

**The death in custody of a man at  
HMP Doncaster – 18 October 2004**

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

**April 2005**

On 18 October 2004, the man, a prisoner at HM Prison and Young Offender Institution Doncaster, was taken to Doncaster Royal Infirmary for treatment. He was subsequently admitted to the hospital but died later that evening. The cause of death was acute peritonitis. A post mortem revealed a large cancerous tumour.

I wish to offer my sincere condolences to the man's family and friends for their tragic loss.

I should also like to thank the Director, staff and prisoners of HMP Doncaster, the staff at Doncaster Royal Infirmary, the Coroner's Office, the local police and the Doncaster Central Primary Care Trust, for the co-operation and assistance given throughout the investigation.

The report highlights the fact that the man was already ill when first admitted to HMP Doncaster, and the post mortem examination established that his death was due to natural causes. The main part of the investigation therefore centres around the clinical review of his treatment and care. There are no serious concerns or matters of major significance in the conclusions and recommendations made in the report. Indeed, it is a pleasure to note that the report commends staff at Doncaster while the clinical review draws attention to specific examples of good practice.

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

## **Summary**

The man was a 58 year old married man, remanded into prison custody at HMP Doncaster on 30 September 2004, after breaching a restraining order to stay away from his wife. On 7 October, The man appeared again at Sheffield County Court and was remanded back into custody for a psychiatric report to be prepared. He was due to return to court on 28 October.

On his initial Induction interview, the man claimed that he had never been in prison before, but it was subsequently discovered that he had spent several short periods in Doncaster during 1999 and 2000. Because of his behaviour and state of mind and perceived risk of self-harm, a form 2052SH was raised on him. This meant that he was under close supervision by staff with a requirement to check him at least every 30 minutes. Notes of his condition were made regularly and full reviews were carried out at specified intervals, noting his behaviour and progress.

After a period of initial aggression and refusal to comply, the man settled down, but he still maintained that he did not know why he was in prison. There were several instances of apparent memory loss and confusion. He regularly refused to take the medication he was prescribed to control his diabetes and to stick to his prescribed diet. As a result, his condition fluctuated and healthcare staff were constantly trying to persuade him to conform to his treatment regime. The man was located in the Healthcare Centre throughout his time in custody.

On 17 October, he appeared to be unsteady on his feet and confused. He ate his breakfast, but could not remember having done so, then ate his lunch but refused tea. During the evening and after lock-up at night he complained of stomach pains. The night nurse gave him some medication and arranged for him to see the doctor the next day. Unfortunately, he would not see the doctor, so staff monitored his condition throughout the day. By lunchtime it was clear that he was in considerable pain and arrangements were made to take him to an outside hospital. He was subsequently taken to the Doncaster Royal Infirmary (DRI), escorted by two prisoner custody officers.

Whilst in the Out-patients department, the man became more unwell and the hospital authorities decided to admit him, with a view to a possible operation the next day. An intestinal obstruction was suspected. He was admitted to a ward where hospital staff continued to monitor and examine him.

The man was difficult and demanding throughout this period and the two prisoner custody officers obtained permission to remove the handcuffs because they were hampering the treatment and monitoring of the man's condition. There was a sudden deterioration in the man's condition at about 9.40pm. The 'crash' trolley was called and emergency treatment was given, but he did not respond and was pronounced dead at 10.05pm.

The cause of death was acute peritonitis arising from a carcinoma. The investigation and clinical review concluded that the man had received a high level of care from staff at Doncaster.

## **Conduct of the Investigation**

Although the man died in an outside hospital, he was still in prison custody and therefore a full investigation was required. The prison authorities notified the Prisons and Probation Ombudsman, who appointed a Senior Investigator and issued terms of reference in a formal Notice of Investigation.

At the same time, the Coroner also issued instructions for a formal police investigation to be undertaken, as is the normal procedure in all such cases. The next of kin were contacted and arrangements were made to keep the family informed of the investigation and to deal with any issues or concerns they might have.

The Senior Investigator visited the prison to collect as much documentary information as was available, and to inform all interested parties of the Ombudsman's investigation. The local Incident Liaison Officer was contacted and notices were posted inviting any member of staff or any prisoner to speak to the investigating team if they felt that they had any information or comments that might assist in the investigation.

In order to ensure that there would be no interference or delay to the police investigation, the Senior Investigator was not able to pursue personal interviews or arrange a clinical review until the formal police investigation was finished. Although there was a strong belief that this was a 'natural causes' death, this could not be formally accepted until the post-mortem had revealed the precise cause of death. This was eventually established as acute peritonitis. The police concluded their investigation, having decided that there were no suspicious circumstances involved.

