PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at Glenfield Hospital, Leicester, in August 2012, while in the custody of HMP Dovegate

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the report of an investigation into the death of a prisoner at HMP Dovegate. The man, who was 32 years old, died of a bleed on the brain at Glenfield Hospital, Leicester in August 2012. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. Staffordshire Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review of the clinical care the man received at HMP Dovegate.

When the man arrived at Dovegate on 28 July, he had very high blood pressure, headaches and vomiting, but it was two days before he was examined by a doctor. The man's high blood pressure was not thoroughly investigated during his medical consultations. The man collapsed in his cell on the evening of 31 July and was taken to hospital. He died a week later.

I agree with the clinical reviewer that the standard of the man's care fell below that which he might have expected to receive in the community. Further medical advice should have been sought in reception and a 48-hour delay before seeing a doctor was too long. After his collapse, the response was too slow and he was given medication that could have worsened his condition.

The man was Latvian and did not speak English. After using a translation service on reception, healthcare staff used another prisoner as an interpreter for the remainder of his medical consultations. This did not allow appropriate patient confidentiality and could have put the man's safety at risk. The level of restraints used while the man was in hospital was not always justified and should have been reviewed at a much earlier stage. The prison waited too long to try to contact the man's family to let them know he was seriously ill in hospital and by the time they got in touch the man had died. I am concerned that a number of these matters have been raised before with Dovegate and the prison needs to ensure that lessons are learned from this sad case and changes implemented.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man was extradited from Latvia charged with an alleged serious sexual offence committed in the United Kingdom in 2010. He was remanded into custody and arrived at HMP Dovegate on Saturday 28 July 2012.

2. The man could not speak English and his reception medical screen was carried out using a professional telephone interpretation service. The man said that he had high blood pressure, and thought he had hepatitis C[1] and pancreatitis[2]. The man's blood pressure was very high, so he was referred to see the doctor on Monday, two days later.

3. On Monday 30 July, the man's cellmate (who was also Latvian and could speak English) acted as an interpreter when he saw the doctor. The man repeated that he had been having headaches and vomiting. The doctor referred The man for an urgent blood test. The man's blood pressure was still high, so the doctor prescribed ramipril[3] and planned to check him again the next day.

4. On 31 July, a nurse took the man's blood pressure which had fallen slightly, but was still very high. The nurse also noted that the man had a subconjunctival haemorrhage[4] in his left eye and the man said that his headache was mostly left sided. When the doctor reviewed him later that morning, the man's blood pressure had gone down slightly to 163/115[5]. The doctor planned to review him a week later when the ramipril would have started taking effect.

5. At 7.30pm that evening, the man collapsed in his cell. His cellmate pressed the cell bell for help and the officer who responded could not see any obvious injury. The officer called reception for a nurse to assess him, but did not check him again. At around 8.30pm, another officer came on duty and the officer explained that he was still waiting for a nurse. When the officer who had just come on duty checked the man, he noticed blood on a tissue he was holding to his head. He got a nurse to the man's cell within five minutes. The nurse took his blood pressure, which was still high so she gave him some aspirin and called an ambulance because of the risk of stroke. The man was taken to hospital at 9.35pm where he was admitted as an inpatient.

6. As there was limited information about the man, he was considered a high security risk and was escorted by two escort officers and double cuffed. The man's risk was not reviewed as it should have been when he was initially admitted to hospital. The double cuffs were not removed to accommodate his treatment until the next day when they were replaced by an escort chain.

7. Hospital staff thought that the man had suffered a heart attack. He was transferred to a specialist heart hospital on 5 August. The man asked to telephone his mother to let her know that he was unwell in hospital, but this was not arranged and nor did the prison inform her. The man's condition deteriorated on 6 August and he was put onto a life support machine, at which point the

[1] A chronic liver infection
[2] Inflammation of the pancreas
[3] Medication used to treat high blood pressure.
[4] Redness against the white of the eye, caused by bleeding of the small blood vessels.
[5] A normal blood pressure reading would be around 120/80, an acceptable higher reading would be 150/90.

escort chain was removed. Prison staff then gave the hospital the man's next of kin contact details. It took some time for the man's family to be contacted and sadly he died before they were told that he had been admitted to hospital.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on 7 August 2012. The investigator issued notices to staff and prisoners informing them of the investigation and asking anyone who had relevant information to contact her. No responses were received.

