Investigation into the circumstances surrounding the death of a man in March 2011 in hospital, while in the custody of HMP Guys Marsh

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is the report of the investigation into the death of a man who died in March 2011, in hospital, while in the custody of HMP Guys Marsh. The man was 29 years old. A week before his death, he was admitted to hospital for an operation to remove a tumour from behind his left eye. In the early hours of 26 March, there was a sudden and unexpected deterioration in his health following a surgical procedure. The man was placed on a life support machine and his family were called to be at his bedside. He died at 2.30pm. I extend my sincere condolences to the man's family and friends at the tragic loss of this young man.

Her Majesty's Coroner for Western Dorset District did not hold a post mortem examination into the man's death. He gave permission for the man's funeral service to take place in accordance with Islamic tradition. The Coroner recorded that the man died of natural causes due to a brain tumour and post surgical complications.

My colleague was appointed as the investigator and a review of the man's medical care was commissioned with Dorset Primary Care Trust (PCT). I am grateful to a doctor for that review.

I would like to thank the Governor of Guys Marsh and his staff for their assistance with this investigation. I am especially grateful to the liaison officer for her help and support.

I make three recommendations in this investigation report. One is for the attention of the Chief Executive of Dorset PCT, relating to information sharing at HMP Dorchester's healthcare unit. (I also note three recommendations made by the clinical reviewer regarding secondary health care.) I make two recommendations for the attention of the Governor. One relates to recording his correspondence and the second regarding contacting named next of kin. As a housekeeping point, I ask the Governor to consider reviewing the risk assessment of prisoners following major surgery and being cared for in high dependency or intensive care units. Finally, I acknowledge the clinical reviewer's commendation of good practice by Guys Marsh healthcare staff and the professionalism of the chaplaincy staff in their care for The man's family.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2011**

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SUMMARY

1. The man was sentenced to 18 months imprisonment in January 2011 for fraud. When he arrived at HMP Dorchester, he was seen by a reception nurse and his medical history noted. The man told the nurse that he had been seen as an outpatient at an eye hospital in December 2010, for a visible swelling behind his left eye, but had no other medical issues.

2. The following day, a Saturday, the man was seen by a locum doctor who noticed the swelling behind his eye. The doctor noted that The man should be referred to a hospital for a computerised tomography (CT) scan. (A CT scan takes images of the body's tissues.) However, there is no evidence that this referral was made. According to the man's medical record, the healthcare unit made contact with an eye hospital for further information about his outpatient appointment. The hospital advised that no further treatment was planned but the man should be referred to a local hospital, if necessary. Nurses saw the man on two further occasions while in Dorchester for minor complaints not related to his eye.

3. A doctor saw the man on his transfer to Guys Marsh on 31 January and made an urgent referral to a hospital. On 8 February, he attended hospital and underwent medical investigations for the swelling behind his eye. However, it was nearly three weeks before the hospital wrote to Guys Marsh to explain what tests had been done at the hospital. By mid-March, the man's eye swelling was diagnosed as a tumour. The doctor arranged for his family to be kept informed and for healthcare staff to be vigilant should the man become unwell.

4. Solicitors acting on behalf of the man and his family wrote to the Governor at Guys Marsh on 8 March asking for a compassionate release. They wrote several other letters which asked that the use of restraints be reviewed and for a transfer to a prison nearer his family. The family's member of parliament (MP) also wrote to the Governor asking that the man be transferred. Although the prison had a record of receiving correspondence, there was no record of what action was taken or whether the Governor responded to the family. Following my investigation, I am satisfied that action was taken in response to the request for compassionate release, but this was not effectively recorded or communicated to the Governor, the man or his family.

5. The man was admitted to the neurosurgical unit at a hospital on 16 March for surgery. The operation was delayed until 24 March because there were not enough intensive care beds to accommodate the man afterwards. He underwent surgery on 24 March, which was stopped due to heavy bleeding. Following a second operation on 25 March, the man's health seriously deteriorated and he died on 26 March.

6. Of the three recommendations made in this report, one refers to the handover of prisoners' healthcare information by weekend staff. The second recommendation reflects the handling of Governor's correspondence. The final recommendation relates to the named next of kin being informed in

cases of emergencies. I make one housekeeping point for the Governor to consider reviewing risk assessments of prisoners in hospital. I note the professional manner in which the chaplaincy team carried out their duties

7. The clinical reviewer makes three further recommendations, which I am unable to endorse as they refer to secondary health care provision beyond the remit of this investigation. However, I ask the Chief Executive of Dorset PCT to consider them.

