wing with supportive friends and wing staff. In interview, the assistant disability officer told my investigators that the man said he did not like being in the healthcare unit as many of the other patients had mental health problems. The noise and general atmosphere of the unit caused him some anguish.
101. In 2005, during an inspection of the healthcare unit at HMP Blakenhurst, HM Chief Inspector of Prisons referred to the décor, cleanliness and general physical state of the healthcare unit and noted that: "The physical environment was good."

Information from the prison

102. The man had suffered from regular bouts of chest infections and was in and out of hospital. His former partner was not told about these admissions and would have liked to have been informed.
103. If an admission to hospital is made for a potentially serious condition, next of kin should be informed and visiting information passed to the family. This is particularly important as the cost of telephone calls from hospital beds is very high.

When a prisoner is admitted to hospital as an in-patient, next of kin should be informed of the admission.

Bedwatch staff

104. The man's former partner made a number of criticisms of the behaviour of bedwatch staff. She alleged that individual officers seemed to have different rules to follow. For example, there was inconsistency about whether they asked for visitors' names. She found some officers to be very helpful and kind but this contrasted with poor behaviour by others. She said that some of the officers from Hewell were fantastic whereas some of the ones from Birmingham were unpleasant. She also said that bedwatch officers slept whilst on duty some nights.

105. She particularly mentioned a male officer from the man's wing who had shown special sensitivity and care. Unfortunately, she could not remember his full name but thought his first name was [name removed]. This officer was able to tell her how well liked the man had been on the wing and how much he would be missed. Another officer from Hewell she marked out for positive comment was a bearded officer, who has since been identified.
106. Interviews were carried out with wing officers and bedwatch staff. Officers from Birmingham told my investigators that they had not seen colleagues sleeping and they had not slept themselves whilst carrying out bedwatch duties. This was also confirmed by another officer who had carried bedwatch duties at night.
107. It is difficult to say more about the allegations made by the man's former partner in light of the denial by the officers. I acknowledge the positive comments by her in relation to officers from Hewell, and can only say that I find the comments made about officers from Birmingham to be disappointing.

Bedwatch staff should be reminded of their duties and the sensitive nature of carrying out those duties with terminally ill prisoners.

Family Liaison

108. Throughout his time in hospital, the man's former partner found it hard to talk with the wide range of individual officers on bedwatch duties. She commented that no members of the prison management team spoke to her, despite making regular checks of bedwatch staff. She would have appreciated a single point of contact, and a named member of staff whom she could have spoken to about her concerns.
109. Daily management checks of bedwatches are made by senior managers. The checks are an essential part of ensuring the prisoner's security and the safety of staff. The management checks should have identified the difficulties of both staff and family, particularly concerning the number of visitors and the negative comments from the man's family.

The Governor should ensure that management checks for bedwatches address the need to support the staff and the family.

110. On the day that the man died, his former partner rang the duty governor at the prison to tell him that the life support machine would be switched off. She felt that it should not have been for her to take the initiative of telling him. If she had been allocated a named link person with the authority to monitor and explain bedwatch policies, she might have been saved some of the discourtesy she says she experienced from some officers.
111. When a prisoner is taken into hospital for serious and terminal medical care, the support of a family liaison officer is helpful to address issues and concerns as they arise from the family and staff. This is even more essential when the prisoner is entering the final phase of a terminal illness. Good communication

with the family at this very emotional time can provide support and comfort. It also ensures that the practicalities following a death can be carried out sensitively.

A family liaison officer should be appointed when a prisoner is seriously or terminally ill in hospital.

Support for the man on the wing

112. The man was offered support and assistance by staff and prisoners on the wing. It was noted that he was a compliant and pleasant prisoner. Although very unwell, he asked if he could do any small task and was given the job of cleaning the cell cards. This small piece of work gave him an opportunity to spend some of his time in a constructive manner.

113. The man's friends on the wing and those who worked in the servery assisted him to carry and share food so he could have a meal when the kitchen failed to provide a suitable diet. The officers on the wing also supported him in their regular communication with the kitchen staff and healthcare staff, challenging the inadequate meals sent for him. In particular, the assistant disability officer tried to address the issue of his poor diet. I am pleased to recognise the support and assistance given to the man by the assistant disability officer, and by other staff and prisoners on houseblock six.

