Investigation into the circumstances surrounding the death of a man in January 2010 at outside hospital while in the custody of HMP Dovegate

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the circumstances surrounding the death of a man in January 2010 whilst in the custody of HMP Dovegate. The man, who was 58 years old, died at outside hospital as a result of a neuro-endocrine tumour (cancer). His health was good when he first arrived in prison in 2004 but he was a heavy smoker. In 2008, having previously been seen only rarely by prison doctors, he started to complain of persistent diarrhoea. After several months of investigation, following an emergency admission to outside hospital, the man was diagnosed with cancer of the liver in January 2009.

The man initially allowed doctors at the hospital to treat him, but in May 2009 he refused all further treatment. He continued to be looked after by healthcare staff at Dovegate, without the intervention of palliative care services from the community until his death in January 2010. I do not believe that prison healthcare staff always fulfilled the standards expected of their profession most notably on 6 November when he was attended four times because of severe pain, but without further action being taken to relieve it.

I would like to extend my personal condolences to the man's family and friends for their loss. I apologise for the delay issuing my report and any additional distress this may have caused the man's family.

This investigation was carried out by my colleague. A clinical review, for which I am most grateful, was undertaken by a clinical reviewer on behalf of South Staffordshire Primary Care Trust (even though they are not the commissioners of health services at Dovegate as this is a private prison). I also thank the Director of HMP Dovegate and his staff for their help and co-operation during this investigation.

I make seven recommendations in this report together with a suggestion that the Director considers the implications of the further recommendations made by the clinical reviewer in her review. My most significant recommendation relates to what I believe was the inappropriate and regrettable use of handcuffs on a dying man and the need for the Director to reconsider his instructions to his bedwatch staff. I also repeat recommendations about record keeping which I have made in previous investigations at Dovegate.

I am happy to report that all the recommendations that I made in the previous draft version of my report have been accepted.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2011**

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SUMMARY

The man was sentenced to ten years imprisonment by a crown court on 25 May 2004 for serious sexual offences. He was first sent to HMP Liverpool, but was transferred as part of his sentence plan on 16 November 2004, to HMP Dovegate. At the time of his initial sentence, the man had no recorded physical health problems, although he was prone to depression and anxiety.

His progress in offender programmes terms was hampered initially by the man's inability to read and write so much of his time was occupied in learning these skills. He refused to engage fully with sex offending programmes throughout his sentence because he maintained his innocence. He was therefore refused parole on the basis that he had not made any attempt to show that he had reduced the risk he posed to the general public which would justify early release.

In October 2006, the man's wife died as a result of cancer. His friends described how this had a devastating effect on him and they suggested that he lost the will to live, although they made it clear that he was not actively suicidal.

The man began having bowel problems in March 2008. Tests were undertaken by doctors at the prison to determine the cause of these problems, but no definitive diagnosis was reached. In October 2008, the man went to the accident and emergency department at outside hospital with chest pain and pain in his abdomen. He was thought to have a viral infection and was sent back to prison the same day.

On 21 October, one of the doctors at the prison (whose signature is illegible) suggested that the man might have gastrointestinal cancer. Despite the NHS procedure for urgent referrals of suspected cancer patients, no referral for the man was sent. On 9 November, the man was taken back to A&E because of severe pain (he had been suffering increasingly since the end of October). He was found to have a perforated duodenal ulcer and was operated on by surgeons at outside hospital.

During the operation, surgeons saw what they believed to be tumours on the man's liver, and recommended that further investigations and tests be carried out. A consultant gastroenterologist subsequently confirmed that the man did indeed have cancer of the neuro-endocrine system. (This is a rare form of cancer in that it acts to overproduce hormones throughout the body, rather than the more common over production of cells that lead to a 'mass' within the body.) He was informed of the diagnosis on 12 January 2009.

