

**The death in custody of a male prisoner
at HM Prison Weare on 10 July 2004**

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

April 2005

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This is the report of an investigation into the death of a prisoner at HM Prison Weare on 10 July 2004.

The prisoner was found by his cellmate in the shower area of his cell at 3:20am on 10 July with serious breathing difficulties. The first staff on the scene placed him in the recovery position but he stopped breathing at about 3:50am as the first nurse arrived. All attempts to resuscitate him failed and he was pronounced dead at the scene by the prison doctor at 5:00am. A post mortem examination revealed that he died from internal haemorrhage caused by the effects of a cough-induced fracture of the ribs.

The investigation was carried out by one of my investigators on my behalf.

I also commissioned an independent clinical review of the management of the prisoner's health needs whilst he was at Weare. This was conducted by the West Dorset Primary Care Trust (PCT).

My thanks go to the Governor and staff of Weare as well as to the West Dorset Primary Care Trust for their ready help and co-operation with this investigation.

There is a question mark over the prisoner's allocation to Weare. There was also a delay in calling an ambulance when he was found collapsed. However, neither factor is likely to have influenced the way events unfolded. The cause of death was a rare one, and it was not surprising that it was not diagnosed either in prison or in hospital.

The prisoner died just two weeks before he was due for release.

This published version of the report does not include the original annexes. This material was extensive and included in the original version.

Stephen Shaw CBE
Prisons and Probation Ombudsman

2. Summary

The prisoner was a 52 year old man at the time of his death. He had been serving an 18 month prison sentence from which he was due to be released on 24 July 2004. He died at HMP Weare on 10 July 2004 from internal bleeding caused by a cough-induced fracture of the ribs.

I have drawn the conclusion that, in general terms, he was given appropriate care and treatment while he was at Weare, both by the Prison Service and by the NHS. In the clinical review, the PCT offers the view that, given the cause of the prisoner's death, it was very unlikely that even the most expert of teams would have been able to resuscitate him.

I make four recommendations relating to the arrangements for calling an ambulance in a life threatening incident, record keeping, the use of opiate patches (buprenorphine) within prisons and the use of a F2052SH/ACCT when a prisoner overdoses on prescribed or illicit drugs.

3. Investigation methodology

The investigation was opened on Monday 19 July 2004 when my investigator met with the acting Governor, the chair of the establishment's Independent Monitoring Board and the chair of the local branch of the Prison Officers' Association. On the same day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone who had information relevant to the prisoner's death to make themselves known to the investigation team.

An independent clinical review was carried out by a representative of the West Dorset Primary Care Trust.

My investigator met with the deceased's mother at her home in Surrey on 22 July to explain the nature and scope of the investigation and to offer her an opportunity to raise any concerns she might want the investigation to examine.

4. The deceased

The prisoner was born on 1 April 1952 and was brought up in London. He left school with no qualifications at the age of 15. Thereafter he obtained work as a steeplejack, a job which he held for ten years. At this time he began to drink heavily and to take drugs. He experienced mental health problems in the 1970s and again in the 1990s. He was brought to Hastings by his father in the early 1990s following his discharge from a psychiatric unit in London. He had been married for about ten years but had divorced. There were no children from his marriage.

He had criminal convictions recorded against him dating back to 1981. On 27 October 2003, he was sentenced to 18 months' imprisonment at Lewes Crown Court. He began his sentence at Lewes prison but, on 5 November 2003, was transferred to Weare.

Staff at Weare described him as a mature man who presented no problems on his wing. He apparently worked hard and, on 31 January 2004, achieved the enhanced level of privileges.

He died 14 days before he was due to be released from prison.

5. HM Prison Weare

HMP Weare is a 'prison ship' moored in Portland Harbour near Weymouth in Dorset. It came into operational use in 1997. It functions as a closed establishment for up to 398 low security prisoners who are in the last nine months of their sentence.

The provision of healthcare is organised on a cluster basis with other prisons in Somerset and Dorset. The cluster is managed by the South West Dorset Primary Care Trust (PCT). In-patient facilities are provided by Dorchester prison. The medical lead is also based at Dorchester. There are two practice managers in the cluster. Weare has a practice manager based at HMP The Verne.