8. The clinical reviewer concludes that the man received equitable care to that in the community and that healthcare staff should be commended for their good practice in supporting him. I agree with the clinical reviewer that healthcare staff kept the man's family well informed of his situation, which was sensitive and appropriate.

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THE INVESTIGATION PROCESS

9. The investigation into the man's death was opened on 1 April 2011, when the investigator visited Guys Marsh. She was met by the liaison officer and reviewed the man's prison files. The investigator asked for selected documents from those files to be sent to her.

10. Later, the investigator visited the healthcare unit and met with the healthcare manager. She also visited Saxon wing and spoke to two prisoners who had known the man, and an officer. The investigator saw the cell that the man had occupied before he was admitted to hospital. Finally, she met with the Governor.

11. The Ombudsman's notices of investigation and terms of reference were sent to the prison in advance of The investigator's visit. Up to the circulation of this report, there have not been any responses to the notices. The Independent Monitoring Board (IMB) or the Prison Officer's Association (POA) did not ask to see my investigator. (The IMB are volunteers drawn form the community who monitor the day to day life of the prison, its staff and prisoners. The POA is the trade union for prison officers.) The investigator's contact details were left for each organisation should they wish to speak to her at anytime during the investigation.

12. A review of the man's medical care was commissioned with Dorset PCT. A doctor undertook that review on behalf of the PCT and it is the first annex to the investigation report.

13. One of my family liaison officers,(FLO) spoke to The man's sister and brother. His family raised several points that they would like the investigation to consider. Furthermore, the FLO telephoned the man's named next of kin from his prison record, his former partner. The former partner raised one point for consideration. Those points include lack of communication from the prison, the use of restraints, compassionate release, visits, informing the next of kin and the role of the Governor on the day the man died. All the points raised will be discussed in the issues section of this report.

14. On 23 May, an assistant ombudsman visited Guys Marsh and spoke to the Governor, his secretary, a governor and the chaplain. Following the visit, the investigator wrote to the Governor on 11 May to feed back her initial findings of the investigations.

15. In this final report the prison service has noted one inaccuracy, a misspelling of a name for which I apologise. Paragraph 36, the Governor disputes that four letters were sent to him with reference to The man's solicitor's requests for his compassionate release. Paragraph's 43 and 80 have been amended with the addition of the name of the chaplain. All recommendations have been accepted.

16. The investigator and the FLO met with the man's brother and his partner on 18 October. At the meeting, the man's brother expressed his continued

dissatisfaction regarding his and the family's care by the management team at Guys Marsh. It was agreed with the man's brother, that he would write to us outlining his comments on the draft report. The FLO advised the man that any further issues should be raised at his brother's inquest or through legal systems.

17. Following a meeting with the man's next of kin, the investigator wrote to the Governor on 26 October 2011 and asked him to accept the following recommendation, which was originally a housekeeping point in the draft report. The investigator wrote:

> "The Governor should ensure a risk assessment is undertaken for all prisoners prior to major surgery and those transferred to a high dependency or intensive care unit"

18. On 2 November the Governor replied:

> "It is my firm belief that the use of restraints was appropriate given the circumstances and responsive to the needs of the man and the medical team. Systems are already in place to review the use of restraints in all cases and this was shown to be successful in that the restraints were removed at the appropriate times."

In light of our original findings, and the Governor's response, we have not made this recommendation.

19. On 29 November, the man's brother wrote to the FLO giving his comments on the draft report.

- The man's brother reiterated concerns about the Governor's failure to respond to correspondence from The man's legal team We share the family's concerns and have considered the matter at paragraphs 67 to 70 of this report, with an associated recommendation.

- The family remain distressed by the presence of the prison officers at the man's bedside when he was seriously ill. The family commented that they felt this was disrespectful and insensitive. The family also questioned the timeliness of the risk assessment which was only carried out when The man's condition had deteriorated further. The man's brother in response to the draft report commented that they were unhappy about the decision to complete a further risk assessment at that time. The man was in custody at the time of his death, and consideration as to appropriate security measures had to be taken by the Governor's representatives. Consideration has been given to the appropriateness of restraints and the associated risk assessments at paragraphs 79 to 84.

- The man's family expected the Governor to attend the hospital. They were upset that he did not visit the man or speak to them personally after the man had died. It is unfortunate that the family were led to believe that

the Governor would attend them, and this matter is considered at paragraphs 85 and 86.

