

**Investigation into the circumstances surrounding the
death of a man
at HMP Swaleside in December 2009**

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

October 2011

This is the report of an investigation into the circumstances of the death of a man on in December 2009 at HMP Swaleside. He was 59 years old when he died and had been ill for some time before his death.

I would like to offer my condolences to his family and to all those touched by his death. I apologise for the delay in the production of this report, and for any additional distress this might have caused. I would also like to thank his family for their contribution to the investigation under the most distressing of circumstances and their patience in waiting for my report.

The investigation was undertaken by my colleague. Both he and I would like to thank the management and staff at HMP Swaleside. In particular, I thank the Governor of Swaleside and the Senior Officer, who acted as liaison officer, for their cooperation during the course of my enquiries. I am also grateful to the clinical reviewer who was commissioned by the local Primary Care Trust (PCT) to review his medical care whilst he was in prison.

He was found dead in his cell in the morning in December 2009. He had been treated for pancreatic cancer since February 2008 and, in August 2008, had his pancreas and spleen removed following the discovery of a tumour. He remained very independent, taking responsibility for administering his own medication as far as possible and choosing not to move to healthcare but to remain on the wing. In the days before his death, staff on his wing noticed that he seemed to be deteriorating, but he refused a medical assessment. When he was found unresponsive in his cell, staff and paramedics attempted to resuscitate him but were unsuccessful.

I make two recommendations as a result of this investigation. They relate to sharing concerns about prisoners and going into cells at night.

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.

Thea Walton
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October 2011

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SUMMARY

The man was found dead in his cell at HMP Swaleside in December 2009. He had been diagnosed with chronic pancreatitis in March 2008 and his pancreas and spleen were removed in August 2008 after a tumour was found. The removal of his spleen meant that he became diabetic and totally dependant on insulin and penicillin therapy.

In August 2009, he attended hospital for a scan. Something showed on his scan, and he was told that it was likely that the cancer had returned. He was both upset and angry that he had been given conflicting information about his life expectancy. He was originally told that he had up to two years to live but, in late August, he was told by doctors that his life expectancy was now only six months.

In December 2009, staff noticed that his condition had started to deteriorate. As prison staff were checking prisoners prior to unlocking cells, he was found lying on the floor of his cell. There was a delay before staff went into the cell, but when they did so, they did not find any signs of life and started to resuscitate him. The paramedics arrived shortly afterwards and declared that he had died.

I make two recommendations as a result of this investigation. These relate to sharing concerns about prisoners and going into cells at night.

THE INVESTIGATION PROCESS

1. This office was notified of his death on 20 December 2009. An investigator was appointed to lead the investigation. Notices were issued to staff and prisoners at Swaleside informing them that an investigation would be taking place and inviting those who wished to see the investigator to make themselves known. No prisoners came forward to speak to the investigator.
2. He opened the investigation on 5 January 2009. He spoke with various members of staff, and asked for copies of the man's full prison records including medical records, wing sheets, security information, hospital bed watch logs and the family liaison log. (A bed watch log is a history, recorded by escort officers, of events while a prisoner is an in patient at hospital outside the prison.) A Senior Officer was appointed as the investigator's liaison officer. He visited Swaleside again on 30 March and 28 June. On 22 July, he returned to interview an officer who had been off work following the man's death.
3. The investigator also contacted HM Coroner for Mid Kent to advise him of the nature and scope of the investigation and to ask for a copy of the post mortem report.
4. An independent clinical review of the care provided for the man was commissioned from the local PCT. They appointed a clinical reviewer to conduct a review. The investigator received the review in June 2010.
5. One of the Ombudsman's family liaison officers contacted several members of the man's family to explain the purpose of my investigation and invite them to raise any questions or concerns to be considered. The investigator and, in the first family liaison officer's absence, another of my family liaison officers met with members of the family on 16 March 2010. The family have raised the following matters of concern:
 - They wanted to know more detail about the night he died, and in particular whether he was found on the floor of his cell or on his bed.
 - The family had been told that he had fallen over a number of times on the wing.
 - The family wanted to know whether healthcare staff had regular liaison with wing staff concerning the management of his illness.
 - They wondered whether wing staff could have spotted his deterioration.
 - The family are worried that he was too weak to press his cell bell.