The healthcare centre is open between 8:00am and 5:30pm on weekdays and between 8:30am and 5:00pm at weekends. The healthcare staff complement comprises a Healthcare Senior Officer employed as Healthcare Manager, three Registered General Nurses and one Registered Mental Nurse. Out of working hours there is always a GP on call.

HMP Weare was last inspected by Her Majesty's Chief Inspector of Prisons in July 2004. In the report of that inspection a number of recommendations were made in respect of healthcare. However none of them is relevant to this investigation.

6. Events prior to the prisoner's death on 10 July 2004

The prisoner was transferred to HMP Weare on 5 November 2003. The next day he was seen by a doctor who wrote in his Inmate Medical Record (IMR):

"Transferred from Lewes. 18 months remaining. On multiple meds including Morphe benzodiazapines. Long term drug abuse, spondylosis, disc problems. Need to discuss with Lewes Prison inappropriate transfer."

No record was made of any follow-up action taken.

Soon after his reception at Weare, the prisoner was given antidepressants after admitting that he had fleeting thoughts of self-harm. He also complained of back pains for which the use of an opioid skin patch was considered.

Between January and March 2004, there was some evidence to suggest that he was abusing prescribed drugs. In January he told the doctor that he had taken an overdose of 14-20 nefopam, a non-opioid analgesic painkiller. No F2052SH was raised. In February, staff noticed discrepancies in his medication and changed the collection frequency from a weekly to a daily basis. In March, he twice tested positive for methadone.

On 3 June 2004, he was thought to have pulled a muscle on the right side of his ribcage although nothing of note was found on examination. On 19 June, a nurse referred him to the doctor after noticing that he was pale and in pain. The next day he was admitted to Dorchester County Hospital with severe chest pains. Although he had no obvious signs of bruising or swelling, the right side of his chest was tender. He was supplied with non-opioid painkillers and returned to the prison. For the remainder of that month he continued to complain of the same symptoms. On 26 June, the doctor could see bruising on his ribcage. Tests revealed some signs of bacterial infection that led the doctor to give instructions that antibiotics should be given if the symptoms persisted. No evidence could be found in his medical record or in his prescription charts to show that these were subsequently given. However I understand that a cellmate has commented in a statement given to the Coroner's Officer that the deceased confirmed to him that he had been given antibiotics. A note in his IMR shows that he was advised to deep breathe and to make himself cough as he was a smoker and was at risk of chest infection.

No other significant events took place until 10 July 2004.

7. Events on 10 July 2004

At about 3:25am on 10 July the prisoner's cellmate found him in a collapsed state in the toilet area of his cell. The cellmate had been aware of the deceased's condition for some time and had often come to his aid when he was in pain. The cellmate noticed that the prisoner was conscious but in great distress and he therefore summoned staff. Staff arrived at the scene at about 3:30am. They placed him in the recovery position after noticing that he was still breathing.

The record of the time of events after the initial discovery of the prisoner varies between the IMR, individual staff statements and the establishment incident log. The latter is taken as the most reliable.

The log includes an entry at 3:29am which reads, "standby to call ambulance". At the same time a duty nurse was called at her home. The record shows that she was at the scene about 20 minutes after being called. By the time she arrived at the prisoner's cell, he had stopped breathing, had no pulse, and had fixed pupils.

According to the incident log an ambulance was called at 3:52am and it arrived at 4:09am. If this record is accurate, it suggests an acceptable response-time but the lapse of time between the discovery of the prisoner in his cell and the arrival of the ambulance was nearly 40 minutes.

Attempts were made to resuscitate the prisoner before and after the paramedics arrived, but they were unsuccessful. The incident log records that the prison doctor was called at 4:33am and that he arrived at the establishment at 4:55am. He pronounced death at 5:00am.

The deceased's mother was informed of his death by the police at approximately 1:20pm on 11 July.

8. Consideration of the issues arising from the investigation

The main issues arising from this investigation are:

- **Allocation of the prisoner to the Weare**

On 6 November 2003, after noting the prisoner's condition and requirements, the prison doctor at The Weare wrote in the Inmate Medical Record (IMR), "need to speak to Lewes prison re inappropriate transfer." The doctor made no record of the reasons for questioning the transfer. Neither was any record made of any follow up action taken. If the doctor at HMP Weare did follow up this entry he should have made a record of what was said or done.

