Investigation into the circumstances surrounding the death of a man in outside hospital, whilst in the custody of HMP Doncaster, in November 2007

Report by the Prisons and Probation Ombudsman for England and Wales

December 2008

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 prisoner at HMP Doncaster, who died from natural causes on 19 November 2007. He was 47 years old.

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 my colleagues. He and I would like to thank the Director of HMP Doncaster and his staff for their assistance. Doncaster Primary Care Trust were asked to undertake a review of the man's clinical care and I also much appreciate their help.

The man was taken by ambulance to an outside hospital on 17 November and it was there that he died during the evening two days later. I have made two recommendations in this report. I have also noted the issues highlighted by the clinical reviewer and I endorse the recommendations made in her review. The prison will develop an action plan to address the matters raised.

I have also made two separate recommendations about the management of bedwatches and hospital escorts. The man had very limited mobility and was in ill health. He was a most unlikely escape risk. Yet for all of his time in hospital he had a two-officer bedwatch, and he was cuffed for most of the time too.

Jane Webb
Deputy Prisons and Probation Ombudsman **December 2008**

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SUMMARY

The man was born in 1960. He was 47 years old when he died in outside hospital. The man died from natural causes as a consequence of heart failure on 19 November 2007.

The man had been received into prison custody in March 2007 after he had been convicted of theft. In April, he was sentenced to 21 months imprisonment at a local Magistrates' Court.

The man's left leg was amputated in 2006 and he had also previously been diagnosed with diabetes. He had use of an artificial leg and a wheelchair and required pressure bandaging for his stump. The man had also previously contracted MRSA (methicillin resistant staphylococcus aureus) and required barrier nursing to protect others from possible infection. Due to his mobility and health problems, the man was located on the healthcare wing of Doncaster prison. He remained on the healthcare wing for the duration of his time in custody.

The man experienced problems with lack of mobility throughout his time at Doncaster and put on weight due to this and his poor diet. The man was also unable to visit the gym and library due to problems with access to these services for prisoners with mobility problems. Due to his weight gain the man was unable to use his artificial leg and his family brought him a second heavy duty wheelchair.

The man was taken to hospital for treatment on numerous occasions whilst he was in custody. He was also admitted to outside hospital for eight days in May after experiencing tightness in his chest. The man was again admitted to outside hospital from 28 June until 17 July after he developed an infection.

On 16 November, after the man developed an infection in his right foot he was referred to outside hospital. He was admitted to hospital during the early hours on 17 November. The man's family were allowed to visit him whilst he was in hospital.

Around 7:15pm on 19 November, the man stopped breathing. Attempts to resuscitate him commenced immediately. At 7:40pm it was decided that the resuscitation attempts should stop and death was pronounced by a hospital doctor.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used and two officers needed to be at his bedside. The risk assessment was not revised and the man remained in restraints until he died.

The clinical review carried out on behalf of Doncaster Primary Care Trust concludes that the man's clinical care was not satisfactory. I have endorsed the six recommendations made in the clinical review. I have also made two recommendations in relation to the management of hospital escorts and bedwatches.

THE INVESTIGATION PROCESS

1. The investigation was opened on 21 November 2007 when one of the Ombudsman's investigators issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. In the event, nobody came forward. The investigator also studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff.

2. The investigator visited Doncaster on 14 February 2008 and discussed aspects of the man's treatment with staff at the prison. He also interviewed the clinical manager at Doncaster. The clinical manager was able to provide background information concerning the man and his activities whilst in custody.

3. The Doncaster Primary Care Trust commissioned someone to carry out a review of the man's clinical care. I am grateful to them for undertaking the review.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.

5. One of the Ombudsman's Family Liaison Officers wrote to the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. The family had a number concerns relating to the medical treatment the man received whilst he was in custody:

    - The man had the use of an artificial leg before he arrived in custody but when his family visited him in Doncaster he was using a wheelchair.
    - As the man was not using the artificial leg he put on weight and his family had to purchase another heavy duty wheelchair for him. This caused problems as the width of the chair meant that it did not fit easily through doorways.
    - The difficulties the man experienced when trying to move around the prison due to his lack of mobility and the lack of access he had to the facilities at Doncaster.
    - The cessation of certain medication when he arrived in custody.
    - The resistance from staff to accommodating the man's special arrangements for visits from his family.
    - The man not having access to the gym which again did not assist with his weight management.
    - The diet available to the man whilst he was in custody
    - The number of hospital appointments for the man which were cancelled by Doncaster.
    - The management of the man's pain.

