

**Investigation into the death of a man whilst in the custody
of HMP & YOI Moorland Closed on 21 December 2008**

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

January 2010

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

This is the report of an investigation into the death of a 49 year old prisoner at HMP & YOI Moorland Closed. The man died on 21 December 2008 in outside hospital from natural causes. He had been admitted to the hospital on 8 December.

The man was a highly decorated former member of the armed forces who suffered from post traumatic stress after his discharge. The man also had a long history of alcohol abuse which was ultimately the cause of his early death.

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

This investigation was undertaken by one of the Ombudsman's investigators. In addition a review of the man's clinical care was commissioned by Doncaster Primary Care Trust. I am grateful for the assistance the clinical reviewer and investigator received from staff at HMP & YOI Moorland Closed and would ask the Governor to pass on these sentiments. I must apologise for the delay in issuing this report which was caused by the late receipt of the clinical review.

Although the care that the man received was comprehensive, the clinical reviewer concludes that aspects of it were not of an equivalent standard to that he would have received in the wider community. Particular mention is made of the importance of timely responses to blood test results. The reviewer identifies a number of learning points that the prison health partnership will wish to consider.

Jane Webb
Deputy Prisons and Probation Ombudsman

January 2010

SUMMARY

The man was born in 1959 and was 49 years old when he died in outside hospital on 21 December 2008. The man's death was from natural causes, as a consequence of liver failure.

The man was remanded into custody at HMP Brixton in February 2006 and transferred to HMP Standford Hill on 12 September. He was sentenced at Crown Court in March 2007 to five years imprisonment. This was later reduced to 42 months and the man was released early from custody on licence on 12 November.

The man was recalled to custody on 3 April 2008 after he failed to comply with his licence conditions and committed a further offence. He was initially held at HMP Doncaster before being transferred to HMP & YOI Moorland Closed on 6 October 2008.

During his health screening interviews, it was recorded that the man had a history of alcohol abuse which led to him developing a chronic liver condition. He had previously been diagnosed with Post Traumatic Stress Disorder.

During the morning of 8 December, the man appeared to be confused and had not eaten his meal from the previous day. After an assessment by a doctor and nurse he was taken to outside hospital. The initial security risk assessment concluded that an escort chain was to be used with two officers present at his bedside. The risk assessment was revised later and the restraints were removed.

After his admission to hospital the man's condition continued to deteriorate and his death was pronounced at 9.35pm on 21 December.

After it was confirmed that the man had died, Moorland activated its death in custody contingency plan. The police were informed and visited the hospital. They found no suspicious circumstances and the man's body was released to the undertakers who removed him to the mortuary for post mortem examination. The Coroner's officer informed the Head of Residence at Moorland who was managing the prison's response following the man's death, that he had died from natural causes.

The clinical review identifies a number of issues relating to the care provided for the man, especially regarding prompt attention to the results of blood tests. The review highlights areas of practice that could be improved, and makes three recommendations for service improvement at Moorland and one recommendation for the Primary Care Trust to consider.

THE INVESTIGATION PROCESS

1. The investigation was opened on 22 December 2008 by one of the Ombudsman's investigators. He issued notices announcing the investigation to both staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the man's death to make themselves known. In the event, no one came forward. The investigator also studied all relevant prison records, which included the man's main prison record and his medical records.
2. The investigator visited HMP & YOI Moorland Closed on 10 February and 11 March 2009 and discussed aspects of the man's treatment with staff. He interviewed three Prison Officers and a Senior Officer. The investigator also interviewed a member of the chaplaincy team at Moorland.
3. The Doncaster Primary Care Trust commissioned a Quality Commissioning Governance Manager to carry out an independent review of the man's clinical care. I am grateful to him for undertaking the review.
4. The investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner.
5. One of the Ombudsman's Family Liaison Officers contacted the man's brother. This gave him the opportunity to discuss the purpose of the investigation and raise any concerns that he wanted to be addressed. He chose not to raise any concerns at that time. The man's brother spoke very positively about the help and support he received from prison staff.