The man was initially reluctant to cooperate with the clinicians at the hospital because he was anxious about the treatment he might require, but staff at Dovegate managed to reassure him. He went to the hospital for follow up consultations during the next few months but declined all further opportunities of treatment or re-referral to consultants after 19 May. Dovegate healthcare staff looked after the man's prescription needs to keep him pain free over the following months, but it does not appear that he was ever formally referred to palliative care services. On 7 November, he was in severe pain and nurses attended four times during the night, but without taking any further action to relieve his discomfort. No 'End of Life Care

Package', a guideline laid down for terminally ill patients, was ever instigated for this man.

He continued to deteriorate over the following months and, in January 2010, was taken back to outside hospital because of severe pain in his abdomen. Doctors at the hospital assessed him as being close to death and made him as comfortable as possible. The man's nominated next of kin were contacted but he died at 11.55pm, before they could arrive. Regrettably, he was still handcuffed to a prison officer and the restraints were only removed three minutes after he passed away.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of my investigators. He first visited Dovegate on 2 February 2010 and was given access to the man's prison records. My investigator saw the healthcare unit and the unit where the man lived during his time at the prison.

2. During this initial visit, my investigator met members of the Independent Monitoring Board (IMB), the prison chaplain and the Prison Officers Association (POA). He invited them to provide any information regarding the prison or the circumstances surrounding the man's death that they thought pertinent to my investigation. (Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.) My investigator also interviewed a former roommate of the man's.

3. South Staffordshire Primary Care Trust (PCT) was asked to undertake a clinical review of the care that the man received whilst he was in custody, particularly during his time at Dovegate. They appointed a clinical reviewer to undertake the review on their behalf. The clinical reviewer was asked by the investigator to particularly consider whether the prison health authorities had acted correctly in identifying the man's condition and whether there had been any delay in his treatment.

4. One of my family liaison officers contacted the man's brother, as his listed next of kin, to explain the purpose of my investigation and invite him to ask any questions or raise any issues for consideration. The family raised no issues of concern at the outset of the investigation. They were also offered an opportunity to receive and comment on the draft version of the report, however, to date, have chosen not to do so. I hope that the findings of my investigation answer any questions they may have, should they receive the report in the future.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion of this investigation, a copy of my report will be sent to the Coroner. The inquest into the man's death was held on 8 September 2010 when the jury returned a verdict that he had died of natural causes. The Coroner did not request a post mortem report as the man died whilst in the care of doctors at outside hospital. He was confident that the cause of death was hypovaleamic shock due to a perforation of bowel viscous as a result of metastatic liver disease (meaning that the man died of cancer of the liver).

HMP DOVEGATE

6. Dovegate opened in 2001 as a prison for adult male prisoners sentenced to over four years. It now also caters for local remand prisoners from surrounding courts. It is a private prison managed by Serco under contract to the National Offender Management Service (NOMS). It currently holds up to 1,146 prisoners, 946 men in the main prison and 200 in the Therapeutic Community (TC). Serco Healthcare has a contract to provide healthcare at HMP Dovegate. They directly employ two doctors who work Monday to Saturday (and are on call on Sunday). There are 18 nurses and 11 healthcare assistants available to work shifts that cover the 24 hour day, with two qualified nurses on duty at night. There are 11 single rooms in their in-patient unit. The local Primary Care Trust is not responsible for delivering healthcare at HMP Dovegate, but does provide clinical guidance support.

7. Her Majesty's Chief Inspector of Prisons last reported on Dovegate following an announced inspection in October 2008. The Chief Inspector made the following comment about healthcare:

> "Primary health services were reasonable, but were compromised by shortages of staff and accommodation, which needed a substantial increase in funding for healthcare to move forward. Chronic disease management was maintained despite staff shortages, but staff needed more time to give a quality service to prisoners. Many NHS appointments were cancelled or rearranged, and pharmacy services needed further development."