9. HM Coroner for South Staffordshire District was informed of the investigation. A copy of the investigation report will be sent to the Coroner to assist his enquiries.

10. Staffordshire PCT appointed a clinical reviewer to review the clinical care the man received at Dovegate. The clinical reviewer was given the man's medical record. The clinical review was received on 15 November 2012.

11. The investigator received all documentation relating to the man's time in custody and liaised with the Director of Dovegate throughout the course of the investigation. On 4 October, the investigator and a colleague interviewed three members of healthcare staff, a prison officer and the Duty Director. The investigator interviewed another prison officer by telephone on 23 October.

12. One of the Ombudsman's family liaison officers, contacted the man's family's representative and explained the purpose and scope of the investigation. The man's family had the following concerns:

    - The prison paid for the man to be repatriated to Latvia, but his family had to pay for the funeral themselves. (After we raised this matter we were assured that the Director has arranged to pay reasonable funeral costs.)
    - His family wanted to know how prison staff communicated with the man, as he did not speak English, and whether he was able to explain his health concerns appropriately.
    - The man's family wanted to know why they were not told that he had been admitted to hospital and only found out after he had died.

13. The man's family received a copy of the draft report. They made a number of comments that do not impact on the factual accuracy of this report. In particular, they were concerned about the arrangements for interpretation in confidential healthcare settings.

14. The prison considered our draft report and recommendations and has accepted these. No factual inaccuracies were raised. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included here, after the recommendations section.

HMP DOVEGATE

15. HMP Dovegate is a category B prison, privately run by Serco. The prison holds over 1,100 adult male prisoners, both on remand or convicted. Primary healthcare at Dovegate is provided by Serco Health, including an 11 bed inpatient unit.

HM Inspectorate of Prisons (HMIP)

16. The most recent published report on Dovegate by HMIP followed an unannounced short follow up inspection in October 2011. The Inspectorate found that there were good relationships between the prison and the healthcare department, and prisoners had improved access to both inpatient facilities and, where necessary, external hospital appointments.

17. The Inspectorate found that professional telephone interpreting had been used only 14 times in the six months before the inspection. The foreign national policy indicated that formal interpreting services should be used in settings such as Assessment, Care in Custody, and Teamwork (self-harm monitoring) reviews, hospital appointments or adjudications, but the Inspectorate was not assured that this was consistently the case. Staff were unclear about when, where and under what circumstance they could use interpreting services and the Inspectorate repeated a recommendation from the 2008 inspection:

> "Accredited translation and interpreting services should be used for prisoners who do not understand English well whenever matters of accuracy or confidentiality are a factor."

Independent Monitoring Board (IMB)

18. All prisons have an Independent Monitoring Board made up of unpaid volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. The most recent IMB annual report for Dovegate covers the period 1 October 2010 to 30 September 2011. About health services the Board noted that a new Assistant Director for healthcare had been appointed. Nursing staff were given responsibility for a specific house block and the dispensing of medication on each house block was closely monitored. Staff were better organised and supported by primary care staff where necessary. The IMB were confident that the healthcare services had improved over the previous twelve months.

Previous deaths at HMP Dovegate

19. In the last two years, there have been five deaths through natural causes at Dovegate, including that of the man. In previous investigations we also found that prisoners were not referred appropriately for further medical review after their health screen in reception and that there were delays responding to potential emergency situations. In one investigation, appropriate translation services were not facilitated and the use of restraints in hospital was not justified by the escort risk assessment.