HMP & YOI MOORLAND

6. HMP & YOI Moorland is a large and complex prison divided between two sites known as Moorland Open and Moorland Closed. Moorland Closed is a training prison for both adults and young offenders. Moorland Open is located a few miles away. Both sites are located in a rural setting approximately eight miles from Doncaster town centre and have a mixed population with a capacity to just over 1,000 men.
7. The investigator reviewed the Ombudsman's reports into earlier deaths from natural causes at Moorland Closed. He found no issues in common with this investigation.

Independent Monitoring Board

8. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The most recent annual report by the Moorland IMB was published in February 2008. The IMB found that Moorland Closed provided a high standard of healthcare, and commended efforts to ensure that prisoners had purposeful activity through work and education. The IMB report summarised the prison in the following way:

“HMP& YOI Moorland is a well-established, high-performing prison, providing a safe, secure and aesthetically pleasant environment for prisoners together with ample provision for education, purposeful activity and opportunities for outwork.”

Her Majesty's Chief Inspector of Prisons

9. The most recent inspection of Moorland by Her Majesty's Chief Inspector of Prisons, Dame Anne Owers, was an unannounced inspection in October 2008. The report of this inspection was published in April 2009. In her report, the Chief Inspector found that Moorland was a reasonably safe prison. However, the Chief Inspector said that: “neither the physical environment nor staff-prisoner relationships were sufficiently good”. She described the relationship between prisoners and staff as “distant and distrustful” and said that personal officer work was “virtually non-existent”.

KEY EVENTS

10. The man was remanded into the custody of HMP Brixton in February 2006 after he committed an armed robbery. During his first reception health screening interview, it was recorded that he had a history of alcohol abuse and had been previously diagnosed with Post Traumatic Stress Disorder following his experiences in the armed forces, particularly whilst serving in the Falklands War. In the man's case they included anxiety, insomnia, blackouts, flashbacks and nightmares.
11. On 22 March 2007, the man was sentenced at Crown Court to five years imprisonment. This was the man's first experience of prison. The Court of Appeal reduced the sentence to 42 months on 22 August. The man transferred to HMP Standford Hill on 12 September.
12. The man was released early from custody on licence on 12 November. The licence included a range of conditions including:
 - Be well behaved, not commit any offence and do anything which could undermine the purposes of your supervision, which are to protect the public, prevent you from re-offending and help you to resettle successfully into the community.
 - Keep in touch with your supervising officer in accordance with any instructions that you may be given.
 - Permanently reside at an address approved by your supervising officer and notify him or her in advance of any proposed change of address or any proposed stay (even for one night) away from that approved address.
 - Undertake only such work (including voluntary work) approved by your supervising officer and notify him or her in advance of any proposed change.
 - Attend all appointments arranged for you with the mental health and criminal justice team (or equivalent) and co-operate fully with any care or treatment they recommend. To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your alcohol and offending behaviour problems.
 - The Secretary of State may vary or cancel any of the above conditions, in accordance with Section 250(4) of the Criminal Act 2003.
13. The man missed a re-arranged appointment with his case manager on 6 December 2007 and was sent a warning letter. When he attended on 11 December, the man told his case officer that he had been working but did not provide any evidence. The man also showed some signs of being under the influence of alcohol.
14. A further warning letter was issued when the man missed another appointment on 29 February 2008. However, the man produced a police incident number to confirm that he had been involved in a road traffic accident and the absence was recorded as acceptable. Another warning letter was issued the following week after the man missed an appointment on 6 March. Subsequently on 14 March, the man was issued with a final warning letter from the Divisional

Manager for failing to comply with the licence condition to 'Keep in touch with your supervising officer in accordance with any instruction that you may be given'.