- The family wanted to know why he was not checked overnight more often.
- The family wanted to speak to other prisoners at his memorial service but the prisoners were taken back to Swaleside before they had the opportunity to do so.
- The family expressed concern whether his in possession medication was monitored effectively to ensure that he was taking it.
- The family also wanted information about his pain management plan, and asked whether he was capable of making his own decisions and how much he understood about his illness.
- They also asked whether his illness could have been managed better at home or hospital?
- The family were concerned that they did not have access to a letter of 7 September 2009 from a doctor, and why were they not consulted about his treatment plan.
- Could the family have be offered more visiting time?
- Why, when he was in hospital, was he handcuffed in public areas but not handcuffed in his own room?
- The family have been told that there was a possibility that he could be released on compassionate grounds, given his terminal illness, and be provided a place in a hospice. This did not happen and they question what consideration was given to releasing him on compassionate grounds.

I hope that the findings of my investigation address the family issues and help them to better understand the circumstances of his death.

Family response to the draft report

6. The family received a copy of my draft report as part of the consultation process. Their comments in response to the investigation findings are reflected on page 24.

HMP SWALESIDE

7. HMP Swaleside opened in 1988 and is one of three prisons on the Isle of Sheppey which, along with HMP Elmley and HMP Stanford Hill, are known as the Sheppey cluster. The cluster is managed by a chief executive.
8. HMP Swaleside is a category B prison holding convicted men aged 21 and over. Prisoners are categorised A, B, C and D according to the seriousness of their offence and the risk posed to the public should they escape. Category A prisons hold the most dangerous prisoners with category D being the least secure and generally known as open prisons. The man was assessed as a category B prisoner which means that the potential for him to escape must be made very difficult.
9. Swaleside has the capacity to hold 951 prisoners. All the prisoners are serving four or more years with around half the population serving life sentences.
10. The local Primary Care Trust is responsible for commissioning healthcare services at Swaleside. The prison has a healthcare unit with 18 beds and provides a general practitioner service every weekday between 8.00am and 5.00pm, with out of hours service cover provided by the local NHS. The prison healthcare unit provides clinics for diabetes, cardiac conditions, physiotherapy, dental health and hepatitis C.
11. In the most recent Ministry of Justice quarterly ratings for prison performance, the Sheppey cluster of prisons was assessed as “good performing”.

Independent Monitoring Board

12. All prisons in England and Wales have an Independent Monitoring Board (IMB). The IMB is made up of local people who volunteer to visit the prison and deal with a range of issues including prisoner complaints, commenting on the prison regime, the standard of healthcare and issues that affect security. IMB members have full access to the prison and prisoners. Each IMB is required to publish an annual report.
13. The latest published report for the IMB at Swaleside covered the period between May 2008 and April 2009. They reported that the refurbishment of the healthcare centre was complete. Plans for telemedicine were at an advanced stage, which would allow for speedier consultations via the internet and reduce the need for bedwatch escorts and the use of restraints. The IMB also noted that prisoners were represented on a consultative committee, which had improved communication between the wings and healthcare.

HM Inspectorate of Prisons

14. The prison is also subject to inspection by HM Inspectorate of Prisons. Following the last inspection in 2008, inspectors made the following judgement on the healthcare services provided at Swaleside:

“Health services offered prisoners access to a broad range of clinical specialisms in the prison and through external NHS sources. The management of long-term illnesses was good, as was the GP service. Dental services did not meet the needs of prisoners, and the lengthy waiting lists would grow with the increase in prisoner numbers. Relationships with the primary care trust were developing well, and the healthcare team benefited from the strong support of the governor. Despite the positive aspects, prisoners were extremely dissatisfied with perceived poor attitudes by healthcare staff, who they claimed denied them access to some services.”

15. In her foreword, the then Chief Inspector also noted that staff-prisoner relationships were “a particular strength”.

Previous deaths in custody

16. There have been 19 deaths at Swaleside since 2004 when the Ombudsman was given responsibility for investigating all deaths in prison custody. Of these, there are none with similar circumstances to those in this investigation.