- **The deceased's drug abuse**

The prisoner entered prison with a long history of abuse of alcohol and drugs, both prescribed and illicit. In January 2004, he admitted to the prison doctor at Weare that he had taken an overdose of 14-20 nefopam the previous evening. This should have been treated as an act of self-harm, and consideration should have been given to the use of a Form 2052SH to monitor his behaviour and mood. He was, however, temporarily changed from weekly collection of his medication to daily collection. In March 2004, he twice tested positive for methadone but denied he had taken any.

- **Prescription of antibiotics on 26 June 2004**

The prisoner was admitted to the Dorset County Hospital in the early hours of 20 June 2004 with severe pains in his chest after a bout of coughing. He was supplied with non-opioid painkillers and allowed to return to the prison. On 26 June, it was noted in his medical record that he was still in pain. Sputum tests showed signs of a bacterial chest infection. The prison doctor suggested that antibiotics should be started if the symptoms continued. The PCT could find no documentary evidence to show whether any antibiotics were subsequently given. The prisoner's cellmate, however, told the police that the deceased had been given them.

Clear entries should have been made in the prisoner's IMR or prescription charts to show that the drugs had been both prescribed and administered.

- **Delay in calling an ambulance on 10 July 2004**

There was a considerable delay in calling for an ambulance after the prisoner had been found in a collapsed state on 10 July.

The log includes an entry at 3:29am which reads, "standby to call ambulance". This is a misleading term which implies that at the time staff were indecisive about the need for an ambulance. At the same time, a duty nurse was called at her home. She arrived about 20 minutes later. By this time, the prisoner had stopped breathing, had no pulse, and had fixed pupils. An ambulance was actually called at 3:52am, some twenty minutes after he had been found

in distress. The ambulance arrived at 4:09am, nearly 40 minutes after the incident was discovered. Had an ambulance been called straightaway it would probably have arrived before the nurse did.

A prompt call for an ambulance is unlikely to have prevented the prisoner's death. Nevertheless, staff must be reminded of the need to call for an ambulance promptly in any potentially life-threatening situation and of the fact that there is no need to wait for a healthcare professional to make the decision.

Family concerns

The deceased's mother raised the following issues:

- **Her son had told her that he could not obtain the right medication for his back and neck pains whilst he was at HMP Weare.**

There is no evidence that the prisoner was not given appropriate medication for his condition whilst at Weare. There was evidence that he had been abusing some of the medication that had been prescribed and the healthcare staff took this into account in their management of his ailments.

- **The deceased's mother felt that her son should have been taken back to the Dorset County Hospital for a check up about a fortnight after he had been told that he had broken his ribs.**

When he was admitted to the Dorset County Hospital in June 2004, he was found to be tender over the mid right side of his chest, without any bruising or swelling. On 26 June it was noted that he had bruising down the left side of his trunk. There is no evidence that he was told that he had broken his ribs.

- **The deceased's mother was concerned about the delay in calling an ambulance on 10 July.**

My concerns about this issue are expressed above.

9. Conclusions

I have drawn the conclusion that, in general terms, the prisoner was given appropriate care and treatment while he was at Weare, both by the Prison Service and by the NHS. In the clinical review, the PCT offers a view that, given the cause of death, it was very unlikely that even the most expert of teams would have been able to resuscitate the prisoner.

Nevertheless I am especially concerned about the failure of staff to call an ambulance quickly after discovering the prisoner in a collapsed state in his cell at 3:30am. Steps need to be taken by the prison to ensure that the 40 minute delay that occurred on this occasion is not repeated.

I am concerned about the evidence of poor record keeping. The prison doctor did not make clear in the IMR whether he had contacted his counterpart at HMP Lewes on or after 6 November 2003 about the appropriateness of the prisoner's allocation to HMP Weare. No entries could be found in the IMR or in the prescription charts to show whether he had been prescribed antibiotics in June 2004.

I fully understand the concern expressed by the prisoner's mother as to whether he should have had a check up about a fortnight after he left the Dorset County Hospital in June 2004 because he had, she thought, broken his ribs. He was found to have tenderness, and, later, bruising on his chest and trunk but there is no evidence that he was diagnosed as having broken ribs. A check up in these circumstances was not essential.