15. On 29 March, the man was arrested for theft and five days later (on 3 April) the Public Protection Unit of the Ministry of Justice informed the man that his licence was revoked and he was recalled to prison. He arrived at HMP Doncaster on the same day.
16. The man was admitted to healthcare on 10 April, for 'odd behaviour' (no more details are provided in the wing file). He was also referred to the Prison Community Mental Health Team by a prison doctor. Three days later the man fell from a toilet and was found with his right foot stuck in the bowl. He received a cut to his head and was placed under observation. On 19 April, the man moved to the upper healthcare dormitory.
17. Five days later, on 24 April, the man was admitted to outside hospital as he appeared to be confused. He returned from hospital the following day and was again located on the healthcare wing.
18. On 30 April, other inmates expressed concerns to officers as the man had urinated in a corner of the dormitory and spent the night sitting up in bed.
19. The man was again taken to outside hospital on 2 May for an echocardiogram (a test which uses high frequency sound waves to create an image of the heart and surrounding tissues) and, on 23 May, for an endoscopy. (An endoscopy is a test that looks inside the body. The endoscope is a long flexible tube that can be swallowed. It has a camera and light inside it.) He returned to the prison later that day.
20. In his letter to Doncaster dated 17 June, a Community Mental Health Nurse said that the man:

“no longer presents as confused and delusional, he may have some memory problems, but recently scored 30/30 on the Mini Mental State Examination test. ... (the man) no longer needs the support of Prison Community Mental Health Team and I will be discharging him from my caseload. There are no plans for follow up by Mental Health Services in Doncaster.”
21. On 18 May, the man was sentenced at Magistrates' Court to one month's imprisonment.
22. The man moved to wing 2B on 7 July and was given a job as a wing cleaner. He gave the job up on 2 October.

23. Four days later, on 6 October, the man transferred to HMP &YOI Moorland Closed. After his induction the man was located in a single cell on Houseblock 2. When asked why the man was transferred from Doncaster, the Head of Residence at Moorland, said:

“Doncaster is a remand prison and regularly send short term prisoners to us to make room for those from court, it is not uncommon for prisoners with as little as four weeks [to serve] to arrive each week.”

24. The man was seen by a prison doctor on 28 October. After an assessment was carried out, the doctor referred him to the Mental Health In Reach Team and the optician. The doctor also requested various blood tests and an electrocardiogram (ECG is a graphical recording of the electrical activity of the heart) test was carried out. On the following day a fasting blood test (including fasting glucose levels) was taken from the man. A urine sample was also taken and sent for analysis to the hospital. The urine sample was analysed and reported as normal. The man’s blood sample showed a high glucose level.
25. A Consultant Forensic Psychiatrist assessed the man on 5 November. He recommended that a further assessment was carried out the following week which should include consideration of his brain (cognitive) function. The assessment was carried out on 13 November, when the man had a ‘normal test’ and no significant cognitive deficit was identified. In his letter following the assessment, the psychiatrist noted that the man had a complex medical history. He recorded that, in addition to his existing conditions, the man had an abnormal expansion of the veins in the throat that occurs as a result of liver disease and Korsakow’s syndrome (This is characterised by profound short-term memory loss in which the person is not able to remember recent happenings). The psychiatrist concluded that the man did not display any active symptoms of mental illness.
26. On 20 November, the man was seen by a prison doctor about pain in his leg, which related to an injury that occurred four to five years previously. The injury had been aggravated approximately two weeks earlier when he was getting out of bed. The man was prescribed pain killers and a referral was made to the physiotherapist. A urine sample was also sent for analysis. The result of the test was issued four days later, on 24 November. There is no indication that the results were given any attention until 18 December when it was signed as having seen by the prison doctor. By this time the man was no longer in Moorland.
27. The man was seen again by the prison doctor on 28 November as he was experiencing ongoing pain, particularly in his lower back. Further pain killers were prescribed. The notes in the man’s record suggested that he had previously ‘overdosed’ on ibuprofen which had led to him experiencing a nose bleed. An intramuscular injection was given.
28. Nursing staff saw the man again the next day as he was under the impression that the pain killing injections were going to continue. It was explained it had

been prescribed on a one off basis. The man was advised to keep mobile especially when he had sciatic pain. A note was made for a further review in the afternoon. (This is the first mention within the notes of the pain being sciatic type pain.)