KEY EVENTS

20. The man was arrested in Latvia on a European Warrant. He was charged with an alleged serious sexual offence committed in the United Kingdom (UK) in 2010. On 28 July 2012, the man was extradited to the UK and was immediately remanded to HMP Dovegate.

21. The mental health nurse completed the reception health screen, and used a telephone interpretation service. The interpreter told the mental health nurse that the man sounded calm and fine, and he was being supported by his mother. The man said that he had hepatitis C, bronchitis[6], pancreatitis and high blood pressure. He said that he had been prescribed medications, but had not taken any for two weeks. His blood pressure was recorded as 221/138, which is extremely high compared to the normal range of 120/80.

22. The mental health nurse told the investigator that the man was anxious but she was not concerned about his health, based on his appearance. She said that she was confident that the man had understood the questions asked during the health screen and answered appropriately. She explained that prisoners often arrive with high blood pressure because of the stress of coming to prison. A more accurate reading is usually taken two days later, once the prisoner has had time to settle. She said she discussed the man with the nurse in charge, who agreed he should see a doctor on Monday, two days later. She said that if she had concerns she could have used the out of hours' doctor service, but she did not because the man was not worried about his health or said that he wanted any medication.

23. The man's cell sharing risk assessment[7] concluded that he could share a cell with another prisoner. Due to the nature of his alleged offence, the man was taken to the vulnerable prisoners unit[8] and given a cell with another Latvian prisoner, who could speak good English.

24. On 30 July, the man had a secondary health screen[9] with the healthcare assistant. The healthcare assistant asked the man's cellmate to act as an interpreter. The man told the healthcare assistant that he had a family history of diabetes and thought he had hepatitis C. He said he also suffered from stomach problems and headaches. The healthcare assistant noted that he was about to see the doctor and did not record his blood pressure.

25. A doctor reviewed the man after his appointment with the healthcare assistant. The doctor also used the man's cellmate as an interpreter. The doctor noted that the man's cellmate was worried about contracting hepatitis C while sharing a cell with him. The man was reluctant to discuss if he had been treated in the UK before, and the only information the doctor had was from the man's reception screen. The man said that he had been extradited from Latvia, had pancreatitis

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[6] Infection of the main airways of the lung.

[7] All prisoners are subject to a Cell Sharing Risk Assessment on reception. The process is designed to assess the risks posed by an individual to other prisoners which includes taking into account the situational context of any previous violence or mental health issues.

[8] A unit for prisoner's who are separated from the main prison population for their own protection, either because of the nature of their offence or for other vulnerabilities.

[9] The second reception health screen identifies any other medical issues or concerns and repeat his basic observations, including blood pressure.

and hepatitis C, but he had never been treated for it. He said that he had been having headaches for three weeks, which were getting worse. The doctor examined the man and found that he was alert, had no neck stiffness and his abdomen was soft and tender. His blood pressure was recorded as 189/152 and the doctor prescribed ramipril and co-codamol (strong pain relief). The doctor explained that although his blood pressure was high, he did not think he had a bleed on the brain, as the man had no other symptoms. The doctor requested urgent blood tests and planned to take the man's blood pressure again the next day.

26. At 11.42am, on 31 July, a nurse wrote in the man's on-going clinical record that she had been asked by the doctor to check the man's blood pressure again. She took it twice, and both times it was 170/118. The nurse used the man's cellmate as an interpreter. He explained that the man's headache was more left-sided. The nurse recorded that the man had a subconjunctival haemorrhage in his left eye and he had not been sick. The nurse spoke to the doctor, who asked for the man to be given an appointment that afternoon.

27. The doctor reviewed the man at 3.42pm, and his cellmate interpreted. The doctor told the investigator that he noticed the subconjunctival haemorrhage, which can occur if someone has high blood pressure or has been vomiting, but he was not concerned. The doctor noted that the man said he felt better and his headache was easing. The doctor said he would review the man in a week, as he had only just started taking ramipril. His blood pressure was recorded as 163/115.