KEY EVENTS

2006- 2008

17. The man appeared at Crown Court in February 2006 and was sentenced to life imprisonment under the terms of Imprisonment for Public Protection (IPP) legislation. (IPP means that offenders can be sentenced to life but must have a minimum period of imprisonment specified at the time of sentence, which is known as the tariff. Prisoners can be considered for release once the tariff period has been served. His tariff was three years and six months.) He served the early stages of his sentence at HMP Parkhurst and transferred to HMP Swaleside in July 2006.
18. At reception into Swaleside, he was seen by healthcare staff and considered to be fit for normal location and work within the prison. Apart from an eye check and a prescription for lenses, he had very little contact with healthcare in the early stages of his sentence at Swaleside.
19. On 1 February 2008, he was seen by healthcare staff. He complained of having yellowness to the skin, clubbing of the fingers (this deformity of the fingers is often associated with cancer) and weight loss.
20. He was immediately referred to hospital and admitted with a diagnosis of obstructive jaundice (usually caused by an interruption to the draining of bile). On 12 February, his symptoms were discussed at a multi disciplinary conference which noted that there was an abnormality to the head of the pancreas. A decision was made to investigate further. The procedure was booked for 15 February, but this did not take place. The clinical reviewer notes in her clinical review that the medical record does not explain why the procedure did not take place, although it is recorded that he had a stent (an artificial tube) inserted temporarily to relieve an obstruction in the bile duct to relieve the jaundice.
21. On 19 February, following a medical conference, he was referred to liver and pancreatic specialists at the hospital. A week later, on 26 February, the hospital reported that his symptoms were consistent with chronic pancreatitis. This diagnosis was accepted and he was given an outpatient appointment to be reviewed in May.
22. He met Nurse A at Swaleside, on 4 March. Her role was to lead his palliative care (a form of medical care used to reduce the severity of a patient's symptoms) in the prison. She was interviewed by the investigator and clinical reviewer and she said that he understood the possibility of cancer and did not seem unduly anxious. She also commented that he did not appear to have any pain at that stage apart from occasional mild discomfort.
23. On the same day, Prison Doctor A wrote in his medical record that he had received a telephone call from a doctor at the hospital. The hospital doctor told him that the results had come back from the man's biopsy which

showed that he had chronic pancreatitis (long standing inflammation of the pancreas) and not cancer.

24. He was taken to hospital on 29 March with increased abdominal pain. His chest and abdomen were x rayed and blood tests taken, after which he was returned to prison with further pain relief medication. The consultant who saw him became suspicious that his symptoms could be the result of cancer and he was referred back to hospital. He was admitted to hospital again on 30 April with a recurrence of jaundice and once more medical staff discussed transferring him to hospital for surgery to relieve the obstruction.
25. On 7 June, he was admitted to hospital. He stayed for 24 hours and had a range of tests done. The next day, 25 June, he was readmitted for a diagnostic laparoscopy (an operation using a camera to inspect or diagnose a condition) and biopsy (a medical test where cell or tissue are removed for examination). A tumour on the head of the pancreas was detected and he was booked for surgery on 6 August to remove the tumour and perform a total pancreatectomy (the surgical removal of the pancreas).
26. His operation went ahead on 6 August and during the operation his spleen was also removed. The removal of his pancreas meant that he became diabetic and totally dependant on insulin maintenance. He received a number of immunisations to protect him from infection, which is normal procedure for patients without a spleen. He was advised that he should have life long penicillin therapy to help avoid infection. He was referred to the oncology department for consideration for chemotherapy.
27. He returned to prison on 20 August. Whilst in transit to Swaleside, he told escort staff that he did not want to be admitted to healthcare. On arrival at prison reception, he signed a disclaimer refusing admission to healthcare. Healthcare staff assessed him and decided that they had no concerns about him and that he could return to his wing.
28. While he was still in hospital, he had been given instructions about self administration of his insulin and how to test his blood glucose levels. He was prescribed a variety of medication and nutritional supplements to assist his recovery. Nurse A assessed him once on the wing and advised him how to manage any discomfort such as changing his position regularly when he was seated or lying down. She also spoke to the prison kitchens to ensure that he was given a supply of custard, which he felt he could eat as his diet was limited at that time.
29. On 8 September, he was referred to a specialist diabetic nurse, as his blood sugar level was high. He was visited by a dietician who arranged for his milk allowance to be increased and for glucose and Hypostop (a formula to address low glucose levels) to be available on the wing. The nurse again asked him if he would consider moving to healthcare, but he refused.

30. She introduced him to Nurse B, a specialist palliative care nurse, on 9 September. She had more specialist knowledge to advise and assist him to manage his condition. Nurse A was also concerned to offer emotional and psychological support and referred him to the specialist diabetic nurse, who saw him the next day and altered his insulin regime.
31. Later that month, he experienced breakthrough pain and at this time his medication was increased by Nurse B. He was visited by the diabetic specialist nurse on 19 September and his insulin was adjusted.
32. An appointment was made for him to see a consultant oncologist (cancer specialist) on 24 September. He was given a course of chemotherapy. Medical records from this time show that staff saw him regularly, noting his appointments with the oncologist and also monitoring his temperature.
33. Wing records from this time show uniform staff making regular entries in the wing observation book about him. The entries highlight positive interaction between him and wing staff. He is also recorded as mixing well with other prisoners as well as working on the wing.

