Investigation into the death of a man in February 2009 whilst in the custody of HMP Dartmoor

Report by the Prisons and Probation Ombudsman for England and Wales

September 2009

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.

This is the report of an investigation into the death of a 49 year old prisoner at HMP Dartmoor. The man died on 13 February 2009 in hospital from natural causes. He had been admitted to the hospital the day before.

The man had been in custody since May 2002. In July 2007, he was diagnosed with terminal cirrhosis of the liver.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of the Ombudsman's Family Liaison Officers.

This investigation was undertaken by one of the Ombudsman's investigators. In addition, Devon Primary Care Trust commissioned a review of the man's clinical care. I am grateful for the assistance received from staff at HMP Dartmoor and would ask the Governor to pass on these sentiments.

The reviewer concludes that the man's care was not of an equivalent standard to that he would have received in the wider community. The clinical review raises a number of learning points that the prison health partnership will need to consider. The reviewer makes six recommendations, four of which are relevant to this investigation.

I am impressed by the support given by the prison to the man's family. Although, the actions of two staff were less professional, I am satisfied that they and the prison regret any distress to the family and I am confident that steps are being taken to avoid any repetition.

Jane Webb
Deputy Prisons and Probation Ombudsman **September 2009**

SUMMARY

The man was born in 1959. He was 49 years old when he died in hospital on 13 February 2009. The man's death was from natural causes as a consequence of acute gastrointestinal haemorrhage caused by oesophageal varices (varicose veins in his throat), cirrhosis of the liver and chronic obstructive pulmonary disease.

The man was first remanded into custody at HMP Canterbury on 17 May 2002. He was sentenced in December 2002 to life imprisonment for wounding with intent. The man transferred to HMP Dartmoor on 21 July 2008 after previously being held at HMP Birmingham, HMP Bristol, HMP Dorchester, HMP Gartree, HMP Kingston and HMP Shepton Mallet.

At his health screening interviews it was recorded that the man had a history of alcohol abuse, depression, asthma and problems with his liver.

The man was diagnosed with cirrhosis of the liver in July 2007 and his condition was terminal. Less than a month later, the man tried to commit suicide. Accordingly, a self-harm observation and support regime was started which involved regular checks. The routine was stopped on 3 September when staff decided that the risk of self-harm had abated. On 8 May 2008, the man was advised by a liver specialist that his life expectancy was less than two years.

During the morning of 12 February 2009, staff on the Vulnerable Prisoners Unit were informed that the man was vomiting blood. An ambulance was called and the paramedics took over responsibility for the man's care. He was taken by ambulance to the Accident and Emergency (A&E) department at the local hospital and was later admitted to the Intensive Care Unit.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that an escort chain was to be used and two officers needed to be at the man's bedside. Following an exploratory operation, the assessment was revised by the duty governor and the restraints were removed. The man's family visited him whilst he was in hospital. They commented that most of the staff were very supportive but they were distressed that two staff were less respectful.

At around 11.12pm on 13 February, one of the officers on bedwatch duty was informed by nursing staff that the man had passed away. A hospital doctor pronounced that he had died at 11.30pm.

After the man died, Dartmoor activated its death in custody contingency plan. The police were informed and visited the hospital. They found no suspicious circumstances and the man's body was released to the undertakers who removed him to the mortuary for post mortem examination. The Coroner's office informed Dartmoor that the man had died from natural causes.

The clinical review identifies a number of issues relating to the care provided for the man. The review highlights areas of practice that could be improved, and makes three recommendations for service improvement at Dartmoor. They relate to

improvements to record keeping, reviewing arrangements for prisoners with long term medical conditions and access to assessments for seriously ill prisoners.

I make one recommendation of my own concerning identification for family visits when prisoners are in hospital.

THE INVESTIGATION PROCESS

1. The investigation was opened on 18 February 2009 by one of the Ombudsman's investigators. He issued notices announcing the investigation to both staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the man's death to make themself known. In the event, no one came forward. The investigator also studied all relevant prison records, which included the man's main prison record and his medical records.

2. The investigator visited Dartmoor on 25 March and 28 April and discussed aspects of the man's treatment with staff. He interviewed staff and a prisoner who had been located on the same wing as the man. The investigator also met a member of the Independent Monitoring Board at Dartmoor.