- While the family were grateful for the support of a chaplain and an Imam. they commented on the fact that they were not offered the services of a trained family liaison officer. We recognise the short fall in family liaison training and consider it in detail at paragraphs 87 to 92.

- In conclusion it was the man's brother's opinion was that the prison management had failed to support both the man and his family.

HMP GUYS MARSH

20. Guys Marsh is a category C training prison. (A category C training prison holds prisoners deemed as medium risk of escape and offers opportunities for them with vocational work in preparation for their release.) The prison has grown considerably over the years, is modern in design and takes prisoners from a large catchment area including London, the Midlands and the South West.

21. Healthcare services are commissioned by the Dorset Primary Care Trust (PCT). Guys Marsh does not have 24 hour medical cover. Healthcare staff are on duty from 8.00am to 6.00pm daily, including weekends. Access to healthcare appointments is through an application system, however special arrangements were made for emergencies. A local doctor holds seven consultation sessions a week and there is usually a wait of 48 hours for an appointment.

22. Her Majesty's former Chief Inspector of Prisons carried out a full announced inspection of Guys Marsh in January 2010, said of healthcare services:

> "The healthcare department was generally well maintained, but an increase in clinics meant that there were often difficulties in providing enough clinical and interview rooms. The staff group was well trained and motivated, and prisoners were generally content with most health services. Primary care was good and there was speedy access to the GP and dental services … Relationships between health and prison staff were very good."

23. In their 2009 -2010 report, the Independent Monitoring Board, summarised:

> "The Board continues to view HMP Guys Marsh as a decent and humane environment in which to hold men during their period of imprisonment. There are a high number of good quality, well trained professional staff who seek to work constructively with those under their charge."

24. The man's death was the first death at Guys Marsh for four years.

KEY EVENTS

25. The man was born in December 1981 in Birmingham and he was single. In January 2011, he was sentenced to 18 months imprisonment for fraud at a Crown Court. This was not his first time in prison.

26. On arrival at Dorchester, the man was medically assessed by a nurse. The nurse recorded that he was well except he waiting for a hospital appointment at a eye hospital. The following day, he saw a doctor. The doctor wrote that the man had sustained a serious left eye injury at the age of 16 years old. In December 2010, he had been seen at an eye hospital, as his left eye was swollen and protruding. The doctor noted that the man should be referred for a computerised tomography (CT) scan and blood tests. (A CT scan takes images of body tissues.)

27. A healthcare administrator made contact with the eye hospital on 25 January. The hospital indicated that the man was last seen there on 18 December 2010 and there were no further appointments for him. The hospital advised that the prison would need to register the man with a local hospital if any further treatment was required. There is no evidence in his medical records that the prison registered the man with a hospital.

28. The following day, a nurse wrote that the man had complained of a sore throat. However, she was unable to examine him due to the prison being 'in lock down'. (In lock down means that there is no access to prisoners' cells for security reasons and they are unable to leave their cells.) The man told the nurse that he completed a course of antibiotics before he came into prison.

29. The man was transferred to Guys Marsh on 31 January and was medically assessed by a healthcare worker who referred him to the doctor. The doctor saw the man on 3 February and made an urgent referral for him to see an ophthalmologist (eye specialist) at a hospital . Five days later, he attended the hospital as an outpatient and further tests, including a CT scan, were arranged.

30. A month later, the man had his next outpatient appointment at the hospital. On his return to Guys Marsh, he saw the doctor in the healthcare unit. The doctor noted that the hospital had prescribed Dexamethazone, a steroid and anti-inflammatory medication, Zopiclone to aid sleep and Omeprazole for excess stomach acid. There was concern that a tissue mass (tumour) behind his left eye may be cancerous. The doctor completed an entry in the man's medical notes by saying, "Can have appointments with doctor or nurses at short notice due to medical condition, thank you - high priority."

31. An entry in the wing observation book by an officer noted:

> "The man has a large tumour behind his eye. He will be going to hospital soon and he is on steroid medication. In his possession, by order MO [medical officer]. His general mood is very calm and is talking about it. Please monitor and if required, allow him to use the pin phone etc."

(The man was risk assessed as being able to retain his steroid medication in his possession as opposed to collecting it from nursing staff.)

32. The Governor received a letter from the man's solicitor on 9 March. The letter asked the Governor to consider a compassionate release for the man given his diagnosis of a tumour. The Governor's secretary recorded receipt of the letter on his correspondence log and then passed it to a governor, head of the office for classification and allocation (OCA) to process and respond.