28. At 7.30pm, the man's cellmate pressed the cell emergency bell. An Officer was in the main staff office between the wings when he heard the cell bell alarm, and went to the cell. When he opened the observation panel, the officer said he saw the man sitting with his back against the wall, with his hand on his head. The man's cellmate explained that the man had collapsed while going to the toilet and had banged his head. The Officer said that the man was waving at him to indicate that he was alright and there was no blood. During the evening, all prisoners were locked in their cells, staffing levels are lower, so more officers have to be called to the wing when opening a cell, unless it is an emergency. The Officer said that he did not open the cell as he did not feel it was an emergency situation.

29. The Officer told the man's cellmate that he would ask the nurse to assess the man. He said that if the man felt worse or had any concerns, then he was to press the cell bell again. The Officer telephoned the communications department and asked them send a nurse over to see the man. The Officer did not check the man again.

30. At around 8.30pm, another Officer came on duty for the night shift. The Officer explained that the man had fallen and banged his head and the nurse had not been yet. The Officer checked on the man through the observation hatch. He asked if the man was all right and his cellmate said that he needed to see a nurse. The Officer could see the man crouching on the floor next to the cell door, holding a tissue to his head. The Officer said that he could see some blood on the tissue. He told the man's cellmate that he would ask for the nurse again.

31. The Officer said that about five minutes after he had called, the Nursed arrived, along with two officers and the night manager. The man's cell was opened and he and his cellmate came out onto the wing. The Nurse took the man's blood pressure, which was 184/180. The nurse dressed the cut on his head, which the Nurse said had stopped bleeding. As the man's blood pressure was still very high, the nurse said that she thought he was at risk of having a stroke, so she gave him an aspirin and asked the communications department to call an ambulance. According to the communications log, an ambulance was called at 8.47pm.

32. The man walked unassisted to reception, to wait for the ambulance. The nurse said this was because it was easier than the ambulance staff coming through the prison. The man's blood pressure was taken every ten minutes while he waited to be taken to hospital. During that time, his blood pressure remained very high, but stable. The ambulance arrived at 9.10pm (apparently an average response time as Dovegate is in a remote location).

33. The ambulance paramedics assessed the man initially at 9.12pm. They checked his airways, his blood pressure, his eye movements and his level of consciousness. The assessment was repeated twice, before the man was taken to hospital at 9.35pm.

34. An escort risk assessment is completed when a prisoner goes out of the prison to determine whether handcuffs or other restraints should be used. The risk assessment should consider factors such as the risk of escape and the risk of harm to the public and hospital staff. It should be based on an assessment of the prisoner's actual risk at the time, taking into account his health and physical condition. While the man was being assessed by the paramedics, a risk assessment was completed. As the man had only been in Dovegate for three days and apparently arrived with no paperwork, there was limited information available to assess the risk he posed to staff and the public. For that reason, he was considered as high risk of harm to the public and staff, and of escape. The nurse completed the medical information section of the risk assessment and recorded that the man was able to move independently and his medical condition did not affect his level of risk. The Duty Director for that evening signed off the risk assessment and the man was double-cuffed[10] and escorted to hospital by two officers.

35. The man arrived at Queen's Hospital, Burton on Trent, at 10.15pm. At 10.50pm, he had his blood pressure taken and an electrocardiogram (ECG)[11]. The man remained cuffed and an escort chain[12] was used when he needed to use the toilet.

36. At 12.30am on 1 August, a Russian speaking doctor explained to the man that he would be staying in hospital as his blood pressure was high and he had a kidney infection.

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[10] This means a prisoner's hands are handcuffed together at the wrists in front of him and an officer is also cuffed to the prisoner, using a separate pair of handcuffs.

[11] A test that records the rhythm and electrical activity of the heart. It is used to detect problems with heart rhythm and if someone is having a heart attack.

[12] A six foot chain with a handcuff at each end. One handcuff is applied to the prisoner and the other to an officer.