8. The latest Independent Monitoring Board Annual Report, for the period 2008-09, made the following comments regarding healthcare services:

> "Applications to the IMB regarding healthcare are the second highest number, being 14.01% of all applications. The complaints are about medication, or lack of medication, long waits to see consultants and claims they are ignored by staff.
>
> "During the last reporting year, the healthcare centre has had a reworking of the facility to reduce it from dormitory sized rooms to single cell accommodation. The centre was closed in July 2009 and all in-patients were transferred to HMP Birmingham. Recently re-opened it now has improved facilities, including pharmacy and waiting rooms.
>
> "A new healthcare manager, additional administrative staff, pharmacy assistants and more nurses have been recruited. Hopefully this will bring some much needed stability to this important facility."

9. The man's death was the 12th to have occurred at Dovegate since April 2004 when the Ombudsman began investigating deaths in custody in England and Wales. Of the 11 previous cases, eight were due to natural causes. In three of my previous investigations I recommended that the Director and Healthcare Manager ensure that medical records are maintained to the standard required

by the General Medical Council and Nursing and Midwifery Council. I am disappointed to repeat my recommendation again.

KEY FINDINGS

10. The man arrived at HMP Liverpool from a crown court on 25 May 2004 having been sentenced to ten years imprisonment. His first reception health screen identified that he had never been to prison before and had not recently seen a doctor. He told healthcare staff at Liverpool that he suffered from depression and panic attacks and had been receiving treatment for the past seven years. He had no other medical problems or concerns.

11. For his first few years at Dovegate (from November 2004 until March 2008), the man spent most of his time engaged with educational services and learning to read and write. He did not wish to participate in any reducing re-offending courses because he maintained that he was innocent of the crimes for which he had been convicted. His risk of re-offending did not therefore diminish in the eyes of the Parole Board. The Parole Board reviewed his case in April 2009 and refused his application for release on licence.

12. In health terms, the man remained well, with little need to be seen by doctors or nurses at the prison except for occasional panic attacks or short bouts of depression.

13. On 22 October 2006, following a long illness, the man's wife died from cancer.

14. The earliest indication in the man's clinical record that he was beginning to become unwell is contained in an entry dated 11 March 2008 (made by an unidentified doctor). It states that the man had recently started having bowel problems. The doctor examined him and decided that, if the problems were not resolved within two to three weeks, the man should be seen again for further investigations. There are no other entries until July.

15. When the man was seen on 22 July, he complained of diarrhoea and a doctor diagnosed this was due to an infection. On 10 September, the man was seen by a nurse who referred him to a doctor due to his continued diarrhoea. He was seen again on 4, 7, 8 and 11 October and four times on 15 October for problems relating to loose stools (diarrhoea) and abdominal pain.

16. The man was admitted to outside hospital on 16 October with chest pain and pain in his abdomen. He was treated with antibiotics and discharged back to the prison that day with a diagnosis of a chest infection (pneumonia).

17. Three weeks later, on 4 November, the man was admitted to the healthcare in-patients unit at Dovegate because wing staff were becoming increasingly concerned about his abdominal pains. He was examined by a nurse who found that he had swelling of both his feet. She wondered if he might be suffering from heart failure and therefore referred him to a doctor (the record does not indicate which doctor). Her entry in the clinical record goes on to say 'GP reviewed today and concerns of crackles to chest. GP has faxed off urgent referral query bowel and lung disease'.

18. Later that day, the same nurse reviewed the man’s care. In an entry at 8.50pm she reported that he was complaining of pain and had been given paracetamol, with a further dose held in his own possession to take as required during the night. She recorded his blood pressure as 159/86 and his pulse as being 87 (both results are more or less within normal limits, albeit slightly on the high side). She left instructions for the night nurse to review him, although there is no record that this was done.

19. The next entry in the clinical record was dated 6 November at 5.15pm by an unidentified doctor who examined the man and prescribed Buscopan (a muscle relaxant) and diazepam. The doctor concluded his entry thus ‘If deteriorating during this night I told staff to send to A&E’. The entry from the night nurse says ‘[The man] managed to sleep tonight following diazepam and Buscopan administration around 22.00’. At 2.00am on 7 November, the night nurse was called again by the man and she gave him paracetamol.