29. The nurse saw the man again that afternoon in his cell. He was again advised to remain mobile and go to the treatment room for more medication later that day. It was recorded that the man felt well at this visit and had not experienced any further nose bleeds. An appointment to see the doctor was to be arranged for the following Monday (1 December) if there was no improvement. When the man was seen for the third time that day it was noted that he managed to walk to the treatment room for his medication, albeit 'slowly and cautiously'.
30. On 30 November, as the man did not go to collect his medication in the morning or at lunch time, a nurse went to his cell. The man said that he had been able to walk a little in the morning but that it was now too painful for him to get off his bed. He was again advised to try and mobilise but refused to do so. He asked for more pain killing injections but took the oral pain killers that had been prescribed. It was also noted that the man might need to be reviewed by the Mental Health In Reach Team.
31. Three days later, on 3 December, the man was reviewed by a psychiatric nurse who suggested that he did not need further input and had been discharged by the psychiatrist. The man was also seen by the prison doctor who noted that his pain was not controlled and changed his pain killers. The doctor noted that the man could have diabetes and suggested that this should be followed up. The man was seen again by the prison doctor on the following day and the stronger pain killers were prescribed.
32. On 5 December, nursing staff noted that the man appeared to be slightly confused and he seemed to be under the impression that he was due to be released from custody. During the morning of the following day the man was assessed by a nurse in his cell. The areas of concern which were identified included lack of mobility due to sciatic type pain, and eating and drinking very little. It was noted that he appeared slight jaundiced. His medication was causing him to feel drowsy but was not lessening his pain. A discussion took place with a nurse prescriber and the medication was altered to try and alleviate the pain. Additional supplement/vitamin medications were ordered as well as supplement drinks. The man told the nurses that he had been coughing up blood. He was seen later in his cell in the afternoon and given more medication. It was noted that his pain was better.
33. The man's personal officer recorded the following two entries in the wing observation book on 6 December:

“... the man is suffering from sciatica at the moment. He has received medication from the doctor and is finding it difficult to move around, he states that considering his situation he is ok.”

“The man is being provided medication in his cell by healthcare staff. He has been a little confused today stating that he has had a visit to his cell by his outside probation officer and solicitor. This is obviously untrue and healthcare say that this confusion can be caused by his medication.”

34. On 7 December, the man was seen by nursing staff who noted that he was slightly disorientated. He was drinking and eating and did not complain of pain. His medication was reduced by a small amount to help the slight confusion and arrangements made for him to see the doctor.
35. The following day, 8 December, the man appeared to be more confused and had not washed. He had also not eaten his meal from the day before. The man was seen by a nurse and doctor. He had walked onto the landing but then lowered himself to the floor. The nurse expressed her concerns and the doctor thought that he needed in-patient care. He was taken to the Accident and Emergency (A&E) department at a local hospital. After tests were carried out, the man was admitted to the hospital.
36. Whilst the man was an in-patient at the hospital, a bedwatch was carried out by prison staff. The initial security risk assessment identified that an escort chain should be used and two prison officers should be in attendance. Staff on bedwatch duty maintained a log of activities whilst the man was an in-patient.
37. At around 11.10pm on 18 December, the escort chain was removed at the request of nursing staff, due to swelling in the man's wrist. The chain could not be moved to his other wrist where a cannula (an intravenous tube used to administer medication) had been inserted. Once the swelling subsided, at around 6.30am the following morning, the escort chain was re-applied.
38. One of the officers on bedwatch duty during the evening on 18 December was interviewed as part of this investigation. She said that the man had asked her to contact a member of the prison chaplaincy team. The officer said:

“I'd asked if he had, or somebody had informed his family that he was in hospital and he said that they had asked if he would like them to be informed and he said no. But now he said he feels as if he just needed to see his daughter one more time, tell her how much he loved her. And he asked me, well I suggested that would he like me to contact [the chaplaincy] to contact his family and he said yes he would. Throughout the night then he kept drifting; he was rambling a lot as if, I don't know, as if like he was tired, medication had kicked in or whatever and then he'd wake up and would start talking again but was like that throughout the night. And I saw a big deterioration in him during the night from the beginning to me leaving, it was as if a week had gone by. His health had deteriorated that much.”
39. After the officer finished her bedwatch duty, she telephoned Moorland and informed a Principal Officer of the man's request to see a member of the chaplaincy.