10. Recommendations

I make the following recommendations:

To the Prison Service -

- Medical staff should be reminded that clear and comprehensive entries are made in the Inmate Medical Record (IMR) and prescription charts whenever a patient is seen, a decision is made, a medication is prescribed and administered, or a matter of concern arises about the patient, and that decisions are followed through, in accordance with guidelines issued by the General Medical Council and the Nursing and Midwifery Council.
- In line with the report of the clinical review, the Prison Service should consider whether there is a case for issuing guidelines on the use of opiate patches (buprenorphine) within prisons.
- Where it is clear that a prisoner has overdosed on prescribed or illicit drugs the incident should be treated as an act of self-harm and consideration should be given to the use of a Form 2052SH/ ACCT.

To the Governor of HMP Weare-

- Local contingency plans for the handling of a life threatening incident should be reviewed in partnership with the local Primary Care Trust, and all staff should be reminded that an ambulance must be called as soon as it is clear that a life may be at risk.

Stephen Shaw

Prisons and Probation Ombudsman for England and Wales

April 2005

Annex A

Terms of reference

The investigation was conducted under the following terms of reference:

You are to investigate the circumstances surrounding the death of a male prisoner at HM Prison Weare on 10 July 2004.

You are asked to:

- Establish the circumstances surrounding his death including the care provided by the Prison Service and any relevant outside factors
- Examine any health care issues and assess clinical care in conjunction with the National Health Service
- Ensure that the deceased's family have an opportunity to raise any concerns they may have and that these are taken into account in the investigation and in the report
- Assist in the Coroner's inquest

Time scales

You are to present me with a report of your findings together with any recommendations you may wish to make by 6 September 2004.

Stephen Shaw CBE
Prisons and Probation Ombudsman for England and Wales
12 July 2004

Annex B

Report of a clinical review by the West Dorset PCT

Instructions

I have been asked to prepare a report and comment on the circumstances leading to the death of a prisoner at HM Prison Weare on 10 July 2004. To do this I have read copies of his prison medical records and hospital records dating back to October 1998. I have also read his casualty notes from 20 June. I have interviewed a lead nurse of the prison medical staff involved in his care.

Myself

For 20 years I was a full time principal General Practitioner in West Dorset. I am now a part time assistant GP.

Background

The prisoner was serving an 18 month sentence at HMP Weare and he died two weeks before his release date. As revealed by a letter from his home GP to the prison Medical Officer, he had a "long history of alcohol and drug abuse, both prescribed and illicit, complicated by a history of chronic back and neck pains." His drug abuse had included crack cocaine and ecstasy, but he denied ever having injected drugs. He had taken overdoses in 1970 and 1972 and he had cut his wrist in the 1980s. Between 1991 and 1993 he had been under the care of the psychiatric department of the Hastings and Rother NHS Trust for problems relating to drug abuse and depression.

His back pain and neck pain problems had led him to many visits to his own GP, orthopaedic departments and pain clinics.

In 1999 when he was suffering from spinal claudication (a condition where the process of walking produces pain and weakness in the legs because of increased pressure on the spinal cord) as well as low back pain, an orthopaedic surgeon had offered him spinal surgery if other measures were to prove unhelpful.

MRI scans of his low back and neck in 1999 and 2000 showed moderate amounts of disease. Although there was a considered discussion amongst specialists it was felt that surgery would not help him and so many other attempts to help him were made. These included caudal epidurals, facet joint injections, acupuncture, psychological re-education and the use of TENS machines. None apparently helped him very much and he entered prison taking, amongst other medications directed towards his pain problems, morphine tablets which had been prescribed by his GP.

Initial few months in HMP Weare

The prisoner was transferred from HMP Lewes. Apart from a medical assessment document there were no notes available to me from HMP Lewes.

On 6 November 2003 after noting his condition and requirements, The Weare MO comments, "need to speak to Lewes prison re inappropriate transfer." There is then no record of this having been done.

Right from this time his morphine tablets were stopped (Sevredol 20 mgs twice daily) and non opioid medication was started. The prison medical officer did not make this decision alone but in consultation with the other staff and the prisoner's GP.

Initially the prisoner suffered some depression with "fleeting thoughts of self harm only " and he was commenced on an anti-depressant. No further mention is then made of any depression. When he complained of neck or back pain his request for opiates was declined but he was offered and received a domiciliary visit from an orthopaedic specialist who recommended a medication change and (without opiates) a pain speciality clinic appointment. The pain clinic appointment occurred on 1 June and in this the possible need for an opioid skin patch (slow release through the skin) was mooted for use during or after his stay in prison.