3. The Devon Primary Care Trust commissioned a General Practitioner and a Healthcare Consultant to carry out an independent review of the man's clinical care. I am grateful to them for undertaking the review.

4. The investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner.

5. One of the Ombudsman's Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. The family had no questions about the man's treatment. However they told the Family Liaison Officer that they were concerned about the behaviour of two staff on bedwatch duty. They said that the matter was raised with the prison but they had not received a response. I hope that this report provides the family with a better understanding of the events leading up to the man's death.

HMP DARTMOOR

6. HMP Dartmoor is a category C prison located in the village of Princetown, Devon, with an operating capacity of 646 at the time of the man's death. There are six wings and most of the buildings date from the late 19th century. There is integral sanitation in all but one wing, three wings have recently been fully refurbished and a new kitchen has also been built. Cells have bells which prisoners can use to summon assistance from staff in an emergency.

7. Dartmoor works collaboratively with HMP Channings Wood and HMP Exeter as part of the Devon Prisons Health Partnership. Healthcare at the prison is commissioned by Devon Primary Care Trust. The healthcare department has a doctor available every weekday. Overnight and weekend cover is provided by Devon Docs, an out of hours service commissioned by the Primary Care Trust. There is no in-patient facility within the healthcare unit. A dedicated nurse is based in the Vulnerable Prisoners Unit (which is located on F and G wings).

8. The investigator reviewed the Ombudsman's reports into earlier deaths from natural causes at Dartmoor. He found no issues in common with this investigation into the death of the man.

Multi-Agency Public Protection Arrangements (MAPPA)

9. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan that is drawn up for the most serious offenders benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA.

10. There are three levels of MAPPA:

    - Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.
    - Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
    - Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.

Independent Monitoring Board

11. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The most recent annual report by the Dartmoor IMB was for the period from 1 October 2007 to 30 September 2008.

12. The IMB report summarised the healthcare at the prison in the following way:

> "… staff continue to deliver health services to a varied and at times, demanding prison population in a professional manner, making the maximum use of the resources available. A comprehensive range of health clinics is now running regularly within the prison and waiting lists are well managed."

Her Majesty's Chief Inspector of Prisons

13. The most recent inspection of Dartmoor by Her Majesty's Chief Inspector of Prisons, Dame Anne Owers, was an announced inspection in February 2008. In her report the Chief Inspector found that:

> "… staff were engaged, committed and often overworked …Chronic disease was well managed through lead nurse responsibilities for the management of prisoners with lifelong illnesses. The majority of nurses were appropriately trained, and there were good clinical protocols to support individual practitioners. There were also excellent relationships with NHS community and hospital specialist advisers."

KEY EVENTS

14. The man was remanded into custody at HMP Canterbury on 17 May 2002. He was assessed as MAPPA level three due to the violent nature of his offence. On 11 December, he was sentenced to life imprisonment for wounding with intent (and as he had committed a previous offence where he used a firearm). The court directed that the man serve 42 months before he was considered for parole. He returned to HMP Canterbury that same day.

15. The man was later held at HMP Gartree, HMP Kingston, HMP Birmingham, HMP Dorchester, HMP Shepton Mallet and HMP Bristol before he transferred to HMP Dartmoor on 21 July 2008. During the man's first reception health screening interviews, it was recorded that he had a history of alcohol abuse, depression, asthma and problems with his liver.

16. On 8 December 2004, the man was advised that recent blood tests confirmed that he was Hepatitis C positive. The man thought that he might have contracted this when he had a tattoo.

17. On 16 April 2007, as the man had been participating in addressing his offending behaviour and the risk of re-offending had reduced he was re-categorised as a category C prisoner. (Prisoners are categorised for security purposes. Category A is the highest level).

18. The man was informed by a hospital consultant on 24 July, that his diagnosis of cirrhosis of the liver was terminal and that his life expectancy was between three and five years. He felt depressed and hopeless at the prospect of his limited life expectancy. He made a serious suicide attempt by setting fire to his cell on 21 August. As a result, an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime was started. (ACCT is a flexible, prisoner-centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment.) The document was opened on 21 August and closed on 3 September, after the medical assessment identified that the risk of self-harm had reduced and he had come to terms with his situation. The man was transferred to HMP Dorchester on 17 September.

