Investigation into the circumstances surrounding the death of a man, a prisoner at HMP & YOI Moorland Closed, in October 2008

Report by the Prisons and Probation Ombudsman for England and Wales

June 2009

This is the report of an investigation into the circumstances surrounding the death of a man at Doncaster Royal Infirmary in October 2008. The man was a prisoner at HMP & YOI Moorland Closed. The cause of his death was recorded as cancer.

I offer my sincere sympathy and condolences to the man's wife and family for their loss. One of my Family Liaison Officers was in contact with the man's wife and family during the investigation process.

The investigation was led by my one of my colleagues. I must thank the local Primary Care Trust for the appointment of a clinical reviewer. I am also grateful to the Governor and staff of Moorland, especially the Governor whose assistance was a great benefit to my investigator.

As the man died from natural causes, the findings of the clinical review play a pivotal role in my report. The review of the man's clinical care shows that he received good treatment whilst in Moorland.

I make three recommendations concerning medical records, arranging healthcare appointments and the process for managing requests for samples. I also consider the risk assessments carried out in respect of the use of restraints.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2009**

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SUMMARY

The man had been given a 12 month custodial sentence in August 2008 after he breached a suspended sentence. On arrival at HMP Doncaster, the man had an initial first health screen assessment. It confirmed that the man was on Methadone (heroin replacement treatment) as he had a history of using drugs. He also sufferred from diabetes and emphysema (lung disease). It was recorded that the man's legs were swollen due to venous insufficiency (leg ulcers).

The man was transferred to HMP Moorland Closed in September. Here he continued to receive medical treatment for his conditions, and a care plan was put in place to monitor his legs, diabetes, blood pressure and depression.

In October, the man was seen by a nurse because there were concerns over his general health. The nurse recommended that he should be transferred to the healthcare unit for a period of observation but the man refused saying that he preferred to remain on his houseblock.

Five days later, in October 2008, the man was seen by a doctor who noted a marked deterioration in his health. The man was admitted to the local hospital. The initial risk assessment was for two officers to provide the bedwatch with the long escort chain to be used.

The risk assessment was reviewed every day, and the restraint was removed on 24 October. Two officers remained as escort, but they were located outside the man's room. These arrangements provided privacy for the man and his family. The man died at 3.00pm on 25 October with his family at his bedside.

Three principal issues arise from this investigation. I emphasise that prisoners' medical records should be accurately maintained, and recommend that the processes for healthcare appointments and managing sample tests should be reviewed. Although this is a matter of fine judgement, it is arguable that restraints could have been removed a day earlier than was done.

THE INVESTIGATION PROCESS

1. My investigator visited Moorland Closed and interviewed seven members of staff who knew the man. Notices were posted to staff and prisoners about the investigation inviting contributions, but no one came forward as a result. In addition, my investigator studied all the relevant records including the man's main prison record, medical records and statements made by staff.

2. The local Primary Care Trust asked a medical practitioner to carry out a review of the man's clinical care. I am grateful to the clinical reviewer for undertaking this review. My investigator discussed aspects of the man's treatment with both healthcare staff at Moorland and with the clinical reviewer. My investigator and the clinical reviewer conducted joint interviews with staff.

3. My investigator contacted HM Coroner for South East Yorkshire to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into the man's death.

One of my Family Liaison Officers contacted the man's wife at the beginning of the investigation and asked if she had any questions or concerns to raise about the care her husband received. The man's wife did not raise any specific issues that she wished to be considered by my investigator. A copy of my report will be provided for her.

HMP & YOI MOORLAND CLOSED

4. 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.

5. The most recent inspection by HM Chief Inspector of Prisons was in December 2005. The inspection found that Moorland was generally delivering a safe, purposeful and resettlement-orientated regime. The Chief Inspector said this was commendable, given the mix of types and ages of prisoners, the range of needs they presented, and the variety of accommodation in which they were held.

6. The latest Independent Monitoring Board (IMB) report 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."

7. My investigator reviewed my report into an earlier death from natural causes at Moorland Closed. He found no common issues with his own investigation into the death of the man.

KEY EVENTS

8. The man was born in April 1954 and lived in the Sheffield area. He was married and had two sons and one daughter. He was sentenced to a 12 month custodial sentence by the local Crown Court in August 2008 and taken to HMP Doncaster. The man had a history of using drugs.

9. On arrival at Doncaster, the man underwent a first health screen assessment. This confirmed that he was receiving Methadone as well as suffering from diabetes and emphysema. It was recorded that the man's legs were swollen due to legs ulcers. The healthcare unit at Doncaster contacted both the man's community doctor and pharmacy in his home area to confirm the levels of his medication. A referral was made for assessment by a tissue viability nurse (a nursing specialist in the treatment and management of skin disorders such as leg ulcers).

10. The man was transferred to Moorland Closed on 17 September. He was seen in reception and it was confirmed that his medical details had accompanied him from Doncaster. He was given another first health screen check and said that he was very anxious about his wife who was ill.