- The application of the man’s pressure bandaging and appropriate hospital attention.
- The observation of barrier nursing to avoid possible infection.

The clinical reviewer and my investigator have explored these points and I hope that this report provides the family with answers to their questions.

HMP AND YOI DONCASTER

6. HMP and YOI Doncaster opened in 1994 and is a purpose-built Category B male prison, privately managed under contract by Serco Home Affairs. The prison is made up of three houseblocks, each with four wings and has a maximum capacity of 1,145 prisoners. Its principal function is as a local prison serving the local courts, and the majority of its population are sentenced prisoners.

7. Provision of healthcare within Doncaster is the responsibility of Serco Healthcare. The prison has a healthcare unit with provision for up to 29 in-patients located on the second floor. The lower level is dedicated to the delivery of primary care services. Resuscitation equipment, including the defibrillator, is kept in the pharmacy room. A local doctor provides on site cover 21 hours a week and the prison employs two other part-time doctors to provide a 24-hour service. Prisoners with more serious conditions or clinical needs are referred to the local hospital. The mental health in-reach team is from the Doncaster and South Humber Mental Health Trust. It provides a service to a cluster of prisons in the area. There are also three Registered Mental Health Nurses and a support worker based in Doncaster. A clinical psychiatrist and a forensic psychiatrist also attend the prison for regular sessions.

8. An announced inspection of Doncaster took place in November 2005. Dame Anne Owers, Her Majesty's Chief Inspector of Prisons, found that HMP Doncaster 'was generally well-ordered'. However, the Chief Inspector expressed concern that 'prison managers had allowed important areas to slip below what is safe and decent' since the Inspectorate's previous visit in April 2003. A further inspection was conducted earlier this year but the report has yet to be published.

9. The Independent Monitoring Board (IMB) in its latest report for Doncaster (2006 – 2007) says that overall the prison continues to be well managed. It highlighted the absence of workshop facilities and the failure to occupy many of the prisoners in useful and purposeful activity. The report also said that:

> "Overcrowding continues to be a serious problem affecting programmes designed to address such matters as drug addiction, criminality, and rehabilitation. The Board takes the view that many prisoners need not be imprisoned for relatively minor offences which could be more cost effectively dealt with by a properly resourced Probation Service, be released on bail awaiting trial. Others could be more appropriately treated in mental hospitals or other psychiatric care facilities if diagnosis of their mental health problems was adequately resourced."

10. There were four natural causes deaths at Doncaster in 2008.

KEY EVENTS

11. When the man arrived at Doncaster on 27 March 2007, he had a number of medical conditions. Part of his left leg had been amputated and he had the use of an artificial leg and a wheelchair. The man also had diabetes and as a result suffered from neuropathy, whereby the nerve endings in his feet and hands were damaged. He had also previously contracted MRSA (methicillin resistant staphylococcus aureus) and required barrier nursing. A range of medications was prescribed for the man and he was not allowed to keep these in his possession.

12. The man was located on the healthcare wing at Doncaster due to his lack of mobility and poor health. Doncaster did not supply a copy of the man's first health screen to either the clinical reviewer nor my investigator. However, it was noted in the medical records that the man had tried to take his own life within the past five years.

13. When interviewed as part of this investigation the clinical manager at Doncaster said that he had met the man when he had been serving previous prison sentences. The clinical manager said that he was fully aware of the issues relating to the management of the man's diabetes. The clinical manager pointed out that, since he had served his last sentence, the man had undergone surgery on his left leg which had been amputated below the knee. The clinical manager said that the man had good insight into the management of his diabetes but did not watch his diet.

14. The man attended a diabetic screening interview on 1 April. It was recorded that the man was losing his sight, he had ulcers on his stump and pins and needles in his fingers.

15. On 4 April, the man experienced problems putting on his false leg as his stump was very painful and swollen. Later, after he returned from a family visit, the man experienced chest pain and became cold and clammy. An ambulance was called and, after the paramedics carried out an electro-cardio-gram (ECG), the man was taken to outside hospital. He returned to the prison the following day after being seen by a consultant at the hospital.

16. In a letter dated 20 April, a consultant vascular surgeon confirmed that the man was a poorly controlled diabetic. The surgeon wrote:

> "As for the seriousness of his diabetes, it is safe to say that his poorly controlled diabetes is serious enough to have resulted in vascular and neuropathic complications leading to limb loss."