20. On 9 November, the man was admitted to outside hospital as a medical emergency. He was diagnosed as having multiple duodenal ulcers, some of which were bleeding internally. He required an operation to rectify this and following the laparotomy (that is the operation) on 14 November, he was discharged back to Dovegate five days later on 19 November. During the operation, the surgical team noticed that the man had ‘lesions’ attached to his liver (liver lesions are small masses that grow within the liver). It was therefore arranged that he would have a CT scan (a CT (computed tomography) scan, uses x-rays and computers to take pictures of the internal structures of a person’s body). The man had the CT scan at outside hospital on 31 December.

21. The man went back to outside hospital on 12 January 2009, accompanied by a nurse. He was to have an oesophogastroduodenoscopy (OGD, or a camera that looks at a person’s digestive system and enters the body via the mouth) as a follow up to his CT scan. After the OGD he was told by a consultant gastroenterologist that he had cancer of the liver which might have spread from elsewhere in his body, possibly including his pancreas.

22. On 27 January, the man was due to receive chemotherapy, but he refused to go because, according to his medical notes, he was anxious about the treatment. Despite the efforts of the then healthcare manager, he was adamant that he did not want to go to the hospital for treatment. Over the following week or so, staff at the prison worked hard to reassure the man that he should go to the hospital, initially so that he could be given more detailed information about his condition. He eventually agreed to go and on 11 February, duly went to outside hospital.

23. Throughout February, March and April, it appears from the clinical record that the man was constantly reviewed and attended a number of hospital appointments. On 19 May, he declined any further hospital appointments. There is no explanation in the record as to why this was, nor is the entry signed by the doctor who recorded the man’s decision. The entry does say that the doctor offered to write to the hospital team but that the man declined

his consent. It does not appear from the records that the man went to hospital out patients appointments again after this date, although he had several inpatient admissions. The entries in the clinical record from this point on are restricted to recording physiotherapy sessions and repeat prescription entries.

24. In interview with my investigator, the man's former roommate described occasions when his friend complained of severe pain. He told my investigator that, on one occasion, the pain had reduced the man to tears during the night but the nurse who came to see him rebuked him for persistently calling her out. It appears, from the man's former roommate's account of events, that the nurse was only able to offer mild pain relief such as paracetamol and was reluctant to call a doctor for something stronger to alleviate the man's pain. It is unclear when this incident happened and there is nothing in the records to substantiate the man's former roommate's account.

25. On 25 January 2010, an unidentified doctor wrote in the man's clinical record that he was complaining of abdominal pain which had persisted for four days. The doctor examined him and found that his temperature (36.8) and pulse (70) were normal, but he looked "pasty" and had tenderness of the abdomen when touched. The doctor recorded that the man was not prepared to go to the hospital outpatients' department, but would agree to go to 'AAU', (which I take to be a medical admissions unit at the local hospital). No immediate arrangement was made to take the man to hospital.

26. During the early hours of the day of his death, the man pressed his cell call bell. The agency nurse (who again cannot be identified from the record) wrote in the clinical record that he was:

> 'complaining of abdominal pains. On palpitation [meaning to touch and move] around the umbilical region it felt very hard and he would scream in pain.'

The nurse called for an ambulance and the man was admitted to outside hospital. He was handcuffed to an escort officer who, with a colleague, carried out the bedwatch duties.

27. From the entries in the clinical notes, and the record supplied by officers on the man's bedwatch, it is evident that he was examined by doctors at the hospital who decided that palliative care, rather than active treatment, was required. A decision 'not to operate' on the man was made by clinicians at outside hospital. They determined that the appropriate treatment was to ensure that he had sufficient pain relief and fluid intake to make him as comfortable as possible.

28. A management check of the bedwatch arrangements was made at 7.20pm and the duty manager said that they should remain in place. Two hours later, hospital staff advised the bedwatch staff that the man was very poorly and suggested that his family should be told about his condition. The escort officer told staff at the prison, presumably including the duty manager, and were advised to contact the prison again every half hour.