37. Later that day, doctors decided to move the man to a specialist heart hospital when a bed became available, as the level of troponin[13] in his blood was high, and they thought his condition was heart-related. Another Russian speaking doctor explained to the man the reason for his transfer. The security manager recorded that the man was to be restrained using an escort chain only, and two officers were to remain with him.

38. On 2 August, another prisoner on the man's wing asked an Officer how the man was and if he had been discharged from hospital. The prisoner said that he had heard the man and his cellmate arguing in their cell shortly before he collapsed. He said that he had been overheard on the wing saying that he wanted the man out of their cell by Wednesday and had apparently said that he did not want to share a cell with him as he had hepatitis C and he did not want to catch it. Staffordshire Police investigated the allegation, but concluded that no assault had taken place and the man's head injury was caused by a fall.

39. On 3 August, an entry in the man's bedwatch log says that he was acting strangely. He kept slipping his finger underneath the escort chain cuff and was trying to hide pieces of paper from the escort officers. One piece of paper had a number on it and the other had something written in Russian. (The number on the piece of paper was the number the man gave at reception for his mother, his next of kin, which was also recorded at the front of the bedwatch log.)

40. On 4 August, the man allegedly acted inappropriately towards a female officer. He was restless, pacing when out of bed and was angry when waiting for his medications. The prison's duty director suggested that Language Line or an interpreter was needed. A Russian-speaking hospital nurse spoke to the man at 2.40pm that afternoon and explained his treatment to him. He told the nurse that he wanted to speak to his mother and tell her that he was unwell in hospital. The man calmed down after the nurse had spoken to him.

41. At 7.00pm, the man asked if he could ring his mother. One of the operational managers at Dovegate told the investigator that prisoners are not usually allowed visits during the first seven days of a hospital admission, but a telephone call should have been arranged. The man's mother confirmed to our family liaison officer that she did not receive a telephone call from the man while he was in hospital.

42. The man was moved to Glenfield Hospital, Leicester on 5 August. On 6 August, he had an ECG, which was normal. At 3.00pm, the man vomited and said that he felt unwell. He was pointing to his head and the escorting officers called for a nurse, who referred him for a computerised tomography (CT) scan[14]. At 3.40pm, the man was sick again, and the escort officers called a nurse. The nurse asked two doctors to attend and the escort chain was removed after authorisation from the operational manager.

43. At 4.20pm hospital staff asked for the man's next of kin contact details. Escort officers contacted the prison to get them, although his mother's telephone number was noted at the front of the escort log.

[13] A protein found in blood. Significantly high levels of troponin can signify a heart attack.

[14] X-rays and a computer are used to make detailed images of the inside of the body.

44. The man had a CT scan at 4.35pm. He was unconscious, and breathing with a ventilator. It is not clear when the man fell unconscious. He remained unrestrained with two escort officers at his bedside.

45. A family liaison officer was appointed but she did not try to contact his family. Instead, at 5.10pm, she spoke to staff at Glenfield Hospital and passed on the details of the man's mother and the Latvian Consulate.

46. At 6.10pm, the man's CT scan results came back and showed he had a cerebral bleed. The hospital doctor again asked for his family to be contacted and said that he had approximately 48 hours to live. Hospital staff spoke to the Latvian Consulate, who said they would make contact with the man's mother. At 9.30pm, the family liaison officer was asked by hospital staff for the man's next of kin contact details. She advised them that these had already been given to another member of staff who had noted them in his patient care plan. At 10.00pm, the family liaison officer was contacted again and told that the man's next of kin details had not been noted in his patient care plan and so she gave them again.

47. On 7 August, at 7.30am, the duty director at Dovegate was contacted by the hospital. Hospital staff had emailed the Latvian Embassy advising them that the man's next of kin needed to be contacted urgently for consent to turn off the man's life support machine.