17. The man was sentenced to 21 months imprisonment on 24 April at a local Magistrates' Court.

18. The man was taken to outside hospital and an outside Diabetic Centre, on 25 April and 1 May respectively, for review appointments. On 14 May, the man attended an out-patients appointment at an outside hospital.

19. On 17 May, after he experienced tightness in his chest the man was taken to the Accident and Emergency Unit at an outside hospital. He later transferred to the Medical Assessment Unit before being moved to a ward where he remained whilst clinical investigations were carried out. The prison was in daily contact with the hospital to check on the man's progress. On 24 May, he was discharged from hospital and returned to the prison.

20. The man refused to attend the dressing clinic on 26 May as he said he was in too much pain. He also said that he was not getting enough pain relief and asked to see a doctor. On 29 May the prison doctor wrote that the man's pain management was ineffective and he changed his medication.

21. The man attended a hospital appointment on 8 June for a Computerised Tomography (CT) scan. A letter dated 26 June from a Consultant Cardiologist, confirmed that the man's CT scan showed no evidence of angina. On 12 June, the man attended an out-patients appointment at an outside hospital.

22. On 22 June, the man attended an appointment at an outside hospital for a cast to be taken of his stump. The man also attended the hospital again on 25 June for an out-patient appointment. However, no record or explanation was given in the prison medical record for this attendance.

23. Six days later on 28 June, the man was taken to an outside hospital where he was later admitted as his condition was unstable. He was administered a course of antibiotics and remained in hospital until 17 July. He was then discharged from hospital and returned to the prison.

24. The man attended a review appointment at an outside hospital on 27 July. The hospital was concerned about the man's wounds and drew a black line on his leg. They told the man that if the infection spread to the line, he would need to go back into hospital. He returned to the hospital, on 3 August, and was admitted overnight for further intravenous antibiotic therapy as he had cellulites (inflammation of the deep subcutaneous tissues). He was discharged the following day.

25. When the man attended the dressing clinic at the prison he told staff that he was to have a silver dressing on his leg and that the dressing he had on at the time was only temporary. The nurses at the dressing clinic explained to the man that they had been sent dressings from the hospital and that they were to be put on the wound for five days. The man was not happy with this and the nurse said that she would contact the hospital to discuss the dressings with them. There are no records to show that this action was taken by the nursing staff.

26. On 17 August, an accident form was completed as the man said that he had fallen out of his wheelchair whilst he was in the shower. There was no visible sign of any injuries but the man told staff that he had pain in his right ribs. Staff contacted the Health and Safety Officer at Doncaster, who had previously carried out a risk assessment for the man. The Health and Safety Officer said

that it would be up to the Healthcare Manager to assess the man's disability needs. On the following day another accident form was completed after the man fell out of his wheelchair backwards. Again there were no visible injuries. There was no evidence of further risk assessments being carried out after these accidents.

27. On 4 September, the man attended an out-patients appointment with a Consultant Physician and Honorary Professor of Diabetic Medicine. A letter, dated 6 September, from the Consultant Physician summarised the consultation. The Consultant Physician recommended that the man would need some form of compression bandage and that he should continue on Augmentin (antibiotic medication) until his infection cleared up.

28. On 13 September, the man said that he felt unwell. He was referred to the prison doctor who saw him the following day. The man told the doctor that he had not taken his anti-depression medication (Amitriptyline) for three weeks but he had been given it by mistake for a few nights. One of the side effects of the man's medication was that it caused nausea.

29. On 17 September, the man attended an out-patients appointment at a Diabetic Clinic in an outside hospital. A letter dated 24 September from a Staff Grade Physician in Diabetes, summarised the results of tests carried out when the man attended the hospital. A swab of the man's stump and nose had revealed MRSA (methicillin resistant staphylococcus aureus). This infection is resistant to commonly used antibiotics. Further treatment was recommended by the Physician.

30. The clinical manager confirmed that the clinic nurse would regularly see the man in the treatment room in the healthcare centre to change his dressings. The clinical manager pointed out that treatment plans had been in place for the management of both the man's diabetes and the dressings for his stump. The clinical manager confirmed that the clinic nurse liaised with the Consultant Physician and the Vascular Nurses about the man's care and she regularly updated the clinical manager about this. The clinical manager recalled that on a couple of occasions the man did not attend the treatment room to have his dressings changed as he was about to receive visits. The clinical manager did not remember staff raising any concerns about the process of applying the man's bandages or dressings.

