

**Investigation into the circumstances surrounding the
death of a man
at HMP Doncaster in March 2007.**

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

November 2007

The man in this report died from natural causes in March 2007 at HMP Doncaster. He was a 72 year-old man who had heart and lung disease as well as many other complex health problems.

A post mortem was not carried out, but one of the prison doctors provided a medical certificate of death for the Coroner. He gave the cause of death as ischaemic heart disease (reduced blood supply) with chronic obstructive pulmonary disease (COPD) being a contributory factor. My colleagues and I would like to extend our condolences to the man's family and those touched by his loss.

This investigation into this death was carried out on my behalf by one of my investigators. A review of the man's clinical care was conducted by Doncaster Primary Care Trust (PCT). There was a delay in receiving the review due to a change over of staff in the PCT. The Head of Clinical Governance took over the review and I am grateful for her assistance.

I judge that the man received good, compassionate care whilst at Doncaster. However, it is clear from the evidence that he would have been better placed in a specialist unit geared towards older prisoners with multiple health needs.

I make three recommendations. I have also highlighted two examples of good practice that the Director of HMP Doncaster may wish to share with the medical and discipline staff on the healthcare centre. I am pleased to note that HMP Doncaster have accepted all of the recommendations.

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Prisons and Probation Ombudsman

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SUMMARY

The man at the centre of this report was remanded in custody in August 2006. He arrived in prison with several existing health problems. Before he was remanded, he had been in supported housing and had a carer.

Upon his reception at HMP Doncaster, he was located straight onto the healthcare centre. The staff in the centre attended to his needs, including medication, personal hygiene and general support. The man could not lie flat on his bed as it exacerbated his breathing problems. He had previously slept in a chair, and so was given a chair in his cell. Although a specialist chair was recommended by a tissue viability nurse (a specialist in wound and pressure sore care), this was not ordered until the day before he died. As a result, he used to sleep in a wheelchair.

Whilst at Doncaster, the man was admitted to the local hospital as an inpatient on two occasions. He also had appointments as an outpatient. Staff at Doncaster kept in good communication with the hospital and outreach services.

At a multi-disciplinary case conference on 5 March 2007 to discuss the man's situation, it was agreed that Doncaster prison was not an appropriate place for him to be. It was recommended that he should be transferred to an establishment more able to deal with his healthcare needs. HMP Norwich was identified as suitable and the referral process began. Unfortunately, this had not been completed by the time the man died at the end of March.

THE INVESTIGATION PROCESS

1. My investigator requested all the relevant prison records including the medical and core prison records. She also visited HMP Doncaster.
2. Notices to staff and prisoners were sent to the prison to be displayed. These invited anybody with information to talk to my investigator. In this instance, no-one raised any matters of concern.
3. Doncaster PCT was asked to carry out a clinical review. The reviewer who began this had a job change, and so the responsibility was passed to the Head of Clinical Governance who completed the review.
4. HM Coroner for Doncaster was informed of the Ombudsman's investigation and will receive a copy of this report.
5. The man had identified his brother as his next of kin. One of my Family Liaison Officers contacted the man's brother to offer him and his family the opportunity of involvement in the investigation. The man's brother raised no concerns and said that prison staff had been very helpful following his brother's death. The family will be given a copy of my report.