29. At 11.55pm that evening the man passed away, although he was not certified dead until 1.30am the following morning by doctors at the hospital. The handcuffs were not removed until 11.58pm after permission was given by the Duty Governor at Dovegate.

30. On the day of the man's death, staff from Dovegate attended a debriefing session to consider whether there were any lessons they could learn in respect of his death. I hope this report contributes to that ongoing process.

31. There was initially some confusion as to who should be considered as the man's next of kin. It was originally thought that he had identified some friends to be his next of kin, but might also have living relatives who would wish to be involved in the funeral arrangements. In the event, the man's friends were involved in his funeral arrangements and his family have been kept informed of events concerning the funeral and this investigation. Dovegate paid the costs of the funeral in line with the Prison Service instructions.

ISSUES

Clinical care

32. The man was a reasonably fit 52 year old when he came into prison in May 2004. He remained physically well until March 2008 when he first started having bowel problems. He was initially treated conservatively with antibiotics as the doctors at Dovegate thought that an infection might be causing his diarrhoea.

33. On 16 October 2008, the man was sent to the Accident and Emergency department at outside hospital complaining of chest and abdominal pain. He was discharged back to Dovegate after a few hours with a diagnosis of an infection. No discharge letter accompanied him on his return, and health services at Dovegate did not follow this up.

34. This was important on a number of levels, not least of which is that the man's doctors at Dovegate should have known how he had been treated at A&E and what tests had been performed. Had they made enquiries, they would have become aware of the blood test results that the man had had whilst at A&E. A crucial result was for his C-reactive protein (CRP) which is a standard blood test for proteins which are present in the blood when there is an infection present. In this man's case his CRP level was raised when he attended A&E on 16 October. The clinical reviewer says that this was to be expected if the man did indeed have an infection such as pneumonia (which is what he had been diagnosed with).

35. However, doctors at the prison repeated the blood test for CRP on 21 October which showed a significant increase in the levels of CRP. The levels should have significantly decreased if the original diagnosis of pneumonia and its subsequent treatment had been correct. In fact, doctors at Dovegate failed to review the findings of those later blood tests, and in any event, they did not have the earlier blood tests to help guide them.

36. A similar state of affairs existed in regards to the man's liver function tests. Liver function tests (LFT's) were asked for and might have shown that the pain in the man's lower abdomen was the result of problems with his liver. However, doctors at the prison did not know the results of the tests they had asked for. It is fair to say however, that even if doctors at the prison had been more aware of the blood test anomalies, the clinical reviewer is of the view that:

    ”Had the continuity and progression of symptoms been noted it is feasible that his cancer could have been diagnosed earlier. Certainly his presentation demanded earlier and more comprehensive investigations than appear to have been done. I think it would be unreasonable to have expected the GP's to diagnose a neuro-endocrine tumour but simple investigations would have revealed abnormalities in liver function and biochemistry which may have led to the metastases and other abnormalities being discovered sooner. These investigations,

colonoscopy, abdominal Ultra-sound scan, blood tests, are routine in patients who present with unexplained symptoms. It must be said however that even had his cancer been diagnosed sooner this may have made no difference to the man's final prognosis and terminal illness."

37. However, I believe that inadequate systems at Dovegate led to doctors at the prison failing to enquire about the absence of a discharge letter from the man's visit to A&E in October and their failure to recognise that no one had checked blood test results when they arrived. I therefore make the following recommendation.

The healthcare manager should review the systems for communication with outside health service providers, including secondary care services, to ensure that they are robust and meet the needs of patients at Dovegate.

38. After some months, it became clear to the doctors treating the man that the cause of his health problems might be something more grave than an infection. On 4 November, he was admitted to the prison in-patient unit because staff were concerned about the continuing deterioration of his health. The swelling of his lower legs suggested to a nurse that he might be suffering from heart failure. When the prison doctor saw him, he made an urgent referral to outside hospital for a consultant assessment of the possibility of bowel or lung disease. On 9 November, the man was admitted to outside hospital as a medical emergency and found to have internal bleeding from duodenal ulcers, requiring an operation.