19. On 8 May 2008, the man was seen by a liver specialist who advised him that his life expectancy was less than two years. He went to hospital for a gastroscopy (a gastroscope is an instrument used to examine or view the interior of the stomach). The results showed three varicose veins in his throat and no further investigation was proposed at this stage.

20. The man transferred back to Dartmoor on 21 July. Due to the nature of his offences he had been identified as a vulnerable prisoner, and so he was located on G wing (cell G2-24) which is part of the Vulnerable Prisoners Unit. It was noted in his prison record that the man had previously been given enhanced prisoner status. (The Incentives and Earned Privileged Scheme (IEPS) is a scheme that is designed to encourage and reward good behaviour

in prisons. There are three tiers – Basic, Standard and Enhanced. Incentives include access to in-cell televisions, more money to spend, wearing their own clothes, more time out of the cell and community visits.) The man was downgraded to standard prisoner status on 28 September because he had not attended a drug test two days earlier.

21. The following day, 22 July, a prison doctor saw the man and referred him to a Hepatology Nurse Specialist at the local hospital. The prison doctor also increased the man's dose of Tramadol (a synthetic opiate painkiller) from 50mg to 100mg per day.

22. The man had a blood test on 1 August. Three days later on 4 August, he was seen by another prison doctor who arranged for him to have a chest x-ray. The doctor recorded that the man was concerned about his diuretic medication (to promote the excretion of urine by improving the kidney function). A nurse saw the man the following day at the local hospital. She explained the results of the blood test, which indicated liver disease. The nurse recorded that there was no evidence of an accumulation of fluid in the abdominal cavity. An appointment was booked for him to return to the hospital and see a Consultant Hepatologist.

23. The man saw the consultant on 14 August. The consultant recorded that, as the man had advanced liver disease and was encephalopathic, he was to be assessed for a liver transplant. The consultant wrote to Dartmoor outlining his plan to admit the man for assessment for a transplant and suggested that the man was given a small dose of diuretics.

24. A prison doctor wrote to the consultant on 19 August to ask whether the liver assessment could be carried out before early September. This was because of the man's Parole Board hearing on 4 September. (The prison was eventually informed that an earlier assessment would not be possible because many investigations were required beforehand. Unfortunately, this information was not received until 9 September.)

25. After the man was seen by a prison doctor on 19 August, he asked another doctor to see him again three days later on 22 August so that the diuretics and pain relief could be reviewed. There is no record in the man's medical records that he was actually seen by the other prison doctor.

26. The man returned to Bristol for a Parole Board hearing on 4 September. The Board considered the man's case on 5 September and decided that he was not suitable for early release. The Board wrote:

> "Your evidence demonstrated a lack of clarity in your understanding of why you committed the index offence, and of the events and feelings that led to it. For instance, you were unable to tell the panel why you stopped the assault when you did. You told the prison psychologist that you were in control during the incident, but told the panel you were not … The panel does not consider that your illness constitutes exceptional reasons for release from closed conditions taking into account all the evidence and the current level of risk."

27. The man returned to Dartmoor on 8 September. He moved to cell G2-22 on 5 October. On 21 September, it was recorded in the man's medical record that he complained about not having been seen on 22 August. He also complained about his pain relief and asked for a second opinion of his diagnosis and health care.

28. On 6 October, the man attended an appointment for a liver treatment pre-assessment at the local hospital. An electrocardiogram (an ECG is a graphical recording of the electrical activity of the heart), an x-ray, a Computerised Tomography (CT) scan and blood tests were all carried out. The man returned to Dartmoor the same day.

29. It was recorded in the man's prison record on 26 November that his son was serving abroad with the armed forces. It was agreed that as the man's son could return to the United Kingdom at short notice special dispensation would be made to ensure that his visits could easily be accommodated.

30. On 8 December, the man was taken to hospital for an x-ray, blood tests, an electrocardiogram (ECG is a graphical recording of the electrical activity of the heart) and an endoscopy was also performed. (An endoscopy is a test that looks inside the body. The endoscope is a long flexible tube with a camera and light that can be swallowed.)