CONCLUSIONS

114. The care and treatment received by the man during his time in Hewell was generally well organised and documented by healthcare staff in both houseblock six and the healthcare unit. Significant care and support was also provided by the assistant disability officer, who had a key role to play, and by other prison officers.
115. A more proactive approach to managing the man's illness might have occurred if healthcare staff had had a greater understanding of the management of celiac disease, especially in more challenging circumstances when the condition was not under control and there were indications of previous neglect.
116. Many attempts were made to ensure that the man received an appropriate gluten free and nutritious diet, and he often did. However, there were systemic failings that prevented this happening as a matter of course for every meal. This is very disappointing indeed.
117. Nevertheless, the clinical reviewers conclude that:
- “It is likely that [the man] already had a lymphoma before he arrived in prison, and that this was in part a cause of the symptoms that he displayed during the following months.”

RECOMMENDATIONS

The Chief Executive of the Primary Care Trust

1. The PCT should develop protocols covering healthcare provision in prison, security, booking of appointments and communication for use when prisoners visit a NHS Trust. A copy should be taken by the prison escort officers to hand over to hospital staff at the first attendance.

Accepted – “The PCT has already made significant steps to improve its record keeping and information systems. It has recently, successfully rolled out the Systm 1 national record system. All transfers to hospital should go with a letter outlining the patient’s current situation and any relevant treatment and other details. However, we will look into introducing a pro-forma that ensures some basic information is included along with the communication which is usually from the GP.”

Head of Healthcare at Hewell

1. Prison healthcare staff should improve their awareness of the management of celiac disease. In particular, consideration should be given to the clear and consistent recording of significant indicators such as weight and the results of blood and other tests; the use of referral to a dietician and to nurse specialists; and the use of gastrointestinal review when the disease is not under control.

Accepted – “Training, either directly or through an on-line source to be provided on recognising and treating a patient with celiac disease. The training will reflect the recommendation that particular attention should be made of the patient’s weight and other observations. Links will be made with the dietetic team in county, to see if support can be provided in the prison setting.”

2. Scales used to weigh prisoners should be calibrated regularly to ensure consistent and accurate readings.

Accepted – “Current scales will be reviewed and alternative scales sources if necessary. The calibration will be tested in line with manufacturer’s recommendations.”

3. A record should be made in medical notes if a special diet has been requested by a healthcare professional. Any modifications to such a request should also be recorded. There should be an ongoing accessible and up to date record in the kitchen of any such request for as long as the prisoner remains in the prison and requires the special diet.

Accepted – “Since [the man] was at HMP Hewell, Systm 1 – a new computerised system for healthcare, has been implemented and this record allows for special dietary arrangements to be recorded. Systems are already in place to identify any special medical dietary needs. These are updated as information is received.”

4. The healthcare unit should remind all staff of the importance of signing entries in the medical record, and writing or stamping their names legibly so that they can be identified.

Accepted – “System 1 automatically records the date of entry and who made that entry. Because the entry is typed it is legible and can be tracked back to the person making that particular entry.”

5. Discharge care plans should be documented in the medical records when prisoners move from the healthcare unit to house blocks.

Accepted – “Discharge plans will be developed through System 1.”

The Governor of Hewell

1. The Governor should ensure that all prisoners who require a special diet for medical conditions receive appropriate meals. Steps should be taken to make sure that special and medical diets are provided to the required standard as set out in PSO 5000.

Accepted – “Systems are already in place to identify any special medical dietary needs, however exceptionally food items may not be available through the normal contract. In this instance they need to be procured through PCT. At present there is not a written protocol in place for this. However, this will be addressed.”

2. The Governor should ensure risk assessments are completed when hospital staff raise the use of restraints. Escorting seriously ill prisoners can be within acceptable boundaries and the use of physical restraints can take into account the risk of physical injury to a frail person.

Accepted – “Risk assessment documents will be reviewed to ensuring medical staff give clear views regarding the application of restraints to seriously ill prisoners, as is current practice.”

3. The Governor should ensure that management checks for bedwatches address the need to support the staff and the family.

Partially accepted – “Management visits will ensure support is given to prisoner and staff as is current practice. Advice to be given to bedwatch staff that family liaison officer (FLO). Family will be supported by FLO.”

4. A family liaison officer should be appointed when a prisoner is seriously or terminally ill in hospital.

Accepted – “FLO will contact family when initially transferred to hospital.”

5. When a prisoner is admitted to hospital as an in-patient, next of kin should be informed of the admission.

Partially accepted – “Where a prisoner has been diagnosed as seriously ill, then consideration will be given to notifying NOK based on risk assessment.”

The Governors of Hewell and Birmingham

1. Bedwatch staff should be reminded of their duties and the sensitive nature of carrying out those duties with terminally ill prisoners.

Accepted – “Brief to be raised for staff who are conducting supervision of seriously or terminally ill patients.”