40. When interviewed as part of this investigation a member of the chaplaincy staff confirmed that she saw the man when he was first taken into hospital. At that time the man told her that he did not want his family informed that he was in hospital. When she arrived for work on 19 December, she received a message that the man wanted to see her. She immediately went to see him and he asked her to contact his ex-wife to see whether it was possible for his daughter to visit him. As there were no limitations relating to contact with his family, she agreed to his request and contacted the man's ex-wife.
41. At 3.55pm on 21 December, it was recorded in the bedwatch log that the doctor was liaising with a senior consultant about the man's condition. The nursing staff asked the man at 4.16pm if there were any next of kin he would like them to contact but he declined their offer. At around 5.00pm, after a review by the duty governor and due to the deterioration in the man's health, the restraints were removed and not re-applied. A Senior Officer and Prison Officer took over responsibility for the bedwatch at 7.35pm. Just over an hour later at 8.40pm, the man was reviewed by a hospital doctor who took some blood samples and fitted another cannula.
42. When interviewed for this investigation, the Senior Officer said that he had carried out a previous bedwatch on 17 December. He said that on the previous occasion the man was "sat up in bed talking and joking with us, in quite a good mood. He was in a bit of pain but quite jovial at times". When asked about events on 21 December, the Senior Officer said: "The first thing I noticed about the man was that he wasn't in a well state. He was semi unconscious and breathing erratically."
43. The man's condition continued to deteriorate and at approximately 9.15pm the bedwatch staff noticed that he had stopped breathing. The officers immediately informed the hospital staff who confirmed that the man had died. He was pronounced dead at 9.35pm by a hospital doctor. The Senior Officer informed Moorland that the man had passed away.
44. The prisoners on Houseblock 2 were told the following morning about the man's death. The staff asked whether they required anything or wanted to speak to a Listener. (Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.) When the bedwatch officers returned to the prison they were offered support from the prison's care team.
45. The post mortem report records the man's death as due to natural causes as a consequence of liver failure caused by cirrhosis of the liver and chronic excess alcohol ingestion.
46. After his death the prison informed the man's ex-wife that he had died. She did not wish to meet the prison family liaison officer, and asked only to be informed of the date of the man's funeral. The prison arranged for the man's parents to be informed of his death.

47. When contacted by one of the Ombudsman's family liaison officers the man's brother explained that their father had a stroke about four years ago and suffered from poor health. The man's father was in respite care and his mother was away on holiday at the time of his death. The brother said that when he was sober, the man had been a proud man and he respected the need to protect his parents from his problems. There had been no contact for the intervening four years and the family did not even know that he was in prison. Moorland had asked the local police to inform the family of his death but when they visited the home address neither of the parents were there. It was only when a neighbour explained that the man's brother lived nearby that they were able to break the news to him.
48. The family said that the support the prison family liaison officer had given to the family had been "exceptional". She made all the funeral arrangements and ensured that the family were aware of the financial contribution that the prison would make. They were grateful for the kindness and support given during that difficult time. The family felt that all their questions have been answered by the prison and they had no concerns about the man's death.

ISSUES CONSIDERED

Clinical care

49. In his review, the clinical reviewer records that the man was assessed by healthcare staff at Moorland and a range of medical investigations were carried out. The results of various blood tests indicated that the man had ongoing liver problems. The results also indicated an abnormal glucose level, but the clinical reviewer could not find any evidence of actions taken in response.
50. The clinical reviewer draws attention to a urine sample result sheet which was sent to the laboratories on 20 November. The result was issued four days later but not signed and dated until 18 December by the doctor, which is when I assume they were first read. (By this time the man was being treated in hospital.) The clinical reviewer judges that the man was not given timely and appropriate treatment for the infection which may have contributed to his deterioration.