33. According to the man's medical record, the doctor spoke to the man's sister and father by telephone that morning. The doctor explained that the man had a tumour behind his left eye and the healthcare staff were waiting for advice from hospital about his management plan. The doctor passed on the telephone number of the healthcare unit to the man's family so they could contact them directly for further information.

34. Two days later, a letter written by the man's family's member of parliament (MP) was received by the Governor. The MP asked for further medical information on the man's health from the Governor and asked him to consider transferring the man to Birmingham so he could be near his family. Again, this letter was noted on the Governor's correspondence log and passed to a governor for a response. There is no record of what action was taken. A nurse noted that the man's sister had telephoned the healthcare unit for an update on her brother's health that morning and asked about further hospital appointments.

35. An hour after that telephone call at 10.39am, a healthcare administrator wrote that the man was being admitted to hospital, as an urgent referral on 16 March in preparation for surgery. A nurse spoke again to the man's sister and updated her on the latest news. The nurse suggested that she should contact the chaplaincy department who would assist her in arranging to visit the hospital and offer support.

36. Another solicitor acting on behalf of the man wrote to the Governor on 14 March, asking him to support a transfer to a prison closer to his family. The Governor's secretary logged receipt of the letter on his correspondence log and passed it to a governor to respond. There is no record of a response being sent to this letter.

37. The man was escorted to hospital on 16 March, by two officers. Following a risk assessment, he was restrained by an escort chain. (A risk assessment is completed when a prisoner leaves the prison and assesses their risk of escape and that to the public. The type of restraint used is balanced against that risk. An escort chain is a 1.8 metre length of chain with one cuff attached to the prisoner and the other cuff to an officer). The man was admitted to a ward for pre-operation procedures. However, at 10.10am the following day, the man was told that he would not be having his operation, as there were no intensive care beds available for him after the operation. The man was told

he would remain in hospital for observation until appropriate aftercare was available following his surgery.

38. Later, the man's sister telephoned the healthcare unit for an update on her brother's condition. A healthcare administrator advised her to telephone the hospital directly and speak to ward staff. The administrator also telephoned the ward sister to pass on the man's sister's contact details and the advice she had been given.

39. Between 17 and 26 March, the Governor received four further letters from different solicitors pertaining to be acting on his behalf asking that he be released on compassionate grounds, that restraints should be removed and a transfer considered to a location near to his home. None of these letters were recorded onto the Governor's received mail log.

40. In response to the draft report, the Governor disputes that these letters were ever sent.

41. It was recorded on the bed watch notes that the man's family were allowed to visit him while he waited for his operation and he was allowed to telephone them. An Imam from Winchester visited the man on 23 March.

42. On 24 March, the man was taken to the operating theatre for his surgery and restraints were removed. Following his operation, he was moved to the recovery room at 6.00pm and the bed watch officers were told that the surgery had to be stopped due to excessive bleeding. Twenty five minutes later, the man was moved to the high dependency unit for observation. By this time, he was conscious although sleepy and the escort chain was replaced. The man's father visited him at 6.45pm.

43. The following day, a nurse telephoned the hospital for an update on the man's condition. His father visited his son and spoke to the hospital staff who confirmed that further surgery would be undertaken later that day. One of the bed watch officers, noted that the man's father was concerned that his son was restrained. The officer gave the man's father the telephone number of the prison's chaplaincy department so he could speak to them regarding the restraints. The officer also telephoned the control room to tell them that the man's father would be making contact with the prison. At 2.00pm, the restraints were removed and the man was taken for a CT scan followed by an operation.

44. The man was moved to the recovery room at 6.25pm. Ten minutes later, he was awake but sleepy and the restraints were replaced. The bed watch officers had not received any instructions from the prison that the restraints should not be used, therefore the officers complied with the risk assessment and security arrangements. The man was transferred to the high dependency unit at 7.00pm and he had a visit from his father. An officer noted that both men prayed and spoke together. The officer wrote in the bed watch notes:

"Despite this traumatic experience the man had demonstrated excellent behaviour, he is extremely polite and thankful to all hospital staff he meets. He had shown respect at all times to prison and hospital staff. Excellent conduct throughout."

45. A Senior Officer (SO) was on bed watch duty at 4.20am on 26 March and wrote, "The man, taken a turn for the worse, medical staff now giving emergency treatment". The restraints were removed on the request of a nursing sister. The SO further noted that the man had been taken for a CT scan and moved to the intensive care unit. At 5.50am, he was on a life support machine and unconscious. One officer stayed at the man's bedside while the second officer waited outside the intensive care unit.