31. The man was seen by the prison doctor on 3 October. His leg was unbandaged and the prison doctor said that it was looking better. However, staff were unable to rebandage the leg until the following day as the treatment room was being used for other purposes.

32. On 6 October, the man told staff that he had burned his finger a few days earlier. This had occurred when the man's hand had fallen against the central heating pipes whilst he was asleep.

33. According to the prison medical records, the man did not attend the dressing clinic on 14 and 20 October. His stump was redressed on 22 October. On 16 October, the man attended an out-patients appointment an outside hospital.

34. The man made a formal complaint on 22 October about being refused Home Detention Curfew (HDC). On 29 October the Commissioning Manager from Yorkshire and Humberside Regional Offender Management Service reviewed and replied to the man's complaint. He noted that the man had previously committed offences whilst on bail and had driven whilst disqualified. The manager therefore considered that the man would find it difficult to comply with the conditions of HDC and he could not grant it. The manager suggested that if the man was not satisfied with his response he could take forward this matter with the Prisons and Probation Ombudsman's office. There is no record of the man pursuing this issue further within the prison or with my office.

35. On 26 October, as a result of staff shortages, dressings for the man's stump were not carried out. The man did not attend the dressing clinic on 30 October as he had a visit. The medical records say that the man refused to attend the dressing clinic on 1 November as he had another visit.

36. On 11 November, the man was referred to the prison doctor as he had developed large blisters on his toes. The prison doctor checked the blisters and advised that they should be popped and left to dry out. Swabs for MRSA were also taken. The results of the swabs were received on 15 November and showed that the man had MRSA on his right foot blister, as well as in other places.

37. The condition of the man's right foot deteriorated over the next few days and it became apparent that he would need to be referred to hospital for treatment. On 16 November, the bed manager at the local hospital told Doncaster that they were struggling to find a bed for the man. The bed manager said that there were likely to be bed movements and that he would call back. During the morning, the bed manager rang the prison and informed them that a medic-to-medic referral would have to be completed. Another prison doctor contacted the Consultant Physician's Registrar and arranged the referral. Confirmation that the man was to be admitted to the Emergency Assessment Unit was received by the prison later that same day. During the early hours on 17 November, the man was admitted to outside hospital. During his stay in hospital, the man was visited by his family.

38. Whilst the man was an in-patient at the hospital, a bedwatch was carried out by prison staff. The security risk assessment identified that a closeting (escort) chain should be used and two Prison Custody Officers (PCOs) needed to be in attendance. This was entirely appropriate at that time and enabled the nursing staff to have easy access when they carried out their duties. The use of handcuffs for prisoners on escort to hospital has been the subject of recent case law in relation to the issue of decent and humane treatment. I know that the Prison Service is currently drawing up new guidance in relation to this matter. It was in line with standard procedures to have handcuffed the man in the first instance. At the time the handcuffs were applied, the man was

conscious and could have been judged to have posed a security risk. The risk assessment for the man was not revised during his time in hospital and therefore restraints were not removed.

39. At 7:00pm on 19 November, two prison custody officers took over responsibility for the bedwatch duties. The second officer was handcuffed to the man. On their arrival the man was asleep. At around 7:15pm, the first officer noticed that the man took a deep breath but thereafter his chest did not move. The first officer informed her colleague that she was going to get one of the medical staff as something was not right. The first officer informed a nurse. The nurse tried to rouse the man and then called the emergency team. The second officer removed the restraints and the emergency team tried to resuscitate the man. At approximately 7:40pm, it was decided that the resuscitation attempts had been unsuccessful. They were stopped and death was pronounced by a hospital doctor.

40. The first prison custody officer informed the prison that the man had died. The prison chaplain was identified as the Family Liaison Officer for the prison. He contacted the man's family to inform them of his death and to offer condolences and support. The chaplain was able to assist with the arrangements for the funeral and on behalf of the Director offered financial assistance towards the funeral costs. After receipt of the draft report the man's family stated that it was not correct to infer that prison staff contacted the family to notify them of the death. Hospital staff telephoned the man's ex-wife, to inform her that the man had passed away. The man's ex-wife had a good relationship due to the frequency of her husband's past treatment. On arrival at the hospital the family said that no conversation took place between them and the two prison officers.

41. The post mortem report records the man's death as being due to natural causes as a consequence of acute cardiac failure (heart failure) caused by severe coronary artery atherosclerosis (blocked arteries).

CONCERNS RAISED BY THE FAMILY

42. The man's family had a number of concerns relating to his treatment while in custody. The family felt very strongly that the man had not received appropriate treatment for his health needs. My investigator shared the family's concerns with the prison.