The Head of Healthcare should review its process for managing sample requests to ensure that blood tests and other tests are carried out effectively and the results made available to the appropriate healthcare staff in a timely fashion.

51. The clinical reviewer finds that the overall standard of healthcare record keeping was below adequate levels. The entries in the healthcare record are not clear and some entries were difficult to read and in some places illegible. The clinical reviewer notes that some entries in the healthcare record were not timed and the signature and designation of staff was not always present or clear.

The Head of Healthcare should ensure that all medical staff are trained and kept updated in record keeping. An audit plan should be put in place particularly concerning standards of documentation.

52. The clinical reviewer records that the man was regularly cared for by healthcare staff and other practitioners throughout his time at Moorland. However, within the documents reviewed, there do not appear to be any formal care plans. The clinical reviewer recommends that care plans should be prepared to promote consistent nursing practice. He suggests that the care planning process should be reviewed.

The Head of Healthcare should review the care planning process to ensure that, when necessary, appropriate care plans are developed.

53. The clinical reviewer concludes that the care received by the man was not of an equivalent standard to that which would have been expected within the general community. In particular, he highlights the apparent delay in reviewing the urine sample and that no further action was taken regarding his raised glucose levels.

54. After receipt of the draft report, a solicitor representing the man's family, forwarded representations on behalf of her client. The solicitor asks whether the clinical reviewer could consider the man's overall treatment whilst in custody from the date of his recall in April 2008. In his written response the clinical reviewer wrote:

"The clinical review focused upon the care the man received whilst in Moorlands Closed and did not examine the care received at HMP Doncaster. In relation to the man's history and diagnosis, he did receive assessments and input from Mental Health services that include a Forensic Psychiatrist and Community Psychiatric Nurse and was eventually discharged from their service in June 2008. Whilst in Moorland Closed, the man received assessments from a Consultant Forensic Psychiatrist and this was included within the original report."

55. The solicitor asks whether any liver functions/kidney function tests carried out whilst the man was in prison custody. She says it was hard to ascertain this to any degree of certainty from the medical records provided. In his response, the clinical reviewer wrote:

"Blood tests were conducted during the period of time that he was in custody. The records that were made available for the purposes of the clinical review indicate that blood tests were taken on the 28 October 2008. This is documented within the medical record and also there are blood test results contained within the record."

56. The solicitor states that the man was clearly suffering from back pain in the weeks before his admission to hospital and was diagnosed with sciatica. The Post Mortem Report clearly suggests that he may well have been suffering back pain as a result of an untreated Urinary Tract Infection. The solicitor asks whether sciatica was a reasonable diagnosis in all the circumstances given the overall diagnosis. In response, the clinical reviewer wrote:

"It would be difficult to say from the review of the documents whether this was entirely reasonable or not. It is possible that the man was indeed suffering from sciatic type pain as well as experiencing a urinary tract infection. There are documents within those made available for the review that indicate that the man had previously experienced back pain some years earlier. At the point the man presented to the doctor with painful symptoms a urine sample was also sent for analysis which did indicate that the man was experiencing an infection. The report for this sample was issued by the hospital on the 24 November 2008 although not signed and seen by the doctor until the 18 of December 2008."

57. The solicitor asks for clarification of the significance of the blood test result of the 28 October 2008 which stated that the man was suffering from continuing Thrombocytopenia. In his response, the clinical reviewer wrote: "From the blood test results contained within the documents, the Thrombocytopenia had been long standing and was not at a significantly low enough level to be causing symptoms".

58. The solicitor also asks the significance of the high glucose on 24 April 2008 8.6, 28 October 11.8 when the normal range is 3.3 – 6. In his response, the clinical reviewer wrote:

”I believe that this was addressed within the original report in section 4. It mentions the abnormal blood glucose level and the fact that this did not appear from the documents, to have triggered any further investigation into the reasons for this. Within general practice, results of this nature would have been investigated further.”