46. The man's father came to see his son at 6.45am and spoke to hospital staff. At 10.00am, a hospital doctor told the bed watch officers that The man was seriously ill and not expected to "last the day". Both officers then respectfully made the decision to leave the man's room and stood outside near to the door.

47. When the Governor was notified of the serious deterioration in the man's health, he sought advice from the duty governor and the chaplain about whether he should visit. The Governor made the decision not to visit because he did not want to intrude on the family at such a difficult time. .

48. At midday, an Imam from Winchester made his way to the hospital to offer his support for the man's family and was later joined by Guys Marsh chaplain. (The Imam from Guy's Marsh was on long term sick leave so the Imam's from Winchester and Aylesbury kindly lent their support.) The bedwatch officer updated the duty governor about the seriousness of the situation at 12.10pm and that five members of the man's family were with him.

49. The man's death was confirmed at 2.30pm. An Imam from Aylesbury and the Guys Marsh chaplain acted as liaison officers between the prison and the man's family. His funeral took place on 27 March in accordance with Islamic tradition. A book of condolence was opened at Guys Marsh for prisoners and staff to record their messages of sympathy to his family.

50. The chaplain and Imam visited the man's family to hand over the book of condolence. In early April, they visited the man's former partner to return some of his property. An offer towards funeral expenses was made.

ISSUES

Clinical care

51. A review of the man's clinical care was commissioned with Dorset PCT. A general practitioner undertook the review on their behalf. The doctor considered the man's medical record and spoke to the medical officer at Dorchester.

Clinical care at Dorchester

52. The man arrived at Dorchester on Friday 21 January 2011. He told the reception nurse that his left eye was swollen and he had been seen at an eye hospital in December 2010. The following day, he was assessed by a locum doctor who noted that the swelling behind the man's eye would need a hospital referral.

53. A healthcare administrator contacted the eye hospital on 25 January for more details about the treatment of the man's eye. The healthcare administrator recorded that the eye hospital had advised Dorchester to re-refer the man to a hospital in their area if he had any more problems, but there was no further treatment planned at the eye hospital. The administrator wrote in the medical notes, " the eye hospital will write to confirm this", however, no such letter was attached to the man's clinical record.

54. Furthermore, there is no evidence that a hospital referral was made for the man by the healthcare staff at Dorchester. The man was transferred to Guys Marsh on 31 January and referred to hospital by a doctor on 3 February. The man was then seen at a hospital on 8 February.

55. The clinical reviewer says:

> "When in Dorchester prison was he [The man] in fact referred to the hospital but the letters failed to make the journey to Guy's Marsh and so on to me? Or was the referral never made, and if not why not? I suspect the latter is the case."

56. The clinical reviewer spoke to the medical officer at Dorchester. The doctor told the clinical reviewer that it is normal practice to transfer medical records, both paper and electronic when a prisoner moves to another prison. The man's records were transferred between Dorchester and Guys Marsh, and there was no evidence of a referral despite the locum doctor's assessment.

57. The medical officer explained to the clinical reviewer that he was not told for seven days that the man was a prisoner in Dorchester with a potentially serious condition. Despite the seriousness of the man's eye condition, he was feeling well. The first referral letter found in the man's medical record was written by a doctor on 3 February in Guys Marsh.

58. The clinical reviewer comments:

> "If the man had not been moved to Guy's Marsh, the delay before he realised no referral had been made may have been several weeks, as he felt well and would have believed his needs were being taken care of. There is real concern about the quality of both care and, particularly, handover from weekend staff to their successors on a Monday. "

59. The man arrived at Dorchester on a Friday. A locum doctor provided clinical cover over that weekend. The locum recommended that the man was referred to hospital, but the referral was not picked up. In light of the clinical reviewer's comments, I endorse the following recommendation to the Chief Executive of Dorset PCT:

The PCT must ensure there is a robust system in place for the care provided at weekends to be effectively handed over between staff.

60. The clinical reviewer acknowledges: "I am neither an expert in the study of cancers or their treatment by neurosurgeons." However, in the clinical reviewer's opinion, "surgery even at the first opportunity in December" would not have resulted in a "significantly different outcome".

Clinical care at Guys Marsh

61. As noted, the man was referred to hospital within three days of his arrival at Guys Marsh. However, the hospital took three weeks to write to the healthcare unit outlining what tests they had undertaken on the man. According to his medical record, there was some communication between the hospital and the healthcare unit before this letter arrived in order to facilitate the man's CT scan at the hospital.