43. The family drew attention to the fact that, although the man had the use of an artificial leg, he been quite mobile before he arrived in custody. When the family visited the man in Doncaster he was not wearing his artificial leg and instead used a wheelchair. As the man was not using the artificial leg he had put on weight, due to lack of exercise. This meant that the family had to purchase a heavy duty wheelchair to accommodate the weight gain. However, the family were concerned about the difficulties the man still encountered when trying to move around the prison. As the new wheelchair was wider, the man told his family that, when he moved around the prison, the chair had to be folded and he would have to hop through doorways. The family also felt that the man was not offered the opportunity to exercise or visit the gym.

44. In his written response on 2 June 2008, the head of internal affairs at Doncaster said that the man was challenged on 24 April about the use of his artificial leg. The head of internal affairs said that the man claimed it was too uncomfortable and he was referred to the prison doctor for a review of medication to help facilitate mobilisation. The only record of a problem accommodating the man's wheelchair was on 9 September but no explanation was recorded by staff at Doncaster.

45. When interviewed, the clinical manager at Doncaster said that on arrival in prison the man weighed 20 stone and was overweight for his height. The clinical manager said that when the man arrived at Doncaster he was using a wheelchair and he was later given a second wheelchair which was more robust. The second wheelchair was individually tailored to the man's needs, which had changed whilst he was in custody and was required because he had put on weight. The clinical manager did not recall the man complaining to him about his artificial leg or actually seeing him use it. The clinical manager said that staff were guided by the man on whether he was comfortable using his artificial leg. The clinical manager confirmed that the man's choice of diet and lack of mobility meant that his weight increased whilst he was in custody.

46. The clinical reviewer concluded that no appropriate adjustments had been made with regard to the man's disability needs. This meant that he was unable to visit the library, church or gym and this did not assist him with his weight problems.

47. In response to the draft report the family accepted that artificial limbs do wear out and it was clear that on the man's arrival at Doncaster his limb was speedily removed from him. Their view is that he had worn it to court and it was capable of further use. They believe he should have had the usage of his artificial leg whilst the new one was in the course of preparation. The family felt that as a

consequence of this the man suffered depression and anxiety (according to his ex-wife), was unable to exercise and his weight increased considerably.

48. Due to the man's lack of mobility, special arrangements were made to allow him to meet his family in the rooms used for legal visits. The family appreciated that Doncaster arranged for this to happen but recalled that they encountered resistance from staff who complained about the additional work this caused them.

49. The officer who is in charge of visits at Doncaster said she had several conversations with the man's wife. The officer said that the man's wife did not tell her that staff had complained about the additional work. The officer recalled that the man's wife told her that it was hard to remember to book the visits for the weekend.

50. The clinical manager said that a risk assessment had been carried out to enable the man to see his visitors. This involved him taking a more circuitous route (avoiding stairs) and using lifts. He was also given dispensation to use the designated closed visits rooms, which were usually reserved for legal visits, to see his family. The clinical manager did not recall the man ever having to use stairs when he visited his family and he said that this could only have happened if the lifts were not working.

51. My investigator could not find any supporting evidence that staff had complained about the additional work caused by the arrangements for the visits by his family.

52. In response to the draft report the family drew attention to a visit the man's ex-wife made when she was accompanied by her former father-in-law. She arrived at the prison at about 4:00pm on a Sunday afternoon not having been told that visits in the legal visits hall area were subject to time limit. On her arrival the man's ex-wife went through the search procedure but was not admitted to the prison as staff told her it was "too late for the staff upstairs".

53. The man's family said that, due to his weight gain, he was measured for another artificial leg as his old one was no longer able to hold his weight. However, no appointments were made for fitting inserts to the new leg and so he was unable to use it. The family were also concerned about the number of hospital appointments for the man which were cancelled. They did not think that he received the same level of support with his mobility problems after he arrived in custody.

54. The head of internal affairs' response was that limb fitting appointments were made but had on occasion been cancelled due to security breaches when the man had found out dates beforehand. The man attended a fitting on 17 October and it was noted that he was wearing his artificial leg on 23 October but on no other occasions. Other appointments were cancelled due to conflict of times, for example being superseded by the man already being in hospital. The head of internal affairs said that the man did attend approximately 12 appointments during his time in custody.

55. The clinical reviewer believes that there was poor communication between Doncaster and other parties involved in the man's medical care. This is referred to in more detail in her clinical review. Neither my investigator nor the clinical reviewer find reasons recorded for why some of the appointments were cancelled or re-arranged.