In January, he admitted to the MO that he had taken an overdose of 14-20 nefopam the previous evening. He was temporarily changed from weekly collection of his medication to daily collection.

In February he was offered acupuncture and help in the gym, but although initially accepting he failed to turn up. In the same month the staff again noted a discrepancy in his medication and he was returned to daily medication collections.

In March during voluntary testing he twice tested positive for methadone although denying taking any. The staff mooted that there may have been some crossover reaction with the nefopam he was taking. This never appears to have been verified.

Circumstances leading to the prisoner's death

June 2004

The prisoner was thought to have sustained a pulled muscle in his right side ribcage after coughing in the middle of the night. Nothing of note was found on examination.

19 June 2004

The nurse who administered his daily medication thought he looked pale and in pain and persuaded him to be put on the list to see the MO.

20 June 2004

Ambulance called at 2am and took him in severe chest pain, again after coughing, to Dorset County Hospital accident and emergency department. He was there found to have no bruising or swelling but to be tender over an area mid right chest. His lung function was normal although he had a slight wheeze. His pulse was 90, and blood pressure recorded at 165/70 (both normal in the circumstance). His temperature was also normal. He requested morphine but was supplied with non opioid painkillers and allowed to return to the prison.

22 June 2004

Seen by a locum (?) medical officer who prescribed durogesic (opioid) transdermal painkilling patches.

26 June 2004

Pain noted to continue and observed to have bruising down left side of his trunk. Medical Officer requested to see, and he confirmed the presence of bruising but did not state side or extent. Normal lung function was confirmed and blood tests, sputum culture and urine examination were ordered. (Urine test was normal, blood count showed very minimal anaemia, haemoglobin 12.8 with normal range being 13.5 to 17.5, and the sputum showed some signs of a bacterial chest infection and the MO has written that antibiotics should be started if symptoms of expectoration continued.) I could not find any documentation of antibiotics having subsequently been given.

10 July 2004

The circumstances of his collapse and the attempts to resuscitate him are well documented save for any description of how he had been discovered to be in a collapsed state initially. I telephoned Dorset Ambulance Service and there are certain possible discrepancies on timings.

According to the medical records upon being discovered he was initially breathing and an ambulance was immediately "put on stand-by" and the duty nurse called (3:25am). At 20 mins nurse arrived (3:53am).

At 23 mins he stopped breathing and CPR commenced since he was found to be pulse-less with fixed dilated pupils.

At 56 mins paramedics took over resuscitation attempts.

At 76 minutes resuscitation attempts stopped according to ambulance protocol.

Dorset Ambulance Service state that the request for an ambulance was received at 03:52hrs and the paramedics arrived 04:06hrs. The Ambulance Service states that they have no record of contact before this time.

My observations on the prisoner's medical care whilst in custody.

In the medical profession chronic pain management is renowned for its difficulties. It is seldom that a perfect solution is found and common for partial solutions only to be found after extensive efforts on behalf of both the patient and their medical teams. Medication alone is hardly ever a solution. When a patient has the additional problems of an addiction tendency and inescapable stresses to cope with as well as their pain, the pain problem is further magnified.

On reading the medical records from HMP Weare my general impression is that the prisoner was cared for in an exemplary way. When he arrived in prison he was taking very small doses of oral morphine (20mgs tablets) and this twice daily, which, because it was not a slow release preparation, would have meant that it would have been ineffectual for much of the day. This, to my mind, would imply that it was probably satisfying his addictive needs more than his requirements for pain control.

During his imprisonment, he made several requests for opiate medication to help with his neck and back pain, and the medical staff seemed to go out of their way in trying to offer him every other form of help. On several documented occasions, he failed to take up their offers (acupuncture, gym, etc).

When he finally attended the Dorchester Pain Clinic all the suggestions made by the consultant had in fact already been tried to no avail, save one, and this was the application of opiate skin patches in the form of transtec (buprenorphine) - see notes below.

My observations on the events preceding his death.

"Cough fractures" of ribs are not that common. I am not an expert, but I should imagine that such fractures leading to fatal haemorrhage are very rare indeed.