11. The next day the man was seen by one of the prison doctors. It was agreed that the man would continue to receive the Methadone medication. He was also prescribed a seven day course of antibiotics for cellulitis (infection of the skin) on his legs. The man told the doctor that he was having trouble sleeping due to anxiety about his wife's illness. He said that he had a good appetite but had lost a few pounds in weight. A care plan was put in place to monitor his legs, diabetes, blood pressure and depression.

12. One week later the man had a review with a second prison doctor. He was still having problems with his legs. He also remained very anxious about his wife and this continued to affect his sleep. The second prison doctor decided to review the man's health two weeks later.

13. On 29 September, the man was seen by the tissue viability nurse. A full assessment was made of his legs and a care plan put in place. It involved the man's legs being dressed twice a week using viscopaste (non-sticky dressing to improve healing) and a two layer bandage from toe to knee on both legs. The man was advised to elevate his legs as much as possible. His treatment would also include compression therapy. The treatment required a Doppler Assessment (test of blood flow and pressure in the lower limbs) which was arranged for 3 November. Over the following fortnight the man was seen on five separate occasions by healthcare staff, and his legs were dressed in accordance with the care plan.

14. The man was seen in healthcare on 17 October by a third prison doctor due to concerns over his general health. The third prison doctor asked for blood tests to be taken and suggested an ultrasound scan of the man's abdomen. The man was seen by a healthcare nurse who took the blood samples. No record was

made of the reason for the blood tests or the results or any subsequent treatment that was required.

15. When interviewed by my investigator, the healthcare nurse said that she was concerned that the man needed to be admitted to hospital and raised this with her manager. The healthcare nurse said at interview that she told her manager that she asked for a second opinion as the man was very jaundiced and a very poorly man.

16. The manager recommended to the man that it would be in his interests if he moved to healthcare so that staff could observe and monitor him over a period of time. The man refused to move and said that he wanted to remain on his houseblock. The healthcare nurse made arrangements with the kitchen so that the man's dietary needs could be met. The man was told to contact healthcare staff at any time if he needed more assistance.

17. Five days later, on the morning of 22 October, the man was seen on his houseblock by the second prison doctor. The doctor recorded that there was a marked deterioration in the man's condition. He specifically recorded that the man showed signs of jaundice and was dehydrated. The second prison doctor decided that the man needed to be admitted to hospital.

18. Prior to being taken to hospital, a risk assessment must be conducted to determine the level of supervision and restraint suitable for the prisoner. The initial assessment for hospital escort and bedwatch specified that there were to be two officers with the use of an escort chain. When interviewed, the second prison governor described the restraint as "a long chain that enables the prisoner to be able to move about freely, and nurses and doctors to administer any care to him without the officer getting in the way". The man arrived at the local Infirmary at 12.20pm and was later moved to a side room off a ward.

19. The following day at 10.15am, a hospital doctor questioned the need for the escort chain as the man had been diagnosed with terminal cancer. The Senior Officer (SO) told the doctor that the restraint would have to remain until instructed otherwise. The SO noted the conversation in the bedwatch record. Four hours later, the second prison governor visited the hospital and reviewed the risk assessment. The second prison governor recorded that the man's condition had deteriorated, and that he could not stand unaided and had drips attached to both arms.

20. The second prison governor determined that the existing level of restraint be maintained. When asked the reasons for her decision at interview, the second prison governor said that, "even though his condition was deteriorating, because he had been out at the side of his bed, whether he was going to recover or not, and at that time I felt it was appropriate to retain the escort chain."

21. The next day (24 October), the second prison governor returned to the hospital at 2.30pm to review the risk assessment again. The second prison governor told my investigator:

> "His condition had deteriorated and I'd spoken with his wife, I spoke with the man myself, and I spoke with the nursing staff, and his physical condition was such that he was in no physical state to attempt to make any kind of escape, or cause any concern to the nursing staff, and the general safety of the public, so and he was incredibly poorly and unlikely to improve, and I felt it was only right to remove the escort chain."

22. It was decided that the two escort officers should stay at the hospital but remain outside the man's room to give him and his family as much privacy as possible. The chaplain from Moorland visited at 5.10pm and remained with the man and his wife until 6.30pm. Family members were able to stay with the man throughout the night. The man died on 25 October at 3.00pm with his family at his bedside.

23. Following the man's death the prison's Family Liaison Officer (FLO), maintained contact with his wife and family by letter, telephone and face to face. The prison also offered financial assistance towards the funeral costs.

ISSUES

Clinical care

24. The review of the man's clinical care revealed some issues that could have been improved upon during his time in Moorland. In particular, the review raised issues concerning follow up appointments, record keeping and, communication between the General Healthcare team and the IDTS team.

25. The man did receive assessments when he was received into the prison both at HMP Doncaster and HMP Moorland Closed. The man was seen by general medical staff on the same day when he arrived at HMP Doncaster. When he arrived at HMP Moorland, the man was seen by a doctor within IDTS but it appears that he did not see a doctor within general healthcare for some days.