48. At 11.25am, a hospital doctor examined the man. The doctor planned a brain stem response test that afternoon, to see if the man responded. The tests were carried out at 12.50pm, but the man did not respond and he was pronounced dead.

Support for prisoners

49. The duty director told the man's cellmate personally about the man's death. Notices were displayed in the prison to let prisoners know of the man's death and the support that was available to them. All prisoners subject to suicide prevention monitoring were reviewed.

Support for staff

50. A debriefing session was held by an Audit Manager to offer support to officers. The doctor told the investigator that healthcare staff were not invited to the debriefing session, but had their own meeting a few days after the man's death. The doctor said that the meeting identified some issues about the management of patients with high blood pressure and arrangements for initiating urgent treatment. The doctor suggested during the meeting that the guidelines for treating patients with high blood pressure should be reviewed.

Family liaison

51. The man's brother-in-law contacted the family liaison officer at 4.15pm on 7 August. He said that he worked in England and could speak reasonable English.

He did not know that the man had died. The family liaison officer broke the news to him, explained what had happened and how long the man had been in custody. She explained that the man had not been alone when he died and that a priest had visited the hospital on Saturday and held a service. The man's brother-in-law said that he would speak to his family in Latvia and let the family liaison officer know the preferences for the funeral. The man's body was repatriated to Latvia on 23 August, and his funeral was on 28 August. The prison paid the cost of the repatriation of the body and the Director has arranged to pay reasonable funeral costs.

ISSUES

Clinical care

52. The man arrived at Dovegate with high blood pressure. He said he thought he was also suffering from pancreatitis and hepatitis C. The man was assessed by the doctor two days after arriving at Dovegate. The doctor was concerned about his high blood pressure and started him on medication to reduce his blood pressure to a normal range. The doctor was not overly concerned about his headaches and vomiting as the man said he had been suffering from these for three weeks, and sickness and headaches are symptoms of pancreatitis. The doctor referred the man for an urgent blood test to determine the cause of the high blood pressure and confirm if he had hepatitis C.

53. The clinical reviewer considers that the management of the man's blood pressure fell below the standard of care he could have expected to receive in the community. In particular there was no recorded comment or plan to monitor the man's blood pressure when he arrived at Dovegate, despite the high reading taking in reception. Although prisoners' blood pressure can rise when they first arrive, the clinical reviewer considers that a blood pressure reading as high as the man's should have prompted the nurse to repeat the blood pressure reading and seek further medical advice from the out of hours doctor. The clinical reviewer believes it was not acceptable to wait 48 hours before repeating the blood pressure test.

54. In the investigation report into a death at Dovegate in July 2011, we were also critical of the failure to refer prisoners for appropriate tests when a medical need had been identified. The clinical reviewer says in the review that the man's blood pressure reading should have prompted a full review of his medical history and examination. This does not appear to have been done by any of the healthcare staff who saw the man. We agree with the findings of the clinical review and endorse the clinical reviewer's recommendation:

    The Head of Healthcare should ensure that high blood pressure is promptly and appropriately investigated.

55. The nurse issued the man aspirin to reduce the risk of a stroke. The clinical reviewer comments that giving the man aspirin when he had such high blood pressure was not appropriate. Aspirin should be given with caution to patients who have high blood pressure, as it can cause or aggravate intercerebral bleeding. A stroke can only be confirmed by specialist investigation and aspirin should not be taken beforehand. We make the following recommendation:

    The Head of Healthcare should ensure that all clinical staff are up to date with current guidelines for identifying and treating the symptoms of strokes.

Response on 31 July

56. At 7.30pm on 31 July, the man's cell mate told the Officer that the man had collapsed and banged his head. The Officer decided that the man needed to see a nurse, but did not consider the situation to be life threatening or an emergency. He telephoned for a nurse to come to the wing, but in the interval

he made no further checks on the man to see if his condition had changed. The Officer said that he told the man's cell mate to press the cell bell again if the man got worse or he was concerned. It was a further hour before the man was checked by another Officer, when he came on duty at 8.30pm. The Officer could see that the man had been bleeding from his head and called for a nurse. The nurse responded within five minutes and an ambulance was then called to take the man to hospital.