On 1 November, the Ombudsman's Office approached the Doncaster Central Primary Care Trust (PCT), inviting them to carry out a Clinical Review of the treatment and care given to the man during his time in custody. The Clinical Governance Development Manager, was appointed to conduct the review.

Because the man spent all his time whilst in custody in the Healthcare Department of the prison, there were few other areas to investigate. However, other aspects of his treatment were enquired into by the Senior Investigator, including his initial reception into the prison, the decisions taken regarding his observation and level of risk, and the general level of response and care that were shown to him outside the clinical treatment that he received. A full and comprehensive examination of the man's core prison record, his Medical Record, all correspondence relating to his treatment and his time in prison, and all statements and information collected after his death, was carried out. Throughout the investigation, all members of staff were open and co-operative, all documentation and information was made available and the investigator was given every assistance and courtesy.

A Family Liaison Officer from the Ombudsman's Office was appointed to act as the main contact for the family. There has been regular correspondence and contact with the next of kin to keep them informed of progress, and to explore and deal with any questions and concerns that the family had during the course of the investigation.

The clinical review began in December. A report of the ongoing care and treatment given to the man was produced by the Clinical Manager at Doncaster and this formed the framework within which the review was conducted. The staff involved in his treatment at the prison and at the Doncaster Royal Infirmary were interviewed as part of the investigation. He also reviewed all the available documentation and the medical records relating to the man. The full review was completed on 20 December 2004.

## **Details and History of the Establishment**

HMP Doncaster is a local prison holding all categories of male prisoners, both adult and young offenders. It was built in 1994 and has been managed since that time by a private company, Premier Prison Services, on a contract with the Home Office. The prison has a Certified Normal Capacity (CNA) of 770 prisoners, although it routinely holds a significantly higher number. On the day of the man's death, the prison held 1,117 prisoners.

The Healthcare Centre where the man was located has a normal capacity of 29. There were 18 prisoners in residence on the day the man died.

There have been eight deaths at Doncaster in the past three years, four in 2002, three in 2003 and one 'natural cause' death in 2004. Investigations were carried out into all these deaths and various recommendations made, most of which related to minor changes or improvements to procedures, recording of information and post-incident actions. All of the recommendations have been accepted and put into effect.

There were no serious failures or negligence involved in any of these incidents and no serious criticism or disciplinary action recommended or taken against any member of staff.

The last review by the Standards Audit Unit found no problems with procedures or standards relating to caring for at-risk prisoners or dealing with deaths in custody. The most recent annual report by the Independent Monitoring Board also made no mention of any concern with these issues.

## **Chronology of Events**

The man appeared at Sheffield County Court on 30 September charged with a breach of the injunction made against him by the same court in May 2000.

On arrival at the prison he was un-cooperative and aggressive, refused to answer any questions, and insisted that he should not be in prison. He appeared confused and angry about being in prison, insisting that it was a mistake and that he should not be there. He seemed unable to remember his address and the Healthcare staff interviewing him felt that there might be some indication of psychosis or mental problems that needed investigation. The man eventually confirmed that he had serious on-going medical problems and had discharged himself from hospital the day before his court appearance. He had been receiving treatment for an injury to his head.

Although the man expressed no self-harm feelings, his manner was such that it was decided that he should be put on a regular watch and a form F2052SH was opened. He was located in the Healthcare Centre, where he remained throughout his time at Doncaster.

Initially he was put into a single cell on the Healthcare wing but moved into a dormitory on 4 October where he mixed quite well with the other patients. On 7 October he went to court and on 8 October he was taken to Doncaster Royal Infirmary because of his poor condition. At first he was un-cooperative but eventually allowed the hospital staff to treat him. He returned to the prison the next day, continued his threatening and abusive manner towards staff, but gradually calming down.

The man was referred to the Mental Health Inreach Team, and information about his medical condition was obtained from the hospital where he had previously been treated and from his own doctor. The man was a diabetic and he was put on an appropriate diet and given regular medication and blood sugar checks. Arrangements were made for him to be taken to the local hospital for more intensive examination and treatment. Unfortunately, the man remained un-cooperative, refusing his medication and also refusing to speak to the nurses who were dealing with him. He also refused to stick to his diabetic diet and to allow his blood sugar levels to be checked.

This situation continued for over a week, with the man occasionally taking his medication and cooperating, but usually refusing to listen to any advice or to allow the medical staff to help him. On 8 October his condition had deteriorated and he was very pale and weak. He still refused to allow observations of his condition and also refused to speak to the Medical Officer. He was referred to the Doncaster Royal Infirmary and admitted there at about 6.00pm.