2009

34. On 26 January, he expressed his displeasure to Nurse A about the frequency with which his hospital appointments were rearranged, which he said was often at short notice. (The clinical reviewer, in her clinical review, notes that this was usually because the hospital had rearranged the appointment although this, in turn, caused difficulty for the prison in arranging escorts.) The nurse offered him counselling, which he refused.
35. Further positive entries by wing staff show a good level of continued interaction with him. For instance, on 22 February, Officer A wrote:

“The man went to outside hospital this week. He is coping well and has received many positive comments from staff he has interacted with.”
36. Officer B introduced herself as his new personal officer on 4 April. They developed a good relationship and she wrote in his personal record that he was starting to open up and talk to her.
37. On 1 June, wing staff asked healthcare staff to review him as he had not come out of his cell that morning. He was seen later that day by Nurse A. He denied having any new problems and said that he was not a “morning person”. However, it was noted that he was becoming less willing to engage with staff, and would sometimes refuse to have his temperature taken.

38. Wing observations of him over this period remained positive. He continued to work in the prison laundry and as a cleaner and comments made about him describe his general cooperation and politeness.
39. In August, he attended hospital for a scan. He was told that something was shown on his scan and the assumption was that his cancer had returned. (The clinical reviewer could not find a letter confirming this in his medical records.)
40. On 9 August, Officer C wrote in his personal record that he had received some medical news which he had not expected. He noted that he had decided to delay making a parole application for three months until he received his results from the hospital.
41. He attended hospital on 28 August. He was told that his life expectancy was now six months, despite being told at a previous hospital that his life expectancy was about two years. He discussed this with Officer C on a number of occasions over the following weeks. On 20 September, she wrote in his personal record that his parole application had been rejected. He decided to write to his home area probation officer with the new information about his life expectancy to see if he could appeal against the Parole Board's decision.
42. In September, he also started another course of chemotherapy which involved a regime of taking tablets and weekly hospital visits. He took his medication regularly and, although the medication was prescribed to be taken twice a day, he preferred to take all of his medication in the morning. He also attended hospital as required.
43. On 7 September, he attended healthcare for blood tests and was seen by Senior Healthcare Officer (SHO) A. The SHO said in interview that it was not possible to take blood as his veins "had all been used in previous blood tests". However, he did have a conversation with him which he recorded in his medical record, noting that he said that he did not want to die in prison and hoped that he could apply for "compassionate discharge grounds".
44. His pain continued to be well managed, although on 19 October he did not receive all of his pain relief medication at the usual time as there had been a delay delivering medication to the prison. Staff responded by arranging for a delivery in the evening. This delay caused him some discomfort and upset his management of his pain. His prescription was written up as a dose twice daily and staff delivering the medication would not have known about his preference to take his daily medication in the morning.
45. On 17 October, Officer C wrote in his personal record that she had spoken to a representative of the Parole Board on his behalf. She was told that his letter concerning parole appeal had been received and he would receive a written response within two weeks. No response had been received by 31 October and she emailed the Parole Board for a reply. He

sought the help of his solicitor in December because he was unhappy at the lack of a response.

46. On 10 December, he reported that he was experiencing dizziness. He was seen by both nurses, who asked wing staff to observe him. They also advised him to monitor his blood glucose levels more closely. On 13 December, wing staff noticed that he had not come out of his cell and was not eating much. When checked, he told the staff that he wanted to be left alone. He was offered admission to the healthcare centre but again refused and instead he was checked regularly over the next three days by wing staff.
47. Later that week, on 17 December, wing staff noticed that he had not washed or shaved and he remained in bed in his single cell. Nurse A came to the wing and wrote in his medical record that he looked a little grey and was unwilling to engage with her. She visited later that day with a doctor, but he refused to be seen by the doctor and so a medical assessment could not be undertaken.
48. On the same day, Officer C wrote in his record that he now spent most of his time in bed and other prisoners collected his meals for him. She also wrote that she believed he was deteriorating fast and spending too much time on his own. She completed her entry by noting that “we are still waiting for a decision from the Parole Board”.