62. I agree with the clinical reviewer that it is unacceptable for hospital clinical letters to be delayed because they must inform primary care doctors of their patient's treatments and investigations. This is especially important for prisoners as security arrangements for appointments, treatments and admissions have to be made well in advance. I am not in a position to comment on the systems in place for communication from hospital but I commend the clinical reviewer's findings to the attention of the PCT.

63. The clinical reviewer finds that the man received appropriate clinical care whilst he was at Guys Marsh. Despite his comments on the care and communication by the secondary healthcare providers and the hospitals, the clinical reviewer is of the opinion that Guys Marsh healthcare unit met and "probably exceeded" the standard of care the man might have hoped to have received outside of prison. The clinical reviewer commended the healthcare staff for their good practice.

Secondary healthcare

64. In his review, the clinical reviewer asks why the man was not recalled back to hospital as soon as his CT scan indicated a tumour behind his eye. It is not clear from the prison's medical records exactly when he had his CT scan and what the hospital staff did in terms of making an urgent appointment to see him following the results. The clinical reviewer is also concerned that the man's planned surgery on 17 March was deferred because there was no bed available for him after the operation. He did not have the operation until 24 March. Unfortunately the action of hospital staff and availability of hospital beds is beyond the remit of this investigation, but I raise the clinical reviewer's comments for the consideration of the Chief Executive of Dorset PCT.

Family issues

65. The man's family and his former partner asked for the following points to be considered as part of this investigation.

- Why was there a lack of response to correspondence from the man's solicitors and the family's MP to the Governor?
- Why compassionate leave was not considered?
- Could extra visits have been arranged so the man's family could have visited him more frequently?
- Why was the man restrained in hospital?
- Why the Governor did not visit the hospital on 26 March?
- Why was the man's former partner (and named next of kin) not told of his serious health problems and his death?

Correspondence

66. The Governor received four letters from different solicitors on behalf of the man, and one from his family's MP. The family were concerned that the Governor failed to respond to these letters. The letters were logged onto the Governor's correspondence sheet when they arrived at the prison. My colleague, an assistant ombudsman, spoke to the Governor regarding responses to correspondence addressed to him. She was told that his secretary logs all incoming mail and forwards the letters to the appropriate department to be dealt with, on his behalf.

67. Department heads often respond to Governor's letters by telephone calls or emails. However, it seems this is not logged back onto the Governor's correspondence sheet therefore, it was not possible to fully audit the trail of those responses.

68. The letter to the family's MP and one to his solicitor was in the process of being dealt and within the prison's timescale for a response to correspondence. The letters from the other solicitors, acting on the man's behalf, were in relation to the request for a compassionate release, a move to a prison near to his family and the removal of restraints. These requests were also in the process of being dealt with. They were within the set time scale

and some had been responded to by telephone call, although there was no formal record of these conversations taking place or what was discussed.

69. In total, the man had four solicitors acting on his behalf. The complexity of dealing with four legal firms requesting different actions for the same prisoner may well have delayed a response. Nevertheless, it is important that all the responses to the Governor's correspondence are logged, whether it is by a telephone call, email or letter. A log would then leave a creditable audit trail so that it is clear what responses have been made and how they were made. I make the following recommendation for the attention of the Governor.

The Governor should ensure that responses to his correspondence are logged and retained for audit and review.

Compassionate release

70. A request for compassionate release for the man on medical grounds was made on his behalf by one of his solicitors in a letter sent to the Governor on 8 March. The letter was passed to a governor who tasked an administrator for enquiries to be made. The governor told my assistant ombudsman, that Guys Marsh does not regularly make applications for compassionate release, in fact this would have been only the second one in five years.

71. Enquiries were made with Early Release and Recall section of the National Offender Management Service who oversee compassionate release applications on behalf of the whole prison estate. They explained to the administrator that a prospective application for a compassionate release on medical grounds requires the diagnosis of a terminal condition and a clear prognosis of how long the prisoner is expected to live. Following that advice, the administrator spoke to the healthcare unit who said that the man's condition was not understood to be terminal at that point. According to a note written on the original letter, the administrator telephoned the solicitors to update them.

72. The healthcare unit were in close contact with hospital staff getting regular updates on the man's medical condition. Although, the man was very unwell, hospital staff were apparently confident that his surgery would be successful. His condition rapidly deteriorated on the morning of 26 March in a manner unforeseen by the hospital staff. As the man's condition was not considered terminal, a compassionate release application would not have met the minimum requirements and therefore would have been unsuccessful.