39. During the operation, surgeons discovered what they believed to be cancerous lesions on the man's liver. Further tests after his discharge back to prison confirmed that he did indeed have a neuro-endocrine tumour and that he would require treatment for that cancer if he were to survive.

40. The clinical reviewer considers that during the man's early illness, nursing and medical staff should have been more alert to the symptoms that he was displaying. She writes:

"Nursing and medical staff failed to notice a significant change in [the man's] health and need for healthcare input … The significance and seriousness of [the man's] subsequent deterioration in health does not appear to have been noted by medical or nursing staff alike."

The clinical reviewer's opinion is that:

"the persistence of [the man's] symptoms demanded a specialist referral and should have alerted the medical staff to the possibility of an underlying serious cause, given the patient's age and previous good health."

41. The clinical reviewer adds:

> ”I believe that such a significant increase in health problems, in a 57 year old male smoker, should have triggered suspicion of serious underlying pathology. It would have been clinically appropriate to undertake more comprehensive investigations, as mentioned above [such as blood tests, colonoscopy, referral to a gastroenterologist or abdominal ultra-sound scans] after his symptoms had persisted for more than six to eight weeks.”

42. The clinical reviewer believes that there were a number of contributing factors to this failure, the most important being the lack of an electronic patient record system. I support her recommendation to implement a computerised patient record system.

The Director of Dovegate, in conjunction with the providers of healthcare services to the prison, should install a computerised clinical patient record system.

43. I am disappointed to learn of the actions of nursing staff when the man became acutely unwell in November 2008. He was seen on a number of occasions by nursing staff when he complained of persistent and excruciating abdominal pain between 6 and 9 November. On 6 November, (a Thursday), the on call doctor was asked for advice regarding the man’s severe epigastric pain and swollen legs. The advice to nursing staff from the doctor was that if his symptoms became worse he should be sent to A&E. That night the man called for nursing staff to help him at 11.00pm, 2.00am, 3.00am and 4.20am because of the severe pain.

44. On 7 November, there is no entry in the man’s clinical record to suggest he was seen by a doctor, but his blood pressure was recorded as being 150/105 (which is a high reading). No pulse or other observations were recorded. According to the clinical reviewer, the man’s swollen legs, together with his high blood pressure, could have indicated a life-threatening renal, cardiac, or vascular condition. However, there is no evidence of any appropriate further monitoring or positive action being taken, and no evidence that the man was reviewed by a doctor.

45. The following day his blood pressure was recorded as being 90/45 (extremely low). The clinical reviewer says that:

> ”With the combination of epigastric pain and a low BP urgent hospital admission should have been arranged immediately with the possible differential diagnosis of perforated gastric ulcer, aortic aneurysm, acute Myocardial Infarction (heart attack) or other serious abdominal pathology. Instead the BP is repeated at 0400hrs, and at 0500hrs when a reading of 110/50 is recorded. No pulse rate is recorded. This either represents poor clinical record keeping or a failure of the nurse, or nurses, on duty to recognise serious acute medical illness and to understand the basic physiology they were measuring.“

46. The clinical reviewer's analysis points to an element of incompetence or lack of training on the part of nursing staff on duty at this time. I have been informed that the nursing staff concerned were agency staff who are no longer employed at Dovegate. Had they still been employed at Dovegate I would be recommending a comprehensive assessment of their competence and consideration of referral to the NMC (Nursing and Midwifery Council, nursing's professional body). Instead I recommend that the healthcare manager sends a copy of my report to the agency concerned so that the registered manager can determine what action should be taken.

The healthcare manager should ensure that good standards of record keeping in the medical record are maintained, in compliance with the Nursing and Midwifery Council Guidelines for Records and Record Keeping and Department of Health and NHS Code of Practice Records Management.

The healthcare manager should ensure that patient observations are made and recorded.