On 3 June and 20 June 2004 when he had attacks of severe pain his medical management seems totally appropriate. A history was obtained, he was examined and treated appropriately both in the prison and in the Accident and Emergency Department. (In the absence of signs of internal damage where fractured ribs are suspected it is normal practice not to request x-rays since medical management is unaffected by any revelation of fracture.)

On 22 June 2004 he was commenced on slow release patches which are stuck to the skin and changed every third day. Fentanyl is a powerful opioid

painkiller that was being prescribed in a moderate dose. It is worth noting that this appears to have been prescribed by a different medical officer who must have made a different assessment of the amount of pain he was suffering. He had been having the same dose of patch for over two weeks before his death and the staff report that he was “out and about” during this time, so it is extremely unlikely that the drug would have made any significant contribution to his body’s inability to react to alert him to internal bleeding or further fractures.

On 26 June 2004 a nurse noted that he had extensive “old” bruising down his left trunk. (This is the opposite side to the pain recorded on both previous occasions, but on interviewing the nurse she recalled the bruising being on his left side before I pointed out what she had written in the notes and its possible discrepancy with previous entries.) I am uncertain of any implications of this observation save to say that in my experience bruising from cracked ribs normally tracks up or down the same side as the fracture.

The blood tests ordered by the PMO after his examination the same day only showed a minimal anaemia, which could have had many possible explanations. (Dietary?...in relation to the anti inflammatory medication he was taking for his back and neck pain?) Certainly it would have been impossible to infer problems of internal bleeding.

A sputum test had also been ordered (in spite of only a slight wheeze being detected on examination) and revealed bacterial infection. This would have been a common finding in a smoker with chest movement restricted by pain from tissue damage. For this reason I would have thought that it might have been more appropriate to go ahead with an antibiotic prescription rather than wait to see if “a productive cough continued”. I understand that a chest infection was not featured in the causes of death.

10 July 2004

What were the circumstances of his being found? He had collected his medication as per normal from the hatch and thought to look his normal self the previous afternoon by the nurse.

I spoke to a Prison Officer by phone and he confirmed that on being alerted to the prisoner’s collapse he and other Officers including the Senior Officer entered his cell and found him breathing but unresponsive. They immediately called in the on-call nurse. Because the prisoner’s condition was giving them cause for concern the Senior Officer gave an instruction that an ambulance be put on standby. This was done at almost the same time as the on-call nurse arrived, hence the confusion over an ambulance being put on standby and then called. (An ambulance can’t be “put on standby” since they are always “on standby”.)

The prisoner had been eased out of the shower where he had collapsed and correctly placed in the recovery position, but only ceased to breathe at the moment the nurse arrived, and this is when full cardiopulmonary resuscitation

was commenced.

Post mortem findings tell us that he died from internal haemorrhage from the effects of a cough-induced fracture of the ribs. The cause of his collapse was therefore due to low blood pressure caused by internal blood loss. It was therefore very unlikely that even the most expert of teams, (who at that time would have been unaware of his internal bleeding), would have been able to resuscitate him.

In such circumstances the exact moment as to when a rapidly developing medical situation changes from being urgent to being an emergency is often difficult to judge. It would seem that the prison staff reacted quite appropriately. If there are any lessons to be learnt then it could perhaps only be that in a developing situation, if the thought of an ambulance be called comes to mind, one should then not hesitate to call one straightaway.

General observations and suggestions

The general public, myself included, are aware of some of the problems of the abuse of both illegal and prescribed drugs within prisons. Although opiate prescribing does not appear to have had any bearing on the prisoner's death, there were issues relating to it during his custody. These were:

- whether he would have benefited from the routine prescription of opiates?
- whether or not he was obtaining methadone illicitly from within the prison?
- how best to balance the integrity and economic advantage of self medication against different degrees of supervised medication?

Better brains than mine have grappled with these sorts of questions but within this context I feel that some guidelines could usefully be drawn up within the Prison Medical Service on the use of opiate patches.

Buprenorphine is a synthetic opiate which has very limited street value because of its low ability to produce a "high" and because it blocks the effect of other opiates. For this reason I would (in my naivety!) have thought that it might be a useful tool within the Prison Medical Service.

Finally it took me just under an hour to get the photocopied records relating to the prisoner's case in some sort of chronological order. It might be cheaper to let somebody else do this!

West Dorset PCT