19 December

49. On 19 December, Nurse C went to his cell to deliver his medication. He noted that he did not want to engage in conversation. Later that day, Officer D wrote in his note book that, while he was helping to lock up the wing, he went into his cell and saw that he was in bed. He wrote that he noted nothing out of the ordinary during his check.
50. The same day, Officer B wrote in her note book that she spoke to him when she unlocked his cell. She also allowed a prisoner who was friendly with him into his cell at 5.00pm to deliver some food to him. At 5.10pm, she checked him again and wrote in her notebook that he was in bed, lying on his back with his duvet over him.

20 December

51. On 20 December at 6.20am, Officer Support Grade (OSG) A was undertaking checks on prisoners as he was coming to the end of his shift. (OSGs are prison staff who do not have direct face to face supervisory contact with prisoners. They are used in a support capacity to escort prison visitors, contractors and to carry out patrols when prisoners are locked in their cells.) He went to the man's cell and opened the observation flap which allows staff to look inside. He looked into the cell and saw him on the floor. He put the cell lights on and banged the flap window with his torch to make a noise. He thought that he saw him move

in response to the disturbance. He then carried on with his checks and prepared to handover to the day shift.

52. At 7.00am, Officer E, who had just come on duty, started his routine roll checks. He went to the man's cell and opened the flap to look inside. He saw him lying naked on the floor. The officer started to knock on the cell door, then kicked it and shouted to him. There was no response. He returned to the office and asked the OSG to return to the cell and continue to try to get a response from him. He then called Operations (the communications control for the prison) and Oscar 1 (the person responsible for running the prison at that time) who was the Acting Senior Officer (ASO) to alert him to the man's condition. The ASO had just escorted the night staff from the prison and was making his way back to the main prison. A number of other officers were also instructed to make their way to the cell.
53. The ASO instructed Officer F to go to the healthcare wing to collect the duty nurse. He then made his way to the man's wing. He made notes later that morning and he recorded the time that he arrived at the cell between 7.15am and 7.18am, when he opened the cell door with two officers. Officer G, who arrived at the same time, went into the cell to check him for signs of life. He described him as lying naked on the cell floor. He tried to find a pulse, but did not have any success. He then covered the lower half of his body.
54. At 7.20am, Nurse C arrived at the cell with a defibrillator (a defibrillator is machine which can detect electrical activity in the heart and uses electric shocks to restore an abnormal rhythm) and attempted to administer CPR (cardio pulmonary resuscitation). The nurse could not deliver effective breaths because the man's mouth was tightly shut. He then set up the defibrillator, which advised that no shock should be delivered to stimulate his heart but that chest compressions should continue. The nurse continued to do so until the paramedics arrived at 7.44am. The paramedics went into the cell and, after conducting a number of checks, they declared that he had died.
55. Staff who attended when the man was discovered, and during the emergency response which followed, were invited to attend a hot debrief meeting. (The purpose of a hot debrief is to clarify what happened, support those involved and identify immediate issues and learning.) Some staff did not take part in the debrief as they had completed their shift and left the prison. All the staff who were interviewed commented that they were aware of who they could approach in the prison should they need assistance.
56. The man's sister was contacted by the prison's family liaison officer by telephone to inform her that he had passed away. He rang her a second time later that morning. She told him that she would take responsibility for informing the rest of the family.

57. Prisoners at HMP Swaleside were informed of the death through notices placed on the wings. Staff were also informed by way of a notice, and some staff received telephone calls to their home or to their prison location.
58. The post-mortem into the death was opened on 29 December 2009. The initial findings are that he died from natural causes caused by carcinomatosis (cancer) of the Pancreas.
59. His funeral was held on 21 January and I understand that the prison contributed to the costs of the funeral.