HMP DONCASTER

6. Doncaster is a privately run prison operated by Serco Home Affairs. It opened in June 1994. The prison is certified to hold 771 prisoners but has an operational capacity (maximum crowded capacity) of 1,145. The prison takes men over the age of 18 who are awaiting trial or who have been sentenced.
7. The accommodation consists of three houseblocks each with four wings. There is a healthcare centre that has 29 spaces for inpatients. Serco Home Affairs operate an in-house medical team with links to the local Primary Care Trust (PCT) who also provide the Mental Health In-Reach Team service.
8. The medical team is made up of a healthcare manager, a clinical manager, two senior nurses, 21.75 full time equivalent registered nurses including mental health nurses, and five healthcare assistants. There is also a senior doctor who sub-contracts to four other doctors ensuring that the prison has full time cover.
9. There are also ten Prison Custody Officers (PCOs) and one wing support officer who work on the healthcare centre. These officers work on a rota but are permanently deployed to healthcare. The officers are not medically trained and do not offer medical treatment, but they are all currently completing an NVQ level 3 in Health and Social Care. The officers work closely with the healthcare staff and prisoners to provide all round care and treatment.
10. All prisoners have a medical record that contains a continuous record of all their medical needs and treatment. Doncaster also uses Daily Record Sheets which include care plans. Currently the officers on the unit do not have direct input into these, but there are plans to change this so that there is a more holistic approach.
11. Her Majesty's Chief Inspector of Prisons last carried out an inspection at Doncaster in November 2005. The inspection report commented that inpatients in the healthcare centre were complimentary about the quality of care they received, and that it was easy to obtain help from staff. The inspection report also noted that the inpatients were mainly cared for by the PCOs, although nurses were in regular attendance to administer medications and make entries in the care plans.

HMP NORWICH – NELSON UNIT

12. Nelson Unit at HMP Norwich is a healthcare unit for older life sentence prisoners with specialist healthcare needs. At times, it also takes younger and non life sentence prisoners who have complex healthcare needs.
13. The unit gives 24 hour care provided by registered nurses who are supported by healthcare officers and healthcare assistants. Medical care is provided by general practitioners. Care is co-ordinated using a multi-disciplinary approach and links to services within the Norwich PCT.

KEY FINDINGS

14. The man in this report was received into custody at Doncaster on 31 August 2006. He went through the prison's reception procedures before being located in the healthcare centre. His first reception health screen recorded that he had numerous physical health problems including chronic obstructive pulmonary disease (COPD). This is the term for a number of conditions, including chronic bronchitis and emphysema. The man also suffered from heart disease and frequent angina attacks as well as having leg ulcers and diabetes, although the latter was diet controlled.
15. Due to his health needs, the man was located in the healthcare centre rather than on the main prison wings. When he arrived there he told staff that he had had a carer before coming into custody, and that the carer would give him a bed bath as he could not shower or bath because of his leg ulcers. The man also told staff that he could not lie down flat on a bed and always slept in a chair. He was given a wheelchair to assist with his mobility and he also chose to sleep in it.
16. There are comprehensive medical records of the man's period in custody. They show that during the first few months he received regular treatment for his leg ulcers and had a nebuliser for his COPD. The man's cell did not have an electricity socket, and he was, therefore, unable to keep the nebuliser in his cell. Nevertheless, staff ensured that he could access it when he needed to.
17. On 9 January 2007, the man was sentenced to ten years and six months imprisonment. His daily review record noted that he felt okay when he returned from court, but that over the next three days he spent more time in his cell although he remained talkative with staff. Four days later, on 13 January, the man was admitted to Doncaster Royal Infirmary with a lump on his left leg due to cellulitis (inflammation of connective tissue) that needed to be treated by intravenous antibiotics. Prison healthcare staff remained in contact with the hospital, and were kept up to date with his progress. They were told that the man had experienced urinary retention for which he had a bladder scan. This resulted in him having a catheter inserted. This was still in place when he was discharged from hospital on 5 February.
18. Over the next few weeks, the man continued to have treatment to his legs. He was also experiencing constipation and as a result complained of a sore stomach. He returned to hospital to have his catheter removed and replaced by an intermittent catheter (this would allow the man to use it himself as necessary).
19. A nurse at the prison saw the man on 26 February and noted that he was experiencing shortness of breath. She wrote in the prison medical record that smoking was exacerbating the problem. When my investigator spoke to the healthcare managers, they told her that the man would frequently smoke and then need to use his nebuliser. They felt that this was not a good approach but the man told them that it was one of the pleasures he still had left.