56. The family said that the diet available to the man did not assist with his weight management issues.

57. As mentioned earlier, the clinical manager said that the man had a good insight into his diabetes but did not watch his diet. The clinical manager confirmed that the man was given healthy food options whilst he was at Doncaster but he chose not to accept them. The issue of not pursuing a healthy diet did not aid the man's diabetes or help him to manage his weight. I cannot comment on whether the man did choose to purse the option of a healthy diet as his views on this issue were not recorded.

58. In response to the draft report the man's family did not accept that he did not comply with his diabetic dietary requirements. The family described the man as someone who enjoyed vegetables, fruit and salads but whose blood sugar level was high irrespective of his diet. The family said that the man described the meals provided to him by Doncaster as "rubbish".

59. The family also drew attention to the management of the man's pain. They did not think that this was adequately managed as some of the man's medication was stopped when he arrived in custody. They said that the man was also visibly in considerable pain when they visited him at Doncaster.

60. The clinical manager recalled that he saw the man on a daily basis. The man had occasionally complained about pain relief and the clinical manager said that healthcare staff had responded to his complaints. The head of internal affairs said that all medication is prescribed by the prison doctor with the exception of Zomorph, which was replaced with an alternative analgesia in accordance with local policy. The prison doctor prescribed Zomorph to the man after he saw him on 28 March. The man's medication was reviewed on a weekly basis and alterations were made accordingly. The head of internal affairs drew attention to the large amount of medication the man received and the need for careful consideration of how the medications were combined. The man was in a lot of pain due to his medical condition.

61. The clinical reviewer considers that the man's pain medication was appropriately reviewed and replaced with a stronger analgesia when he was seen by the prison doctor.

62. The family were also concerned about the application of the man's pressure bandaging and the observation of barrier nursing to avoid possible infection. They did not think that Doncaster were proficient in the application of the pressure bandages and did not observe the protocols for barrier nursing.

63. The head of internal affairs said that barrier nursing was carried out at all times as the prison was made aware of the man's infection. Doncaster said that their actions were carried out in accordance with national policies and procedures.

64. The clinical manager referred to a letter dated 6 September from a Consultant Physician and Honorary Professor of Diabetic Medicine. The letter said that the man would need some form of compression bandage although the Consultant Physician did not indicate which type of bandage. This was later clarified when the man attended the Diabetic Clinic on 17 September. Dressings were to be changed two to three times a week and then weekly once the infection had cleared up. When asked whether the man's dressing was secure, the clinical manager said that if it came loose, then staff would re-apply. It had been known for patients to loosen their own bandages or dressings if they were causing discomfort.

65. The clinical manager said that Doncaster was not directed by the hospital to adopt barrier nursing for the man. However the clinical manager said that, after any patient with MRSA was examined in the treatment room, there was a process to ensure that it was cleaned thoroughly. The clinical manager added that the prison was directed by the hospital on numerous issues relating to the man's care. The clinical manager said that whilst the man was in outside hospital his clinical care was managed by them and not the prison.

66. The clinical reviewer noted that there were delays in applying the appropriate bandages and she again refers to this in more detail in her clinical review.

CLINICAL REVIEW

67. The review of the man's medical care was undertaken by someone on behalf of Doncaster Primary Care Trust (PCT). The findings were reviewed by a member of the PCT's Professional Executive Committee and the Head of Quality and Clinical Assurance for the PCT. The review finds that the man had suffered from significant long-term chronic diseases.

68. The clinical reviewer concludes that there are a number of areas where improvements are required and makes some recommendations for improvements to clinical practice.

69. The clinical reviewer notes that the man's medical records were below the required standard. Some of the entries were illegible and wrongly dated. There were also gaps in the records. There was no record of the first and second health screening interviews and the clinical reviewer assumes that neither of these screens were carried out. The only records that were available were for two diabetic screens.

70. The clinical reviewer draws attention to the fact that when the man arrived at Doncaster he revealed to staff that he had attempted to take his own life within the past five years, and stated that his mood was low. However, no further assessment of the man's mental health needs was carried out. Also, as the man was a diabetic, he required a special diet but there was no record of a medical diet order form in his records. The clinical reviewer concludes that, based on the available evidence, the screening process did not establish the man's past or current mental and physical needs.