ISSUES

Clinical care

60. The clinical reviewer, in her clinical review, has included several comments on the standard of care provided for the man at Swaleside. She notes that his cancer was diagnosed at a very early stage, which enabled a surgical intervention to take place. This is not a common outcome for someone diagnosed with pancreatic cancer, which is often detected at a late stage.
61. He seems to have been determined to keep his independence for as long as possible. He managed to control his insulin levels by injecting himself, and his insulin was kept in a fridge on the wing. Healthcare staff visited him every day to ensure that he received his pain relief medication. This arrangement only appears to have broken down on one occasion, on 19 October 2009. He also complained once that he was running out of insulin needles. I believe that these were exceptions, and that the standard of care provided to him was generally good.
62. I am also pleased to note that, while staff respected his wish to remain on the wing or move as an inpatient to healthcare, he was regularly asked whether he wanted to change his mind. His answers suggest that he was happy with the way he was cared for on the wing and that he felt that this was the best place for him.
63. She notes that there were, on occasions, problems with his attendance at hospital appointments (indeed, he complained to Nurse A about this on 29 January 2009). She comments that “this required good liaison with the appointments system in the hospital and good planning on the part of the prison”. She attributes the breakdown of planned appointments to the hospital changing them at short notice. I accept this, and therefore do not make a recommendation on this subject, but suggest that the Head of Healthcare may wish to raise this subject with colleagues at the hospital to see how a repeat of events might be avoided. In not making a recommendation, I also note that Swaleside are planning to make greater use of teleconferencing for medical appointments, which will also help to address this issue.

Liaison between wing staff and healthcare

64. In her clinical review, she comments that he was “fiercely independent and determined to manage his own health within his own terms”. She has also commented in her report that he mastered the skills of self administering insulin and remained in control of his own medication throughout his illness. He was capable of making decisions for himself and there were no grounds for healthcare staff or others to override his wishes.

65. The family have also asked my investigator to ascertain whether he had a number of falls on his wing. There is no evidence that he suffered any falls whilst at Swaleside.
66. Having considered the content of my interviews with medical and wing staff, I am satisfied that there is good evidence of consistent and helpful liaison between both groups of staff. Medical matters are confidential between the patient and their healthcare professionals, such as doctors and nurses. Wing staff, who are not healthcare professionals, do not routinely have access to medical records or any other medical matter such as a diagnosis or treatment. However, in practice, wing staff often learn a great deal about a prisoner's condition, for example, by providing the escort to hospital appointments. I have found that several staff working on his wing took account of his poor health and his personal officer in particular showed great compassion in her dealings with him.

Overnight checks

67. The family have asked whether he should have been checked more often during the night. In the course of the night, and in between routine roll checks, wing staff only check prisoners who are at risk of harming themselves or escaping. He did not come into either category and so there was no reason to check him any more than other prisoners are checked. Had he become an inpatient in healthcare, he may well have been checked more often by nursing staff. However, he chose to remain on the wing which is not a hospital environment.
68. As well as checking specific prisoners, night staff are required to patrol the wings which would include listening for any untoward behaviour such as loud music or other disturbances. There is no evidence that the OSG responded to any such events during the night of 19/ 20 December or that he called for assistance.
69. I have no reason to doubt that all the appropriate checks were made during the night. Although officers had noted that he was deteriorating, he remained on the wing and spent most of his time in bed. Given this, I am satisfied that further checks were not required at that time. I do, however, note that the OSG on duty on the night of his death was not aware of his illness, and I address this more fully in the following section of the report.

Discovering the man in December

70. The OSG said at interview that he is only allocated to work in a specific location when he reports to the prison. He does not know in advance where in the prison he will be working and so he does not get to know the prisoners on the wing which he is to supervise overnight.
71. On the evening of 19 December, he OSG was allocated D wing, the wing where the man lived. The OSG had not worked on D wing before and so he did not know him. He said that he checked with the staff going off duty

whether or not there was anyone who he particularly needed to check on. He told my investigator that he was told there were no prisoners who required regular checks overnight. As I say, it is usually prisoners who are vulnerable to self harm and suicide who will be checked during the night.

72. He then waited for the officer going off shift to complete the last roll check of D wing before he assumed responsibility for his own checks. He described carrying out his own evening checks on the prisoners and said that, whilst doing this, he spoke to him, asking him if he wanted his cell light turned off. He asked for it to be turned off later and he returned at 10.00pm, and asked him if he was alright. He replied that he was. He told my investigator that he saw him sitting on his bed as he turned the cell lights off.
73. The next morning, at 6.20am, he was undertaking cell checks on D wing when he went to the cell. He told my investigator that he opened the cell observation panel, put the light on and saw him lying on the cell floor. He said that he hit the observation window with his torch and saw him move his head in what he believed to be a nodding movement.
74. He said that at the same time a prisoner in an adjacent cell shouted for quiet as it was early in the morning. The OSG said in interview that he may have been put off looking further into the situation by the other prisoner shouting. At interview, he said that he did not believe he was in distress, so he decided to carry on with his cell checks.
75. My investigator asked him if he knew what to do in the event of an emergency. He replied that if he thought a prisoner was in distress he would call for "comms", that is the communications control for the prison, to call for assistance.
76. It appears that he acted appropriately in the circumstances, given that he was not aware of the man or his illness, and thought that he had received a response when he knocked on the observation panel. However, staff on the wing had noticed that his health had deteriorated in the previous few days. This information was not given to him and he therefore did not know that a further check on him might have been appropriate. I do not apportion blame to any member of staff, but I do think that such information should have been passed between staff more effectively.