31. The man was upgraded to enhanced status on 3 January 2009.

32. On 12 January, a prison doctor recorded that, although the man had now stopped smoking, he had developed a chest infection. He was prescribed amoxicillin (an antibiotic). The doctor wrote to the consultant about the man's "deteriorating chest condition".

33. The prison doctor saw the man again a week later on 19 January. He recorded that the man was experiencing mood swings and was quite angry. The man told him that he wanted to see a mental health worker. It was discovered after the appointment that the man had had an appointment to see a mental health nurse on 13 January, but had been unable to attend on time and so it was to be rearranged. The mental health nurse said that the man would be offered another appointment after his return from leave on 12 February.

34. The hospital notified the prison that the man was due to have a pre-transplant assessment in London from 2 to 6 March.

35. The man's cell was unlocked by an officer at around 8.15am on 12 February 2009. In his written response to the investigator, the officer wrote:

> "The man was in cell, in bed, and I enquired if he was working today. He replied he was not feeling well and was sick in cell and had the note from Healthcare. After the roll was reported correct I unlocked the landing allowing those not working to have open doors in line with the prison's policy … At around 10.00am I was in F wing having done my

applications and errands. Someone told me that the doctor had been called to G2 and it was urgent … The first thing I noticed was his sink which was full of blood. The man was conscious and the medical team put in IV line and I assisted by holding the bag of liquid at height."

After receipt of the draft report, the man's family questioned why the officer did not do more to find out what was wrong with him, having been told that he did not feel well. The man told staff later that morning that he had been vomiting blood since 4.00am. The family felt that this was likely to have been evident in the cell. They feel strongly that given the man's history of poor health, the officer should have been more proactive in finding out what was wrong and notifying healthcare staff. The family said they are aware cells are fitted with cell bells. They questioned whether the man used his at any point to notify staff of his distress. The family were concerned his calls may have been ignored.

36. At around 10.00am, a fellow prisoner on the Vulnerable Prisoners Unit informed staff that the man had been vomiting blood. When staff went to check on the man told them that he had been vomiting blood from around 4.00am. They found that the sink in his cell was nearly full with blood and immediately asked for medical assistance. Healthcare staff arrived at the man's cell a few minutes later. They assessed his condition and decided to call an ambulance.

37. The paramedics took over responsibility for the man's care. Whilst the paramedics were on the unit, other prisoners were locked back in their cells so that they were not in the way and the man had some privacy. At around 11.00am the man was taken by ambulance to the Accident and Emergency department of the local hospital.

38. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that handcuffs were to be used and two officers needed to be at the man's bedside. The assessment was revised by the duty governor later that day at 3.20pm and handcuffs were removed. After receipt of the draft report, the family said it was not true that the handcuffs were removed at 3:20pm on 12 February. They said he remained handcuffed until his life support machine was switched off the following day. The family said this had not been of particular concern as they expected a prisoner to be handcuffed. However, what concerns them now, having read the report, is why the prison is saying the handcuffs were removed when they were not.

39. Following an exploratory operation, the man was heavily sedated. To enable nursing staff to have easy access, the officers on bedwatch duty were located in the staff rest area on the ward. At around 5.30pm the man was moved to the Intensive Care Unit.

40. When interviewed as part of this investigation, a Principal Officer (PO) confirmed that he had contacted the man's family after his admission to hospital. The PO said that it had taken him over a number of hours to contact the man's next of kin. The PO used both the computer and written records to try to complete this task. He eventually used the prison's telephone call record

for the man. Although he did not immediately reach the next of kin through this method, he was quickly re-directed to the man's daughter and informed her about her father's admission to hospital. After receipt of the draft report, the family said that they did not accept that the reasons given for the significant delay about the man's admission to hospital. The man's daughter said she had been listed as her father's next of kin for some time and that the prison did not appear to have had difficulty in contacting her on previous occasions. Her correct number would have been in her father's pin phone record and her address would have been registered as someone her father corresponded with. The family felt this was unacceptable, particularly given their distance from the prison.

41. At around 9.00am on 13 February, the bedwatch staff were asked by the hospital matron to move from the staff rest area to a general waiting area. The reason for the move was that the rest area was used by hospital staff to discuss confidential information about patients. The staff on bedwatch duty were given permission by the matron to move to the man's bedside at around 1.30pm.