71. The clinical reviewer recommends that Doncaster should seek medical summaries for all new prisoners from their registered General Practitioner. Typically, prisoners do not access primary healthcare whilst in the community and therefore they suffer from significant health inequality. The clinical reviewer considers that this could be addressed by the prison healthcare system.

    The Healthcare Manager should ensure that staff seek medical summaries for all new prisoners from their registered General Practitioner.

72. The man had previously contracted MRSA and always required barrier nursing to protect others. However, the reviewer could not find evidence in the prison medical records to suggest that this was done. The man also missed some of his appointments at outside hospital and it is not clear, from the prison's medical records, why he was not taken to these appointments.

73. The clinical reviewer believes there was insufficient communication between the prison and external agencies involved in the man's care. For example, the man attended an out-patients appointment on 4 September. He was then supposed to have compression bandages on his feet, but the hospital did not send details regarding the bandaging. It was not until 19 September, when the

man attended a clinic in outside hospital again, that the appropriate bandages were applied and the prison staff were given details.

74. The head of internal affairs at Doncaster, confirmed that discharge letters and clinic letters from out-patient appointments were received. However, as the correspondence was posted, there were delays on occasions before information and advice was received. Attempts were then made to chase information but often clinic staff had finished work for the day.

75. The clinical reviewer draws attention to the lack of handrails, ramps or access to facilities in the prison. The man's movement throughout the prison was very difficult. The wheelchair he used was provided by him and could only go through doors with difficulty. The man had an artificial leg, however, he did not use this leg whilst in custody. He was not able to go to the library, the church or the gym because there were no ramps or lifts available. Exclusion from the gym was a serious difficulty because as a diabetic the man was required to exercise and had put on three stones whilst in custody. In addition, there was no ramp to bathrooms and no handrail in the showers. When having a shower the man had to sit on a plastic chair or on his wheelchair and hold on to the chair to lever himself up when the shower was finished. On one occasion the chair slipped and the man fell over, causing severe pain to his ribs.

76. Doncaster's Disability Policy (Policy Document HMP and YOI Doncaster: Prisoners with physical, sensory and mental disabilities) concerning residential accommodation states:

> "Prisoners with disabilities will be allocated the appropriate accommodation in line with their disability, usually on ground floor level. It is anticipated that one cell per wing throughout the main prison or a number of specific cells in a designated area will be adapted for the use of disabled prisoners – a grab rail and portable toilet cradle will be made available if required. To prevent vandalism, these will only be fitted when the accommodation has been allocated to a disabled prisoner."

77. The clinical reviewer concludes that no appropriate adjustment had been made regarding the man's disability and needs. It seems that the care he received was not comparable with the care he could have expected to receive in the community. The clinical reviewer draws attention to Doncaster's Disability Policy which aims to ensure prisoners with disabilities are not discriminated against in any aspect of prison life and that equality of opportunity in accessing all parts of prison life is offered to all prisoners. The clinical reviewer judges that staff at Doncaster did not follow the policy in this case.

78. The clinical reviewer recommends that all staff at Doncaster are trained and kept up to date in the following areas:

- awareness of and familiarity with HMP Doncaster's Disability Policy
- record keeping
- barrier nursing
- formal referral procedures for secondary care.

The Healthcare Manager should ensure that all staff are trained and kept up to date in the following areas:

- **awareness of and familiarity with HMP Doncaster's Disability Policy**
- **record keeping**
- **barrier nursing**
- **formal referral procedures for secondary care.**

79. The clinical reviewer also recommends that, in the future, every effort is made to:

- improve the communication between the prison and external agencies
- carry out regular audits to ensure standards of record keeping have improved and remain of a high standard
- ensure that first and second screening interviews take place, and that they are appropriately recorded in the prisoner's medical record
- ensure that patients are seen in secondary care when medically indicated and the reason for non-attendance is clearly documented in the prisoner's medical record.

The Healthcare Manager should improve communication between the prison and external agencies.

The Healthcare Manager should carry out regular audits to ensure standards of record keeping have improved and remain of a high standard.

The Healthcare Manager should ensure that first and second health screening interviews take place and that they are appropriately recorded in the prisoner's medical record.

The Healthcare Manager should ensure that patients are seen in secondary care when medically indicated and the reason for non-attendance is clearly documented in the prisoner's medical record.