The Governor should ensure that, when staff have concerns about a prisoner, this information is shared appropriately with colleagues on all shifts.

77. After the OSG made his final check at 6.20am, the next check was made by Officer E shortly after 7.00am. The officer immediately recognised that something was wrong with the man and called for help from his colleagues. Given the timings given by the ASO and the officer, it seems that help only arrived some ten minutes later.

78. I believe that, in the circumstances, staff should have gone into the man's cell much earlier. He was in a single cell and was known to be ill. The OSG was outside the cell with the officer and therefore could have assisted him if he decided to go into the cell. The officer told my investigator that, for reasons of personal safety, he preferred to go into prisoner's cells only when accompanied by another officer. The ASO confirmed that both the OSG and the officer both had the authority and the keys to go into the cell.
79. While accepting that staff have to assess the risk at the time and without the benefit of hindsight, I think that on this occasion they should have gone into the cell at the earliest opportunity. I appreciate that in such circumstances staff have to consider whether there is a risk of assault from the prisoner. It is easy with hindsight but I believe that the staff, one of whom knew the man well, could have reached a different view and gone into the cell straightaway. Although it is unlikely that the outcome for him would have been any different, in other circumstances a life might be saved.

The Governor should remind staff of the procedures for going into a cell during an emergency.

Whether the man was too weak to press his cell bell?

80. Nurse C told my investigator that he spoke with the man on 19 December when he delivered his medication to him in his cell. He told the nurse, who had noticed he was jaundiced and had asked him if he was alright, that he was fine.
81. In interview with the investigator, the nurse said that she checked him twice on 19 December, the last time being at 5.10pm when he was in bed with his duvet over him. She said that he was breathing and looked as though he was watching television. The OSG in his interview said that when he saw him at 10.00pm he was sitting up on his bed. The OSG also said that he did not hear anything untoward from his cell for the remainder of his shift as he went about his wing patrol.
82. The clinical reviewer wrote in her review that his death was sudden and unexpected with no record of him calling for help. Staff statements show that when staff checked on him he was able to communicate appropriately.
83. It may be that he was trying to get to the cell bell when he died and this may explain why he was found on the floor of his cell.

Release on compassionate grounds

84. The family have asked whether his illness could have been managed better at home or at hospital. As noted above, the clinical reviewer has found that his care at Swaleside was good and he generally received the medication and appointments which he required. No formal application

was made for him to be released on compassionate grounds. In the period leading up to his death, he was mobile and functioning appropriately on the wing with both staff and other prisoners. Compassionate release can only be considered for prisoners who can no longer care for themselves and do not present any risk to the public. He was serving a life sentence and, despite his serious health condition, I do not think that there were grounds for applying for compassionate release.

Consultation with the man's family about his treatment

85. The family have also asked why they were not consulted about his treatment and specifically about a letter from a consultant dated 7 September. The clinical reviewer commented that he was in control of his medication and able to represent himself with medical staff when discussing his treatment. Patient confidentiality would have meant that it was his own decision about who to share information with regarding his medical treatment. Had he asked for his family to be involved, I would like to think that his request would have been considered sympathetically.

Availability of extra visiting time

86. He was entitled to two weekend visits or four weekday visits every month. I have seen no evidence to suggest that he applied for any extra visits from his family. While it is possible for the prison to offer extra visits, this is usually only done when a prisoner is clearly very ill. Although he was terminally ill, he was independently caring for himself. Had he wished to do so, he was able to apply for extra visits until shortly before his death. In the circumstances, I do not consider that Swaleside should have offered extra visits.

Use of restraints

87. The family have asked why restraints were used while he was in public areas of the hospital, but not in his own room. Every time that a prisoner such as the man leaves prison to attend hospital, a risk assessment is completed, concerning areas such as likelihood of escape and risk to the public. Each assessment is checked by healthcare and prison management at different stages during the visit. It probable that when he was in a private room, prison managers approved the removal of restraints to make him more comfortable.