The man's location

73. Following his conviction, the man was moved from Dorchester to Guys Marsh to continue his sentence. In the first instance, prisoners are allocated to prison in accordance with where their criminal matters are being dealt with. The man was convicted in the south of the country therefore a move to a prison in that area was justifiable. However, following a letter from one of his solicitors and the family's MP, a governor enquired as to whether the man

could be transferred to a prison near to his family. A prison was contacted to see if they could arrange a transfer for the man however, they were unable to offer him a place at that time.

74. The man's original placement in the South West was a result of the circumstances of his arrest. Whilst I understand that the family found it difficult to visit the man, it is not always possible to arrange transfers until suitable prison places become available. If the man had been relocated before he was admitted to hospital this might have further delayed his treatment.

75. I am satisfied that reasonable efforts were made to re-locate the man nearer his home and it is regrettable that events took over before such a transfer could be secured.

76. The man's family were surprised that the visiting system at Guys Marsh did not allow them to have extra visits following his diagnosis of a tumour. His family would have liked extra visits to support him at this most distressing time. However, there were only two weeks from the man's diagnosis with a tumour to him being admitted to hospital. Whilst I empathise with the family's concern, the prison were unable to facilitate extra visits in such a short space of time. Furthermore I note that the man's family visited him whilst in hospital and his father was allowed to be at his bedside following his surgical procedures.

77. The chaplaincy notes record that the man was allowed a 25 minute private telephone call to his family on 8 March. Four days later, the chaplaincy notes record that he man received a special visit from his brother and an Imam. The Imam brought in holy oils and water to the prison for the man to receive a religious rite. I am pleased to see that efforts were made to accommodate the man's needs.

Restraints

78. The man's family were distressed that he was restrained in hospital until he became unconscious on the day of his death. In a letter to the Governor on 24 March, one of the man's solicitors asked that less security measures be in place. Nevertheless, the escort chain was reapplied to the man as he recovered consciousness following his surgery that same day.

79. The man was visited every day in hospital by a senior officer, who assessed his security risk. Up to the day of his first surgery on 24 March, the man was mobile, able to look after his own personal hygiene and daily care. The assessment of that risk did not change until 4.20am on 26 March, when the restraints were removed following a serious deterioration in the man's condition.

80. I share the family's concerns that the man was restrained whilst recovering from complex surgery and in a high dependency unit. There is no information in the bed watch notes that hospital staff had challenged the use of restraints.

An officer said in her statement that the restraints were re-applied following the man's surgery on 25 March. The man had come round from the operation and was talking. The officer commented after hearing of the man's death:

> " I was genuinely shocked to hear the next day that he [The man] had passed away and upset. I felt there was no indication that he would pass away and my understanding and impression when we left was that everything went well and that a further operation would be carried out the early part of the following week."

81. The officer's observations of the man's condition showed that he was awake and progressing after his surgery. However, I am uneasy that the man was restrained after his extensive surgical procedures.

82. The man's offences were not violent, he was not assessed as a risk to the public or known as an escape risk. It was noted that his behaviour in hospital was good, in the bed watch notes and on the daily management check list. I am satisfied that the man's security arrangements were constantly under review, but I am surprised that restraints were used in the hours after an operation.

83. As a housekeeping point, I would ask that the Governor considers a review of the risk assessment of prisoners following major surgery and being cared for in high dependency or intensive care units.

Expected visit to the hospital by the Governor

84. The man's family said they were told by bed watch staff on the morning of 26 March that the Governor would visit the hospital. However, he did not arrive. The duty governor, had telephoned the Governor, at home, to tell him of the man's deteriorating health. The Governor asked whether it would be appropriate to pay a visit to the hospital to see the family. The Governor went into the prison to meet the duty governor and, after a further discussion with him and the chaplain the Governor felt that a visit to his bedside was inappropriate and intrusive at such a distressing time for his family. An Imam from Winchester and the chaplain made their way to the hospital to offer their support to the man's family.

85. I understand the Governor 's decision not to visit the hospital. The man was on a life support machine and his death was imminent. He decided that it was the time for the man's family to be at his bedside and have privacy. The Imam and chaplain attended the hospital in their roles of family liaison officers and for religious support, which I acknowledge as good practice. However, I trust that the Governor will consider personally meeting the family if such circumstances arise in the future.