42. The man's son arrived at the hospital at 3.05pm. As the initial risk assessment had said that the man was not allowed visitors, the bedwatch officers contacted Dartmoor for further advice. The duty governor told the staff on bedwatch duty that only immediate family members were now allowed to visit the man and that identification must be produced. The man's daughter arrived at the hospital around 3.35pm and was joined by other relatives.

43. Around 3.15pm one of bedwatch officers recorded in the bedwatch log that their colleague: "spoke to doctor who asked if he could speak to the duty governor as the man has an 80% chance of not surviving the next 24 hrs."

44. At 9.30pm, the bedwatch officers were relieved. One of the new staff on bedwatch duty recorded in the bedwatch log at 10.00pm that: "Informed by nursing staff that they might be withdrawing medical treatment within the next few hours".

45. The staff on bedwatch were informed by nursing staff at around 11.12pm that the man had passed away. A hospital doctor pronounced death at 11.30pm. The staff on bedwatch duty immediately informed Dartmoor and it was confirmed that the Deputy Governor would attend the hospital to meet the man's family. When the Deputy Governor met with the man's family at the hospital they raised concerns about the unprofessional conduct of some of the officers on bedwatch duty.

46. The following morning the prisoners on the Vulnerable Prisoners Unit were told about the man's death. Staff on the unit asked whether they required anything or wanted to speak to a Listener. (Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.) When the bedwatch officers returned to the prison they were offered support from the prison's care team.

47. A member of chaplaincy staff from Dartmoor was appointed as the prison's family liaison officer. He met with members of the man's family during the early evening of 13 February and after his death. The man's funeral took place on 27 February and a memorial service was held at the prison. Dartmoor gave financial assistance with funeral costs. After the man's death the prisoners on the Vulnerable Prisoners Unit collected over £159 in his memory.

48. The man's death was from natural causes as a consequence of acute gastrointestinal haemorrhage caused by oesophageal varices (varicose veins in his throat), liver cirrhosis and chronic obstructive pulmonary disease. The verdict of the Coroner's inquest into the man's death, which was held in September 2009, was that he died from natural causes.

ISSUES CONSIDERED

Clinical care

49. In his review, the reviewer notes that there were instances of poor record keeping. They include poor legibility of entries in the man's medical record, failure to identify the individual (and their role) making an entry and some entries were not in date order.

50. All clinical record systems rely on all those making entries to maintain an appropriate standard of record keeping. A paper based record such as that used by Dartmoor is particularly demanding in this regard. Although there is a system in place to utilise a master signature sheet and unique reference number for each record entry, it is not used consistently.

51. The reviewer recommends that Dartmoor reviews its policies and procedures regarding prisoner's medical records and arranges appropriate staff training where necessary to improve the accuracy and consistency of record keeping. This should include regular audits of sample records. The reviewer also recommends the introduction of a computerised medical records system at Dartmoor.

    The Head of Healthcare should review the policies and procedures regarding prisoner's medical records and arrange appropriate staff training where necessary to improve the accuracy and consistency of record keeping. A computerised medical records system should be introduced as soon as practicable.

52. The reviewer found that there was an inconsistent approach to the prescribing of the man's medication for his respiratory problems. Medication changes, such as substitution of a combination inhaler Combivent for the single drug inhaler Salbutamol, do not appear to have been clearly explained to the man. The lung function tests determined that his main respiratory condition was smoking related lung damage (Chronic Obstructive Pulmonary Disease – COPD), rather than asthma or liver disease related lung problems. The reviewer judges that an earlier comprehensive assessment of the man's respiratory condition would have increased the understanding of his condition. This could have improved the prescribing and prioritised smoking cessation interventions.

53. The reviewer recommends a review by Dartmoor of the arrangements for assessment and monitoring of prisoners' long-term medical conditions, particularly those with respiratory problems. The review should ensure that:

    - Appropriate skills and competencies are in place within the healthcare team.
    - There is access to appropriate assessment equipment within the healthcare team with relevant staff trained to interpret results.
    - There is sufficient capacity to ensure that timely assessments are made.
    - There are regular routine reviews.

The Head of Healthcare should review the arrangements for assessing and monitoring prisoners with long term medical conditions.