Once again he refused all treatment, including a blood transfusion and endoscopy examination. However, at about 6.00pm the next day he agreed to have treatment and he remained in the hospital until 11 October, when he was returned to the Healthcare Centre at Doncaster. He refused all treatment and examination for the next two days, then complied with his treatment until 16 October when he again

began to refuse. The next day, Sunday 17 October, he appeared to be unsteady on his feet and seemed confused. The man ate his breakfast but could not remember having done so, then had his lunch but refused tea. During the evening and after lock-up he complained of severe abdominal pain and looked very ill. The night nurse on duty gave him some medication for his complaints, which he took, and arranged for him to be seen by the doctor the next morning.

Unfortunately, he refused to see the doctor, so staff monitored his condition throughout the day. By lunchtime it was clear that he was in considerable pain and arrangements were made to take him to Doncaster Royal Infirmary for treatment.

Initially the DRI said that he could not be seen until the following day. However, the Clinical Manager was so concerned about his condition that she spoke to them again and persuaded them that his condition was such that he should be seen urgently, and they agreed to do so.

He left the prison at about 3.00pm, escorted by two prisoner custody officers. Whilst waiting in the Accident and Emergency Department, The man became very ill and the hospital decided to admit him overnight. At 6.30pm, two new officers took over the bed-watch duties. A full and comprehensive log was maintained by the officers which gives a clear picture of events up to the man's death.

The doctors continued to examine and monitor his condition and eventually suspected that an intestinal obstruction was causing the pain. They decided to operate on him the next day. Unfortunately, the man arrested on the ward at about 9.40pm and died at 10.05pm that evening. He was 58 years old.

The PCOs at the hospital informed the prison authorities, and procedures for dealing with a death in custody were put into effect and carried out fully and correctly. The police and the Coroner were informed and immediate efforts were made to contact the next of kin. These efforts were made more difficult because the man had given very little information concerning his family, except for the address of his estranged wife. Eventually, his son was able to attend the prison and the hospital to collect his father's property.

## **Findings and Conclusions**

The man was already ill before he was received into prison. He had clearly not been following the treatment and life-style that he should have maintained in order to control his diabetes. He had received injuries just prior to his imprisonment and there were signs of physical self-neglect and some mental problems. The post mortem suggested the presence of a carcinoma at an advanced stage.

The man was aggressive and un-cooperative on reception and for most of his time in prison. His refusal to follow advice, take his medication, maintain his diet and allow a proper investigation of his state of health all contributed to the gradual deterioration in his health, despite all the efforts of the Healthcare staff at the prison and at the Doncaster Royal Infirmary, where he was taken on several occasions.

He exhibited signs of confusion and short-term memory loss throughout his time in the prison. These problems may have been linked to his physical condition or some other psychological problems and arrangements were being made to investigate this. No conclusion had been reached regarding this at the time of his death.

Because of his condition, the man was kept in the Healthcare Centre of the prison throughout his time there. His health fluctuated, aggravated by his regular refusals to conform to his treatment regime, and unwillingness to allow proper investigation of his complaints. The day before he died, he complained of increasing stomach pain and he appeared even more confused than normal. The duty nurse arranged for him to see the doctor the next day but the man refused to attend.

As his condition grew worse, arrangements were made to get him to the Doncaster Royal Infirmary. The DRI originally said he could not be seen until the following day, but the clinical manager was so concerned about him that she persuaded the DRI that he should be seen immediately and he was transferred there under escort later that afternoon.

Whilst there he had a further collapse and was admitted to the ward. He was due to be operated on the next day but a further more serious collapse occurred and he could not be saved.

Despite the difficulty of dealing with the man, all the people concerned with his treatment did everything possible to help him and care for him. All the written comments, entries in his medical records, correspondence and actions of staff, demonstrate the concern for his well-being and the extent of the efforts made to diagnose and treat him. The Clinical Review indicates that the actions, care and treatment were of the highest standard and consistent with the level of care that would be expected in any medical facility.

There is no indication of any negligence or failure by any member of staff involved in treating the man. In fact, the healthcare staff at Doncaster did everything possible to help and treat the man, despite the very difficult circumstances that they had to face almost daily. Their persistence and determination to ensure he followed his diet and treatment regime are to be commended.

All the proper procedures were followed, full and precise records were maintained and there is a clear audit trail of all actions, treatment and observations which demonstrates good monitoring and management arrangements.

The level of care, treatment, clinical procedures and requirements were all carried out to a high standard, consistent with the standard that would be expected in NHS hospitals.

## **Recommendations**

The healthcare staff at Doncaster should be commended for their persistence and determination to care for the man, despite the difficult conditions they faced in dealing with him.

The Clinical Review recommends that a Significant Event Analysis should be undertaken to explore the undoubted areas of good practice in terms of the care and management of the man.