Family liaison

86. The chaplain was the liaison officer acting as a link between the prison and the man's family. The chaplain was not a trained family liaison officer. I

understand that the Governor felt it was in the family's interest for her to carry on in this role as she had been a liaising between the family and the prison prior to the man going into hospital. I acknowledge that decision and the sensitive approach to ensure continuity of support for the man's family. The chaplain's approach to family liaison was compassionate and suited the man's own family circumstances. However, she did not adhere to the requirements set out in the annex to PSO 2700 – Suicide and Self Harm Management, which is guidance for family liaison officers, as she had not had this training. I am pleased to note that the chaplain will undergo family liaison officer training.

87. To assist the chaplain in this role, for cultural and religious reasons, two Imams kindly offered their support. (The Imam at Guys Marsh was on long term sick leave while the man was in prison and in hospital.) The man's family were appreciative of the support from the chaplain and the Imams. Although I recognise that family liaison was not carried out in accordance with the guidance, I note the compassion and professionalism of the chaplaincy team.

88. The chaplaincy notes were used to record all the interventions with the man's family as opposed to a family liaison log. A family liaison log should have been completed and trust that the Governor will ensure that such a log is completed in future.

89. The man's former partner was his named next of kin on his prison record. My FLO, telephoned her following the man's death. The former partner told the FLO that she had not been notified by the prison that he was in hospital or that he had died. She heard of the man's death from a member of his family. The chaplain and Imam visited the man's former partner a few weeks after his death to return some of his property.

90. The chaplain told my colleague that the man's parents and siblings were actively involved in supporting him, keeping in contact with herself and insisted that they would be his next of kin. At no time did the family mention his former partner and any involvement the former partner should have in supporting the man through his illness. Furthermore, there was nothing noted in the bed watch notes that the man had mentioned to escort staff that he would like a visit from his former partner.

91. The man's siblings and parents were treated as his next of kin. However, he had told prison staff, on his arrival at Dorchester and it was noted in his personal file, that his former partner was his next of kin. The prison has an obligation to inform his nominated next of kin of his deteriorating health and subsequent death. This important oversight may not have happened had the chaplain, leading family liaison in this case, had the required training. Nevertheless, it is the prison's responsibility to notify the nominated next of kin in circumstances of this kind. Therefore I make the following recommendation:

The Governor must ensure that the named next of kin held in a prisoner's prison file should be contacted if a prisoner's health is cause for concern or in an emergency.

CONCLUSION

92. When the man arrived at Dorchester on 21 January, the locum doctor said he needed to be referred for treatment on his eye. There is no evidence that he was referred to hospital following communication with an eye hospital. However, on his transfer to Guys Marsh on 31 January, a referral was made quickly and he was seen at a hospital on 8 February. Medical investigations were undertaken and a tumour was discovered behind his eye. Sadly the man died on 26 March following two complex surgical procedures to remove the tumour.

93. The clinical reviewer makes a recommendation relating to the handover of medical information at Dorchester. The reviewer comments that healthcare staff at Guys Marsh appropriately cared for the man during the short time he was there and his care exceeded that which he might have received from that in the community.

94. I have made a recommendation relating to responses to correspondence received by the Governor, so that in the future it can be confirmed what actions have been taken and when. I raise one housekeeping point for the Governor to consider reviewing the risk assessments of a prisoner's restraints following major surgery.

95. Finally I acknowledge the professional manner in which the chaplain and Imams liaised with the man's family. However, his named next of kin, his former partner was not told of his deteriorating health or death and I make a recommendation to the Governor.

RECOMMENDATIONS

For the Chief Executive of Dorset PCT

1. The PCT must ensure there is a robust system in place for the care provided at weekends to be effectively handed over between staff.

   Accepted – "A diary system is used by HMP Guys Marsh team to ensure messages are passed from each weekend. Staff who work on the weekend also work on the Monday to ensure appropriate handover. HMP Dorchester have introduced the handover diary system."

For the Governor of Guys Marsh

2. The Governor should ensure that responses to his correspondence are logged and retained for audit and review.

   Accepted – "The Governor's Secretary keeps a log of post addressed to the Governor with an audit trail of where they have been forwarded to for draft response. The content of the correspondence will dictate whether the Governor or the Senior Manager replies. Paper and electronic copies of replies are kept by the Governor's Secretary. "

3. The Governor must ensure that the named next of kin held in a prisoner's prison file should be contacted if a prisoner's health is cause for concern or in an emergency.

   Accepted – "Next of Kin information to be checked upon arrival as part of first night procedures. Contingency plans to be reviewed and updated reminding of the importance of identifying and notifying next of kin. Notice to be issued to Orderly Officers and Duty Governors reminding them of the importance of notifying next of kin."