54. The reviewer notes that, according to the man's medical record, he had been vomiting blood from 4.00am. The man could find no information to indicate what occurred from 4.00am until 10.00am and whether the man had been able to have any medical attention during the early morning. The reviewer recommends a review of the arrangements for medical assessments for prisoners who have serious health problems. This is to ensure that when serious health problems occur, responses are timely and comprehensive in line with unscheduled care provision in the wider community.

The Governor should review arrangements for access to medical treatment for prisoners who are seriously ill.

55. Although I endorse this recommendation, I have already noted above that the man did not bring his condition to the notice of staff. They were informed by a prisoner who visited the man's cell and then raised the alarm. I agree that prisoners should, and I am sure they do, receive access to medical assessments when they are seriously ill.

Behaviour of bedwatch staff

56. As noted earlier in this report, the man's family told one of the Ombudsman's family liaison officers that they were concerned about the behaviour of some of the staff on bedwatch duty.

57. The family were distressed by the unprofessional behaviour of two of the escorting officers whilst their father was in the Intensive Care Unit. My investigator identified the officers. Although the family appreciated that the officers have a job to do, they felt that it was inappropriate and insensitive to sit at the man's bedside laughing and joking together. The man only had a few hours left to live and it was very important for his family to be able to sit quietly with him and make the most of their remaining time together.

58. The family pointed out that other officers had respected their need for privacy and stood back from the man's bed, whereas these two officers did not offer them that courtesy. The family wanted to be clear that the officers who took over (who were on duty at the time of the man's death) could not have been more different and were respectful and sensitive to the needs of the family. The family were angry about the officers' conduct and spoke to the Deputy Governor about it. The Deputy Governor asked if they would leave him to deal with the matter, which they agreed to do, and thought that he would be in touch. However, several weeks passed before they received a letter of apology, which was after they wrote to the Governor.

59. The family also said that the same officers had been abrupt as they had not brought identification with them (despite not being aware that this was required). The family had left their home in a hurry and travelled a long way to

see the man. They felt the attitude of the two officers lacked understanding and sensitivity at what was a difficult and distressing time for them.

60. When interviewed as part of this investigation, one of the staff on bedwatch confirmed that he was very conscious of the importance of security as he been on duty when another prisoner had escaped from custody. He said:

> "The first one to arrive was the man's son who had caught a plane from Iraq I believe, he was still in army uniform. I asked him for ID [identification] so I could check that he was who he said he was. I then contacted the prison because the initial risk assessment that I had looked at had said no visits, so I spoke to the duty governor who confirmed that yes, there would be visits, and I informed the man's son that it had all been cleared. So it was a matter of approximately two minutes maybe, that before seeing his identity card and confirming that there was no problem with him visiting his father. The second to arrive, the prisoner's daughter, was not happy at being asked for ID, informing me that she had already cleared all this with the Governor of Dartmoor prison, which I was unaware of and I informed her that it was my job to verify ID, and that was that."

61. My investigator asked the officer if he knew that the man's family had complained about his behaviour. He confirmed that the Deputy Governor had discussed the matter with him when he returned to duty after the man's death. The officer said that he was told:

> " … that the family were unhappy because of our close proximity to the prisoner's bed, and also they had raised concerns that we had, myself and the other member of staff on duty, had been discussing our plans for Valentine's Day … I sat where the medical staff of the day placed the seats, and I was, I was surprised that the prisoner's family were offended by a private conversation between myself and my colleague. But I also said that if there was any perceived disrespect from either myself or my colleague I was more than happy to write a letter of apology."

62. In his written statement to the investigator, the Deputy Governor said that he met the man's daughter at the hospital on 13 February, and she told him that two bedwatch officers had acted disrespectfully. The Deputy Governor wrote:

> "… she stated that the staff who had been sat at the man's bedside had been laughing and joking, making references to Saint Valentine's Day and one member of staff had been listening to an IPod … I asked if she wanted me to deal with this issue internally, to which she agreed. I explained that I would initially talk to the Governing Governor regarding her concern, and then to the staff involved."