The healthcare manager should provide a copy of this report to the agency which employed the nurses who treated the man.

47. During the early part of 2009, the man went to outside hospital for care and treatment (although it is unclear from the records exactly what treatment he had), but in May 2009, he refused all further treatment. It is also unclear from the records whether health services at Dovegate asked for the advice of palliative care specialists for the man after this date. What is clear is that nursing and medical staff tried to persuade him on many occasions to engage more fully with secondary health services in the community. The clinical reviewer pays tribute to the compassion of the clinical staff:

> ”The consultations recorded in the IMR show that [the man's] input from the healthcare department showed compassion and were in many cases professionally undertaken and recorded.”

48. However, it is disappointing not to see any evidence of 'end of life' care being planned from the point when the man's condition was diagnosed as terminal in January 2009. It does not appear that any attempt to provide specialist palliative care services was made for the man once he refused to go to hospital in May 2009. I cannot be sure whether this was because the man refused all offers of help or because the systems and processes were not present at Dovegate at this time. I recommend therefore that:

The healthcare manager should ensure there is a robust system in place for palliative care patients at Dovegate.

49. The clinical reviewer's report establishes the need for a review of the pharmacy arrangements for non-standard medication provision. The clinical reviewer observes that the man was discharged from outside hospital on 11

November 2008 and should have had a few days' supply of medication. Healthcare staff at Dovegate should have obtained further supplies of his essential pain relief medication, oramorph. However, three days later, on 22 November, his medication had run out and it took several more days to organise further supplies. I can only imagine the pain and discomfort the man must have been subjected to as a result of this failure.

Early release on compassionate grounds

50. Due to the nature of their offence, it is often difficult to grant applications for release on compassionate grounds to some prisoners. However, even at Dovegate and other similar category prisons, it is by no means certain that all applications, even from those convicted of offences of a sexual nature, will be refused. The possibility of release on compassionate grounds should therefore be discussed with prisoners and they should be given the opportunity to apply for such release if they wish. I understand that healthcare staff might well be focussed on the medical care and not on the prospects of early release on compassionate grounds. Nevertheless, discipline staff should be aware of the process and procedure to facilitate such release.

    The Director should ensure that all prisoners who are terminally ill have the opportunity to apply for release on compassionate licence if they wish.

Use of restraints

51. The final matter on which I comment is the use of restraints. The man was taken to outside hospital on the morning of his death. His initial risk assessment said that he should remain handcuffed to an officer and this remained the position throughout the day. At 7.20pm a management check was undertaken by the duty manager who re-affirmed that hand cuffs should remain applied to the man. The entry by an officer at 9.25pm in the log book kept by the escorting staff says:

    > "The sister of the ward approached me and stated that he would not make it through the night and asked if his family had been contacted due to the severity of [the man's] condition."
    >
    > Escorting staff contacted the prison and were asked to make further contact at half hourly intervals. The man remained in handcuffs up to and beyond the moment of his death. It was only three minutes after he had passed away that staff removed the handcuffs.

52. The inappropriate use of physical restraints on gravely ill offenders in hospital is a recurring theme in my reports. I understand why decision-making has become so risk-averse, but I believe there are many occasions when earlier decisions to remove restraints would be more consistent with the Prison Service's own 'decency' agenda. I consider that this is indubitably one such case. It was clear from the information supplied by the ward sister at 9.25pm

that the man's prognosis was extraordinarily grave. He had two officers at his bedside and I believe that action to review the use of restraints could and should have been taken more quickly. In other cases I have investigated, restraints have been removed following a telephone call to the duty governor. Here I think the bedwatch officers should have been given permission to remove the restraints after the ward sister's approach.

53. I should make it clear that my concern relates to Dovegate's risk assessment systems rather than to the decisions made by the duty manager and the escorting officers on the last evening of the man's life. It was not appropriate for the man to be in handcuffs at the time of his death and I recommend that the Director commissions a review of his bedwatch and escort instructions to ensure that such an unseemly situation does not arise again.