57. It is concerning that the man was not checked for an hour after collapsing in his cell. The Officer should have checked on the man and then ensured that the nurse was on her way. Although the two Officers said that the man was alert and did not look unwell, he was not checked again and no one chased up healthcare. Although the man apparently looked reasonably well to the officers, his blood pressure was extremely high and he needed urgent medical treatment.

The Director and Head of Healthcare should ensure that prisoners who collapse in their cell receive prompt medical attention and are monitored until a member of healthcare attends to carry out a full assessment.

Interpreting services

58. A professional telephone interpreting service was used to complete the man's reception when he arrived at Dovegate, including his health screen and his cell sharing risk assessment. The service is used for confidential conversations and the mental health nurse told the investigator that it is easy to use, although conversations take longer.

59. The man's cellmate acted as an interpreter for all other medical appointments, his secondary health screen and doctors' appointments. The doctor said he was new to the prison and at the time was not aware that the telephone translation service was available, so did not stop the consultation. (He said that he has since used the service on a couple of other occasions). The doctor commented that the man's cell mate seemed more interested in his own health during the appointment. He was concerned that he would catch hepatitis C from the man by sharing a cell with him. It appears he had been talking to other prisoners on the wing about this.

60. It was inappropriate for the man's cellmate to have been used as an interpreter for his medical appointments. This breached the man's right to patient confidentiality and sensitive medical information was discussed which could have affected his safety in the prison. All healthcare staff should be aware of the interpreting service and it was not acceptable that the doctor had not been informed. The Inspectorate of Prisons made recommendations about the use of interpreting services in the last two inspection reports, but the man's experience shows that little progress has been made. In a previous investigation, we also indicated the need for interpreters to be used. We repeat the Inspectorate's recommendation:

The Director should ensure that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

Contacting next of kin

61. Prison Rule 22 says that:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of a mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

62. The man was admitted to hospital during the late evening of 31 July. Three days later, on 3 August, the man asked if he could telephone his mother to let her know that he was unwell in hospital. A telephone call was not facilitated, although his mother's telephone number was recorded in the escort documents.

63. On 6 August, nearly a week after the man was admitted to hospital, his condition deteriorated and hospital staff asked for his next of kin to be informed as his prognosis was poor. The details were passed on to the hospital, but they were not recorded properly and the man's family were not contacted until after he had died. If the man had been allowed to speak to his mother when he asked, it would have established contact with his family. The prison did not contact his family to let them know he was unwell.

64. Although the extent of the man's condition was not clear when he was admitted to hospital for further investigative tests, it was thought he might be having a heart attack and this was confirmed a short time later. This constitutes a serious medical condition and we consider his family should have been notified. Prison staff were aware that he was going to be staying in hospital for some time and should have made arrangements for him to speak to his mother, especially when he had asked to do so. If Prison Rule 22 had been followed appropriately, the man's next of kin would have known he was unwell and would have been able to contact the prison or hospital for updates on his condition if they needed to.

The Director should ensure that families are informed when a prisoner is admitted to hospital for a suspected serious medical condition.

Restraints

65. The man was restrained using double cuffs during his escort to hospital. This was because prison staff had a limited knowledge of the man's offences and behaviour, which meant that managers were not able to make a comprehensive assessment of the risk that he posed. The nurse was consulted and said that she did not consider his condition affected his level of risk.

66. Prison Service guidance on the use of restraints indicates that an escort chain must be applied when handcuffs are inappropriate, for example, during a bedwatch. When the man arrived at hospital he remained in double cuffs and an escort chain was used when he went to the toilet. The risk assessment was not reconsidered until the next day, when the restraint was reduced to an escort chain. Following a High Court judgement in 2007 about the use of restraints there is a requirement for a fresh risk assessment to be conducted each time a seriously ill prisoner is moved or their clinical condition is reviewed. The judgement considered that the conditions of restraint applied during a prisoner's stay at hospital should be assessed separately from the conditions of restraint

used on escort and that this also needed to be assessed at the start of each period of stay at hospital and reviewed regularly or when circumstances changed.