59. The solicitor says that in the records following the man’s assessment at outside hospital in June 2008 the clinician stated: “his liver function currently is “reasonable and he could remain well for years so long as he abstains from alcohol”. The man was, and had been, abstaining from alcohol. The Post Mortem report seemed to suggest that the failure to treat the urinary tract infections in the context of severe liver disease would have been enough to tip the liver into decompensation and failure. In his response, the clinical reviewer wrote:

“Again I believe that this was addressed within the original report within section 4. The abnormal urine samples are discussed and that from the documents available, it would appear that the man was not given timely appropriate treatment for this infection. It is possible that this was a factor in his deterioration condition.”

Use of restraints

60. Whilst the man was an in-patient, he was escorted by two officers and remained in restraints until shortly before his death.
61. The use of restraints for prisoners on escort to hospital has been the subject of recent case law in relation to the issue of decent and humane treatment. (Judgment by Mr Justice Mitting on 23 November 2007 in the case of (1) Graham (2) Allen v Secretary of State for Justice.) I know that the Prison Service is currently drawing up new guidance in relation to this matter. Moorland’s decision that the man should be restrained in the first instance was in line with its standard procedures. At the time the escort chain was applied, the man was conscious and was judged to pose a security risk.
62. According to the policy for performing hospital bedwatches when the man was in hospital, the following options were available to the Governor:
- i. Escort and bedwatch with two officers or more, with restraints.
 - ii. Escort and bedwatch with two officers or more, without restraints.
 - iii. 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 for remand prisoners 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).

The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

63. When the man was taken to hospital on 8 December 2008, the security risk assessment was that an escort chain should be used and two officers needed to be in attendance. The use of an escort chain enabled the nursing staff to have easy access to the man when they carried out their duties. The risk assessment for the man was revised during his time in hospital when his condition deteriorated. Restraints were removed and then re-applied when the man's condition improved.
64. The risk assessment was revised on 21 December after the duty governor was informed by nursing staff that the man was terminally ill. The restraints were then removed and not re-applied. The man died later that same evening.
65. I believe that the revision of the risk assessment was timely. The man was poorly but had been in good spirits in the days leading up to his death. The cause of his malaise was being investigated by staff at outside hospital. When nursing staff informed the duty governor that the man's condition was terminal, the risk assessment was revised and the restraints were promptly removed.
66. I am pleased to report that the investigator found that the bedwatch notes were concise, legible and appropriate. The Governor may wish to relay that positive finding to the staff concerned and their managers.

CONCLUSION

67. The man arrived in HMP & YOI Moorland Closed on 6 October 2008. He died in outside hospital 11 weeks later on 21 December 2008. He had a long history of abusing alcohol and it seems that this was the cause of his early death.
68. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital seem to have been suitable, and to have struck a good balance between public protection and respect for the man.
69. In light of the clinical review, I agree with the clinical reviewer's conclusion that the man's care was not equivalent to what he would have received in the wider community. The findings of the clinical review and the Ombudsman's own investigation highlight the need for improvements to healthcare practices at HMP & YOI Moorland Closed.

RECOMMENDATIONS

1. The Head of Healthcare should review its process for managing sample requests to ensure that blood tests and other tests are carried out effectively and the results made available to the appropriate healthcare staff in timely fashion.

Recommendation accepted: A local care pathway will be devised and staff will be asked to acknowledge and sign to agree to comply. All samples will be logged when taken all results will be signed for by a doctor on return and appropriate actions scheduled for further follow up.

2. The Head of Healthcare should ensure that all medical staff are trained and kept updated in record keeping. An audit plan should be put in place particularly concerning standards of documentation.

Recommendation accepted: Staff will receive record keeping guidance and will be asked to sign to say that they have read, understand and agree to comply with it. Record keeping training days will be scheduled and will form part of a rolling programme of mandatory annual training.

3. The Head of Healthcare should review the care planning process within healthcare be reviewed to ensure that when necessary, patients have appropriate care plans developed.

Recommendation accepted: A full review is taking place to include all aspects of care planning and this will be used to develop a policy which is clinically compliant.