Informing the family of his death

88. After he died, his family were informed by telephone by a prison FLO. Prison Service Order 2710, entitled "Follow Up to deaths in Custody", contains an annex giving guidance to FLOs on how to break such news. The preferred option is that news is given in person, and the option to use the telephone is described as being "the last resort".

89. My investigator asked the FLO why he had telephoned the family instead of visiting. He replied that, following two previous deaths in custody, other prisoners had informed the family by using illicit mobile telephones before he had arrived at their home to break the news in person. He was keen that this did not happen on this occasion.
90. While I understand the reasons for his actions on this occasion, the guidance in the PSO is clear in giving a best option, which should be followed when possible. I do not make a recommendation on this occasion, given that the family did not raise this as an issue, and I understand why the FLO reached his decision. However, the Governor might want to consider this issue further and thus I bring it to his attention.

The memorial service

91. The family asked my investigator to look into the prison's management of the memorial service for him. I am pleased that the family were invited to the service and that they were able to accept. Not every family wishes to attend and it is important that they are consulted.
92. In interview with the investigator, the FLO, who chaperoned the family during their attendance at the memorial service, said that he thought the period of time after the service, when the family talked to other prisoners, had seemed to come to a natural conclusion. The prison can allow a certain length of time for memorial services before prisoners and staff have to return to the main prison. I am sorry that the family felt that they were unable to spend time talking to his friends and suggest that they could have been asked if they were ready to leave the service.

CONCLUSION

93. The man died in his cell in December 2009, whilst being treated for cancer of the pancreas. Staff at Swaleside noted that his condition had started to deteriorate earlier that month and he was visited regularly in his cell by other prisoners, wing staff and healthcare staff.

94. Prison healthcare staff and some wing staff including his personal officer were aware that he had received a revised estimate about his life expectancy and that the prognosis was poor. However, he died unexpectedly and, whilst I make two recommendations including ensuring that when staff have concerns about a prisoner this should be shared appropriately, I conclude that staff at Swaleside could not have prevented his death. His family have raised several issues about his treatment and I hope that they are reassured by my findings. I repeat my apology for the delay issuing my report and understand that this cannot have helped to alleviate their concerns.

Feedback from the family

The family made the following observations having considered the investigation findings as part of the consultation process.

- The family told my family liaison officer that they were angered and saddened by the findings and hurt by the prison's failure to acknowledge any responsibility for the events on the night the man died. They are concerned about the inexperience of the officer on duty and do not agree that he acted appropriately in the circumstances. They feel strongly that a prisoner lying naked on the floor of his cell in the middle of December should in itself be enough to prompt further investigation by staff.
- They were concerned by the lack of intervention, towards the end of his life, by his personal officer. Although she identified a decline in his health, noting in his file just two days earlier that he was deteriorating fast and spending too much time on his own, there is no evidence that she took these concerns any further. The family questioned whether personal officers have the appropriate autonomy to bring matters to the attention of others, if they have significant concerns about an individual.
- They also spoke of their frustration that no attempts were made to engage with them with regard to his illness and treatment. They accept the issue of patient confidentiality but feel it is often the case that the individual is too fragile and unwell to initiate contact themselves, particularly when faced with a terminal prognosis. The family feel they were deprived of the chance to care for him in the final stages of his life.
- The family feel that the lack of information sharing between wing staff and night staff about his illness, particularly given this had deteriorated in the days prior to his death, was a significant failing and compromised the care he received. They acknowledge the Ombudsman's recommendation regarding this and hope practise will be improved for the benefit of other prisoners.
- The family accept it was his decision not to move to the healthcare unit, however, given it was noted by wing staff that his condition appeared to be deteriorating, they believe formal checks should have been put in place as a means of monitoring him throughout the night.

RECOMMENDATIONS

NOMs have accepted all of the recommendations. The response to each recommendation is set out below in italics.

1. The Governor should ensure that, when staff have concerns about a prisoner, this information is shared appropriately with colleagues on all shifts.

The most recent Safer Custody Audit conducted in May 2011 highlighted that there are no concerns in this area. Improvements have clearly been made and all staff make full use of the observation book and Cnomis. The Auditor also made comment that communication between Healthcare and the Residential Units is very good.

2. The Governor should remind staff of the procedures for going into a cell during an emergency.

All Staff will be addressed at the full staff meeting on 8th June 2011. A notice to staff will also be published the same day outlining the correct procedures