20. The nurse also wrote that she was concerned about the man not drinking enough fluids. He was still suffering with constipation and had not taken the medication for this over the previous weekend.
21. When the man was seen by the doctor on 28 February his breathlessness was reportedly getting worse. He was also found to have pressure sores and was visited by a tissue viability outreach nurse shortly afterwards. The sores were treated and instructions were given to healthcare staff to monitor his recovery, and to get the man to regularly stand up to relieve the pressure. The outreach nurse also recommended obtaining a special chair (until this point it appears that the man had still been sleeping in his wheelchair).
22. A multi-disciplinary case conference was held on 5 March. The meeting discussed many issues relating to the man's health, including how his smoking was exacerbating his breathing problems and therefore reducing his mobility. The participants also discussed the lack of power supply in his cell and the need to get a special chair for his pressure sores.
23. The medical record notes that everyone agreed that the man's general health was deteriorating, and he would be better placed in a more suitable establishment. The healthcare managers told my investigator that the healthcare centre at Doncaster had limited specialist care and equipment. They felt that he should transfer to somewhere that had the extra support and was more restful. HMP Norwich was identified as suitable as it has an elderly patients unit, which has specialist facilities for older prisoners with complex health needs.
24. The necessary paperwork was obtained to make a referral to Norwich. The man was also referred for a smoking cessation course and physiotherapy. The doctor wrote a supporting letter that day, and the referral was sent to Norwich on 8 March 2007. Unfortunately, a decision was not reached before the man died.
25. The man was admitted to hospital again on 11 March with suspected pneumonia. He was initially treated with intravenous antibiotics, followed by oral antibiotics. After nearly two weeks, the man was discharged and returned to the prison with the necessary medication. Again, the records show that communication between the prison healthcare and the hospital was good.
26. The daily review record of 26 March shows that the man had initially been in a low mood during the morning. He told staff that he did not want to be resuscitated if he died and he did not want to go out to hospital if his health deteriorated. Staff told him that he would need to contact his solicitor to formalise his wishes. His mood picked up slightly after he was given a shave and a bed bath. The following day (27 March), an entry in the daily medical review log shows that the man wanted to see his brother. Staff duly contacted his brother and a visit was arranged for two days later.

27. Also on 27 March, the man's care plan was revised. The plan recorded that he was presenting as low in mood and that he felt he was dying. A registered Mental Health Nurse (RMN) completed an action plan which included allowing the man to express his feelings and for staff to assess his mood daily. The plan also recommended that staff should try to get him to focus on the positives in his life, engage in wing based activities and maintain contact with his brother.
28. During the morning of 28 March, staff recorded that the man's health appeared to be deteriorating further. The daily medical review notes show that he became irritable and wanted to be left alone. He also refused to take his medication. He changed his mind at lunchtime however, and took his medicines. Staff recorded that his mood brightened and he was smiling and joking.
29. The specialist chair had still not been ordered by 29 March. The man would not sleep in his bed, telling staff that it exacerbated his breathing difficulties. Healthcare arranged an urgent delivery of a special chair so that the man could be comfortable.
30. The man's brother visited on 29 March. This was permitted to be an extended visit given his poor health. Unusually, the visit was allowed to take place on the healthcare centre so that the man did not have to experience any discomfort and difficulty getting to the domestic visits room. The healthcare managers told my investigator that the man was very tired throughout and after the visit.
31. The following morning (30 March), a Prison Custody Officer (PCO) was on duty. At 6.30am, during his rounds, he saw the man who told him that he did not want any breakfast. The man did, though, take the cup of tea that the PCO had made for him. The PCO said in his statement that he thought the man was looking physically worse than when he had seen him two days earlier.
32. At 7.00am, the man was asked again if he wanted any breakfast but he declined. Approximately 20 minutes later, the Healthcare Manager, arrived in the centre and the PCO asked her to see the man.
33. In her statement, the healthcare manager said that the man was sitting in his wheelchair when she went into the cell and looked very unwell. His breathing was laboured and his pulse was very weak. She told him that he needed to go to hospital but he told her he did not want to go. A second PCO arrived at the cell shortly afterwards. The man asked for a fresh cup of tea, which the second PCO went to make. The healthcare manager said that the man's pulse had become barely palpable and so she asked the first PCO to fetch another nurse.
34. As he was doing this, the second PCO returned to the man's cell with the tea. The healthcare manager instructed him to call for more medical assistance. A healthcare member of staff was taking a telephone call from the first PCO

when he heard the medical response call over the radio. He made his way to the man's cell. With the help of the prison officers they put the man on the bed, and the healthcare manager and other member of staff commenced cardiopulmonary resuscitation (CPR) and oxygen therapy. Although the man had told staff a few days earlier that he did not want to be resuscitated, this was never formalised and therefore staff had to attempt to resuscitate him. After a period of trying, they could get no response from the man. They stopped CPR but continued with oxygen therapy.