ISSUES

80. According to Doncaster's own management responsibilities for hospital escorts and bedwatches (HMP and YOI Doncaster Security Escorts and Bedwatches – Hospital escorts and bedwatches management responsibilities 20 July 2007) the following options are available to the Director:

    i. Where the risk assessment indicates that restraints are necessary, escort and bedwatch with two officers or more with restraints applied.
    ii. Where the risk assessment indicates that restraints are unnecessary, escort and bedwatch with two officers or more, without restraints.
    iii. Where the prisoner's medical condition or lack of mobility is such that he or she cannot escape unaided, and there is no evidence that an escape attempt is likely, escort and bedwatch with one officer, without restraints.
    iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
    v. Exceptionally temporary release remand prisoners to remain in hospital if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952).

81. Doncaster did not provide my investigator with evidence that the risk assessment for the man was revised (to acknowledge his limited mobility and lack of evidence of an escape attempt).

    The Director should review HMP Doncaster's policy for the management and conduct of hospital escorts and bedwatches.

    The Director should ensure that staff adhere rigorously to published policies on risk assessment of prisoners receiving in-patient treatment in outside hospital.

CONCLUSIONS

82. The man arrived at Doncaster in March 2007 and, after being transferred to outside hospital, died of natural causes in November 2007. From the bedwatch log, I believe that the staff involved with the man's care behaved with compassion and sensitivity.

83. However, the security arrangements at the hospital, although initially suitable, were not revised in the light of the man's specific circumstances. Doncaster had the option of reviewing and revising the risk assessment. There should have been a careful risk assessment and it should have paid attention to the man's severe disability problems. The option of removing restraints and having two officers on bedwatch duty could have been a more appropriate response in this case. It is indeed very sad that the man was still handcuffed when he died. I recommend that the Director of Doncaster reviews the policy for the management of hospital escorts and bedwatches. This review should consider the recent case law relating to prison escorts (Mr Justice Mitting's judgement on 23 November 2007) and the particular circumstances of this death.

84. Both I and the clinical reviewer conclude that no appropriate adjustment had been made regarding the man's disability and needs, and it seems that the care he received was not comparable with that he could have expected to receive in the community. HMP Doncaster has a Disability Policy to ensure prisoners with disabilities are not discriminated against in any aspect of prison life and that equality of opportunity in accessing all parts of prison life is offered to all prisoners. It is clear from the evidence that staff in HMP Doncaster did not follow the policy with regard to the man.

85. The man arrived in custody with serious medical needs which required support to be provided by Doncaster. I do not consider that adequate support was given to him. The man's diabetes and related conditions needed close supervision. His particular special needs also required individually tailored care which was not made available. The man's care was not satisfactory and was not equitable to that he would have received in the wider community. The findings of my own investigation, and the clinical review, highlight that improvements to medical practices and access to facilities at Doncaster need to be made. I endorse the recommendations from the clinical review. These need to be addressed by the Director of Doncaster and his healthcare provider.

RECOMMENDATIONS

Operational

1. The Director should review HMP Doncaster's policy for the management and conduct of hospital escorts and bedwatches.

   Accepted - This will be reviewed as part of the preparation for the visit by Standards Audit Unit (SAU).

2. The Director should ensure that staff adhere rigorously to published policies on risk assessment of prisoners receiving in-patient treatment in outside hospital.

   Accepted - Security Unit Managers/Senior Management Team (SMT) to carry out checks in line with procedures laid down in National Security Framework (NSF)/Local Security Strategy (LSS).

Medical

3. The Healthcare Manager should ensure that staff seek medical summaries for all new prisoners from their registered General Practitioner.

   Accepted - There is a system in place to carry out this procedure for any prisoners with chronic illnesses or medication issues.

4. The Healthcare Manager should ensure that all staff are trained and kept up to date in the following areas:

   - awareness of and familiarity with HMP Doncaster's Disability Policy
   - record keeping
   - barrier nursing
   - formal referral procedures for secondary care.

   Accepted - These issues will be added to the annual training plan.

5. The Healthcare Manager should improve communication between the prison and external agencies.

   Accepted - Links with external agencies have improved and we now work more closely with the PCT to develop information sharing protocols.

6. The Healthcare Manager should carry out regular audits to ensure standards of record keeping have improved and remain of a high standard.

   Accepted - There is now an audit in place to spot check record keeping.

7. The Healthcare Manager should ensure that first and second health screening interviews take place and that they are appropriately recorded in the prisoner's medical record.

Accepted - This takes place during the reception process.

8. The Healthcare Manager should ensure that patients are seen in secondary care when medically indicated and the reason for non-attendance is clearly documented in the prisoner's medical record.

   Accepted - A system is in place to record and monitor any out-patients appointments that are cancelled or postponed and the reasons for this.