The Director of HMP Dovegate should conduct a review of bedwatch and escort instructions. They should include explicit guidance for staff on the action to be taken when a prisoner is gravely ill.

CONCLUSION

54. The man was 52 years old and in relatively good health when he was sent to prison in 2004, although he was a heavy smoker. He remained in good health until early 2008 when he started having prolonged periods of diarrhoea and related stomach problems. When he was operated on for a perforated duodenal ulcer, it was found that he had cancer of the neuro-endocrine system. The clinical reviewer says this is a difficult cancer to diagnose.

55. The man's cancer was initially treated at outside hospital but in May 2009 he refused all further help and assistance from the hospital. Notwithstanding that, staff at the prison continued to support him throughout his illness. However, they failed to put in place an important element of care for him which was a palliative care pathway. This resulted in a lack of engagement of community Macmillan services which might have been of benefit to the man in the end stages of his illness.

56. On the day of his death, the man was admitted to outside hospital and was found to be dying. Staff at the prison were advised of this and were asked to contact the man's friends and family (which they did). I regret that the man was not afforded a dignified death free from handcuffs. These were not removed until after he had died just before midnight, despite a clear indication that he posed no security risks. I am critical of that decision in this report.

RECOMMENDATIONS

For the healthcare Manager at Dovegate

1. The healthcare manager should review the systems for communication with outside health service providers, including secondary care services, to ensure they are robust and meet the needs of patients at Dovegate.

   Service response: Recommendation accepted. The HCC department since March 2010 has changed all processes for hospital communication and referrals. All blood tests are now recorded and reported on when returned from hospital. All referrals are screened, noted and followed by the administration team. Two systems in place to ensure all hospital correspondence is recorded. All letters are now seen by the resident doctor prior to filing. One member of staff maintains the referral processors.

2. The healthcare manager should ensure that good standards of record keeping in the medical record are maintained, in compliance with the Nursing and Midwifery Council Guidelines for Records and Record Keeping and Department of Health and NHS Code of Practice Records Management.

   Service response: Recommendation accepted. This is an ongoing issue, however with new staff, new clinical leads and new management record keeping and documentation has increased. All staff are fully aware of the importance of record keeping and maintaining medical records. This will be audited in 2011.

3. The healthcare manager should ensure that patient observations are made and recorded.

   Service response: Recommendation accepted. As above, all the clinical staff are fully aware that they must maintain correct information in the medical record.

4. The healthcare manager should provide a copy of this report to the agency which employed the nurses who treated the man.

   Service response: Recommendation accepted. Report will be sent to the required Agency and the Clinical Governance Lead for Serco Health for further action as required.

5. The healthcare manager should ensure there is a robust system in place for palliative care patients at Dovegate.

   Service response: Recommendation accepted. Palliative care policy being confirmed by Senior Management at Serco Health. A dedicated cell in AAU now allocated to deal with this. Dedicated AAU nursing staff and clinical team available as required.

For the Primary Care Trust

6. The Primary Care Trust should install a computerised clinical patient record system.

   Service response: Recommendation accepted. This is the responsibility of the PCT. However, it should be noted that the PCT have arranged for the installation of the system – scheduled for January 2011.

For the Director of Dovegate

7. The Director should ensure that all prisoners who are terminally ill have the opportunity to apply for release on compassionate licence if they wish.

   Service response: Recommendation accepted. Eligible prisoners have the opportunity to all apply for release on compassionate licence. Applications will be processed appropriately and the Controller's Team would be involved in this process. ***It should be noted however that any decision whether to grant is not within the remit of the establishment.***

8. The Director of HMP Dovegate should conduct a review of bedwatch and escort instructions. They should include explicit guidance for staff on the action to be taken when a prisoner is gravely ill.

   Service response: Recommendation accepted. We will revise our local protocol to ensure that the actions currently taken in respect of terminally ill/dying prisoners are formally recorded as per "end of life" procedure/protocol.