63. The Deputy Governor confirmed that he interviewed the bedwatch staff about the complaint when they returned to duty. The Deputy Governor wrote:

> "I subsequently spoke to him regarding the concerns raised. He immediately accepted that he had, at time, during the bedwatch, played a personal IPod and had also held a conversation with his colleague regarding Saint Valentine cards. During the interview the officer was clearly upset at the thought that he had in anyway offended the man's family and he offered to contact them himself and apologise for any perceived disrespect. Having agreed with [the man's daughter] that the prison would deal with the matter internally, it was decided that should she receive an unsolicited apology at this stage it may unduly upset her. However, I made it clear to the officer that the behaviour of the bedwatch staff fell short of what was expected of a professional Prison Officer … It is regrettable that [the man's daughter] believed that I would inform her of the outcome of my enquiry, as this was not agreed at the time. However, it would not have been an issue to advise her, and as soon as her letter arrived, this was done".

After receipt of the draft report, the family questioned the Deputy Governor's evidence. They felt he had agreed to inform them of the outcome of his enquiry and they were surprised by his denial of this. They also felt it was unfair of the prison to have said they no longer thought this was an issue as it was not raised when staff visited to return their father's property. The family had spoken with the Deputy Governor and assumed this was being taken forward. The family thought they would be contacted separately when this was resolved and therefore did not feel the need to raise the matter again on this occasion.

64. While there seems to have been some confusion about what was agreed between the Deputy Governor and the man's daughter, I would have expected him to have informed her of the outcome of her complaint. I am glad that this was put right once the man's daughter raised the matter and I hope that the Governor will ensure that complaints from families are dealt with more effectively in the future.

65. I also think that the man's family should have been informed beforehand that they needed to bring identification with them. This would have avoided any possible confusion or confrontation. I recommend that families are told to bring identification if they are visiting a prisoner in hospital. This should also be clearly recorded and the staff on bedwatch duty should be informed.

The Governor should ensure that when a prisoner's family are informed that a relative is in hospital that they will need to bring identification when they visit. The notification of this information should be clearly recorded.

66. The family stressed that these were their only negative experiences and spoke positively about the help and support they had received from the chaplaincy at Dartmoor, the Deputy Governor and the other officers who were on bedwatch duty.

67. My investigator was shown a copy of the guidance made available to staff undertaking escorts outside the prison. The guidance gives no advice on how staff should act whilst they are on bedwatch duty. In his statement to my investigator, the Deputy Governor confirmed that Dartmoor will review the bedwatch protocol with regard to the behaviour of staff whilst they carry out escort and bedwatch duties.

CONCLUSION

68. The man came into custody in 2002 and transferred back to HMP Dartmoor on 21 July 2008. He died in prison custody in hospital seven months later on 13 February 2009.

69. In the light of the clinical review, I judge that the man's care was not equivalent to what he would have received in the wider community. The findings of the clinical review and the Ombudsman's investigation highlight the need for some improvements to healthcare practices.

70. The Governor will wish to review and strengthen existing procedures at Dartmoor for the monitoring and support of staff on bedwatch duty. The Governor may also wish to consider how to inform relatives about bringing identification with them when they visit prisoners in hospital.

RECOMMENDATIONS

1. The Head of Healthcare should review the policies and procedures regarding prisoner's medical records and arrange appropriate staff training where necessary to improve the accuracy and consistency of record keeping. A computerised medical records system should be introduced as soon as practicable.

   Recommendation accepted by HMP Dartmoor - The need for legible and accurate record keeping is reinforced at monthly Healthcare staff meetings. Information Technology programme (SystmOne) should be in place by end of year.

2. The Head of Healthcare should carry out a review of the arrangements for assessing and monitoring of prisoners with long term medical conditions.

   Recommendation accepted by HMP Dartmoor - Assessment of needs has been identified and passed to the new providers, Devon Partnership Trust, to review current training needs.

3. The Governor should review arrangements for access to medical treatment for prisoners who are seriously ill.

   Recommendation accepted by HMP Dartmoor Devon Partnership Trust has taken over the Health Care provision at HMP Dartmoor with effect from 1 August 2009. The Governor will initiate a review with the new provider

4. The Governor should ensure that when a prisoner's family are informed that a relative is in hospital that they will need to bring identification when they visit. The notification of this information should be clearly recorded.

   Recommendation accepted by HMP Dartmoor - A notice to staff will be issued to all departments instructing the relevant staff to inform visitors of the requirements when visiting prisoners in hospital. To be included in all relevant contingency plans.