26. The second prison doctor requested a two week review following his consultation with the man on 25 September. This would have meant that a doctor's appointment should have been made a week later. It did not take place and the man was not seen by a doctor until 17 October. I agree that an appointment should have been made for a formal review by a doctor, although nursing staff did have the opportunity to raise concerns in the intervening period.

    The Head of Healthcare should review the appointment process to ensure that all appointments take place promptly and according to need.

27. After the man saw the third prison doctor on 17 October, discussions took place between the healthcare nurse and her manager as to the appropriate ongoing medical and nursing arrangements that were necessary to meet the man's needs. The healthcare nurse was of the opinion that the man needed hospital treatment and requested a second doctor's opinion. Her manager recommended to the man that he move to healthcare for a period of observation, but he refused. These decisions, and the rationale behind them, are not evident in the medical records and there is no evidence that a second opinion was arranged.

28. The prison medical records do not evidence that there were any healthcare interventions with the man after 17 October until 22 October. Given that there was a care plan in place following the assessment of the tissue viability nurse, there should have been at least two entries concerning dressing his legs.

29. There is no record of the time the second prison doctor recommended that the man be admitted to hospital. It can only be assumed that this was prior to receiving his Methadone medication at 8.15am. The man was not sent to hospital until 12.00 noon. There are no reasons recorded to account for the time elapsed or the care provided in the intervening period.

30. Despite the second prison doctor's recommendation to admit the man to hospital, he was next seen again in healthcare before being admitted to hospital. The reason for this is unclear.

The Head of Healthcare should remind healthcare staff of the requirement for accurate and contemporaneous record keeping, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

The Head of Healthcare should review the process for managing sample tests to ensure that tests are carried out effectively, with the results made available to staff and maintained within the medical records.

Use of restraints

31. On 23 October at 10.15am, a hospital doctor questioned the SO about the need for the restraint due to the man's condition. This was properly recorded in the bedwatch record. The second prison governor reviewed the risk assessment at 1.00pm. Despite the documented comment in the bedwatch record and the SO's awareness of the situation, she determined that the level of restraint should remain.

32. The following day (24 October), the second prison governor conducted a further risk assessment and decided that the restraint was to be removed. The two officers were to remain on bedwatch. They were instructed to remain outside the man's room to provide him and his family as much privacy as possible.

33. In April 2008, all Governing Governors and Heads of Groups were sent a written communication from the Head of Security, National Offender Management Service. It provided a summary of two judicial reviews concerning the risk assessment procedures for hospital escorts and bedwatches, with particular emphasis on the use and application of restraints. Specifically, the summary says that:

"The Judgement …

- Makes the distinction between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit, and those risks posed by the same prisoner when suffering from a serious medical condition. Medical opinion regarding the prisoner's ability to escape must therefore be considered as part of the assessment process.

- Deems the restraining by handcuffs of a prisoner receiving chemotherapy (and, by implication, other life saving treatment) degrading. Such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

- Requires that each decision is properly considered taking account of all relevant information and be proportionate to the risks involved.

- Requires a fresh risk assessment to be conducted each time it is reviewed in order to establish: the level of restraints to be used during transportation to and from the hospital and the level of restraints to be used during the prisoner's stay in hospital."

34. I have great sympathy with Governors making decisions regarding use of restraints. Balancing protection of the public and an individual prisoner's needs is not an exact science. However, in light of the advice offered to all prisons in April 2008, it is arguable that changes to the man's bedwatch arrangements should have been made from 23 October. At this point it was known that the man had terminal cancer and there had been a significant change to his condition.

35. As the restraints were removed the following day, I make no formal recommendation. However, the Governor may wish to amend the Local Security Strategy to incorporate the guidance from the National Offender Management Service regarding the risk assessment procedures for hospital escorts and bedwatches.

36. During the consultation process on the draft report, the man's family urged me to make what I have written in para 36 above a formal recommendation. Sadly, I have presided over a number of investigations where I have commented on the issue of restraints. Recommendations generally occur when there has been a lack of assessment and prolonged use of restraints. Whilst I appreciate the concerns raised by the man's family, I remain of the view that in this case a formal recommendation would not be justified, notwithstanding the criticisms I have made.

RECOMMENDATIONS

1. The Head of Healthcare should remind healthcare staff of the requirement for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   Accepted. All staff to be written to personally advising them of the requirement for accurate and contemporaneous record keeping. A notice to be produced and publicly placed above the record storage facility and in nursing staff areas. To be completed by 30 June 2009.

2. The Head of Healthcare should review the appointment process to ensure that all appointments take place and according to need.

   Accepted. A system to be introduced that ensures follow up appointments are recorded and that the patient attends. This to be manual until the IT is in place and dependable. To be completed by 30 June 2009.

3. The Head of Healthcare should review the process for managing sample tests to ensure that tests are carried out effectively, with the results made available to staff and maintained within the medical records.

   Accepted. A system to be introduced to register appropriately the taking of samples and reason, the dispatch of samples, the results of samples, the follow up care required and the action taken. To be completed by 30 June 2009.