67. When the man was admitted to hospital in the night of 31 July/1 August there was no review of his risk assessment and the assessment for his escort journey continued to be applied. It appears from the escort documentation that the man remained handcuffed until the next day when an escort chain was applied instead, although there is no evidence of a further risk assessment. We consider it was inappropriate for the man to have been kept in double handcuffs after he had been admitted to hospital and the risk assessment should have been reviewed as soon as his circumstances changed.

The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, are reviewed as necessary and are based on the actual risk the prisoner presents at the time.

CONCLUSION

68. When the man arrived at Dovegate his blood pressure was found to be very high, but he was not examined by a doctor until two days later. The man's blood pressure readings were then repeated, rather than being fully investigated as they ought to have been. Three days after the man arrived at Dovegate he collapsed in his cell and was taken to hospital, where he died a week later. The clinical reviewer concludes that the man's blood pressure was poorly managed.

69. Appropriate interpreting services were not used during most of the man's confidential medical consultations. This breached patient confidentiality and could have affected the man's safety in the prison. The man's family were not notified that he had been taken to hospital as they should have been, and his family did not know he had been unwell until they were informed he had died. When the man was first admitted to hospital his risk assessment was not reviewed and the level of restraints used was not justified by a risk assessment which fully took into account his circumstances and health.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that high blood pressure is promptly and appropriately investigated.

2. The Head of Healthcare should ensure that all clinical staff are up to date with current guidelines for identifying and treating the symptoms of strokes.

3. The Director and Head of Healthcare should ensure that prisoners who collapse in their cell receive prompt medical attention and are monitored until a member of healthcare attends to carry out a full assessment.

4. The Director should ensure that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

5. The Director should ensure that families are informed when a prisoner is admitted to hospital for a suspected serious medical condition.

6. The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, are reviewed as necessary and are based on the actual risk the prisoner presents at the time.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that high blood pressure is promptly and appropriately investigated.	Accepted	The head of healthcare accepts this recommendation. NICE guidance CG127 has been handed to all staff and is also available in Reception. Task's are generated for healthcare staff to review prisoners BP with high blood pressures and this is now overseen by the clinical lead and audited on a monthly basis.		Completed
2	The Head of Healthcare should ensure that all clinical staff are up to date with current guidelines for identifying and treating the symptoms of strokes.	Accepted	The Head of healthcare accepts this recommendation. NICE guidance CG68 has been handed out to all staff and a copy now located in Reception.		Completed
3	The Director and Head of Healthcare should ensure that prisoners who collapse in their cell receive prompt medical attention and are monitored until a member of healthcare attends to carry out a full assessment.	Accepted	All PCO staff are trained in first aid as first on the scene, prisoners will receive prompt medical attention from these first aid trained staff until arrival of healthcare staff at scene. PCO staff have been reminded of this requirement		Completed

4	The Director should ensure that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.	Accepted	The Director accepts this recommendation, The head of Healthcare will reinforce the need to use the appropriate interpretation service for all patients requiring access to interpretation services.		Completed Language Line in use.
5	The Director should ensure that families are informed when a prisoner is admitted to hospital for a suspected serious medical condition.	Accepted	Resilience has been built into the family contact officers role at HMP Dovegate, prisoners families are being updated on admission to hospital for serious conditions	June 2013	Completed Additional staff have now been trained
6	The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, are reviewed as necessary and are based on the actual risk the prisoner presents at the time.	Accepted	The Director accepts this recommendation but would like to confirm that a risk review was undertaken at an appropriate point when the Duty Manager became aware that there was a change in the prisoner's condition.		Completed