35. In the meantime, an ambulance had been called. It arrived at the prison at 7.38am. The paramedics checked for vital signs and confirmed that there was no cardiac activity. Shortly afterwards, one of the prison doctors arrived at the prison and went straight to the man's cell. He formally pronounced death at 8.05am.
36. The doctor wrote the medical certificate, giving the man's cause of death as ischaemic heart disease (reduced blood supply to the heart) with COPD being another contributing factor.

ISSUES

Location in HMP Doncaster

37. When the man arrived in prison, he already suffered from complex health problems. Because of his medical needs, he was located in the healthcare centre rather than on the main residential wings.
38. Following a multi-disciplinary case review on 5 March 2007, it was agreed by those present that the man was inappropriately placed at Doncaster because he needed more specialist care and equipment. Although the clinical reviewer recommends that the protocols and arrangements remanding prisoners with complex health needs should be consulted, I make no recommendations regarding the matter.
39. The clinical reviewer has found that staff at Doncaster were committed to providing the man with as good a quality of care as possible. They made use of outreach teams and maintained contact with secondary care providers. However, I agree with the reviewer's comment that it might have been more appropriate to have considered the man's transfer to Norwich at an earlier date. That said, the man's outstanding hospital appointments needed to be taken into consideration before a transfer could take place.

The prison healthcare team should consider an early case conference, ideally within one week of their initial health assessment, should they receive a prisoner with complex health needs.

Specialist chair

40. The man had very poor mobility and was wheelchair bound, even sleeping in his wheelchair because lying down was too painful. Staff had been aware of this since the man's reception. Due to being wheelchair bound, he also suffered from pressure sores. He was seen by a tissue viability outreach nurse at the end of February 2007, and a specialist chair was recommended. However, it was not ordered until 29 March and so was not received before the man died.

The prison healthcare team need to take earlier advice from specialist teams where there is an identified clinical need for equipment and ensure relevant equipment is made available as soon as possible.

Electricity in cell

41. There was no electricity socket in the man's cell. This made it difficult for him to have his nebuliser permanently available, although the evidence shows that staff let him have access as prescribed.
42. The problem of lack of electricity was discussed at the multi-disciplinary meeting on 5 March 2007, but there is no recorded outcome.

The Director and Head of Healthcare should resolve the lack of safe and secure electricity sockets so that similar situations are avoided in the future.

RECOMMENDATIONS

- 1. The prison healthcare team should consider an early case conference should they receive a prisoner with complex health needs, ideally within one week of their initial health assessment.**

HMP Doncaster have accepted this recommendation. This process has been reviewed and any prisoner with complex needs will have a case conference within a week. The resulting action plan will take into account any specialist equipment needed.

- 2. The prison healthcare team need to take earlier advice from specialist teams where there is an identified clinical need for equipment and ensure relevant equipment is made available as soon as possible.**

HMP Doncaster have accepted this recommendation and it will be incorporated into the case conference as detailed in recommendation 1.

- 3. The Director and Head of Healthcare and the prison should resolve the lack of a safe and secure electricity sockets so that a similar situations are avoided in the future.**

HMP Doncaster have accepted this recommendation. A cell is being converted to allow an electric supply and potentially other modifications as necessary.

GOOD PRACTICE

- 1. Overall, the staff in the healthcare unit made good efforts to address the man's complex health needs. They maintained good communication links with secondary care providers, especially when the man was in hospital.**
- 2. The man's brother was able to visit him before he died. This visit took place in his cell so that he had minimum disruption and discomfort.**