

**Investigation into the circumstances surrounding the
death of a man
at HMP Doncaster on 6 July 2008**

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

January 2010

This is the report of an investigation into the circumstances of the death of the man on 6 July 2008, a day after he arrived at HMP Doncaster on remand. He was 32 years old at the time of his death from a drug overdose. His death was sudden and it must be very difficult for his family and those who knew and loved him to bear such a loss. I would like to offer my sincere condolences to his family, friends and to all those who knew him.

My colleague conducted the investigation on behalf of the Prisons and Probation Ombudsman. An independent review into the man's care was undertaken by the Quality Commissioning Governance Manager, on behalf of NHS Doncaster. I am grateful for his valuable contribution. I would also like to thank the Director of Doncaster, and the Head of Internal Affairs, for their cooperation and assistance with the investigation. I am particularly grateful to the member of the prison staff who provided a very high standard of liaison.

I apologise for the delay in producing this report. The investigation was suspended for a considerable time while the police conducted their own enquiries. Misusing controlled medication is a serious matter, particularly when it occurs in prison. I am satisfied that the Director and the local police are taking appropriate action.

Recommendations aside, the report concludes that for the short time the man was at Doncaster, the medical care he received was appropriate and in accordance with local policies at the time. However, it is acknowledged that illegal drugs and drug abuse in prison are a national problem for both state and privately run prisons such as Doncaster. The man's death could not have been foreseen by the prison. He took Subutex illegally in prison and this, combined with his poor health and prescribed methadone, proved to be a fatal combination.

I make four recommendations, three relating to recordkeeping and one regarding family liaison. The first recommends that escort staff record any symptoms indicating ill health or injury on the Prisoner Escort Form. The clinical reviewer has commented on the poor quality of healthcare records and the second recommendation asks staff to remember the requirement to keep accurate and legible records. In common with a past investigation at Doncaster, the investigation has found that a culture of falsifying records continues. Once again, I recommend that the Director make sure attention is given to ensuring compliance with the requirement for accurate recording of observations and effective management checks.

Sadly, the prison's handling of conveying the news of the man's death to his family fell short of what is expected and was not compliant with Prison Service instructions. The consequences were avoidable and caused distress to his mother. It is recommended that in the future, all circumstances are taken into account in deciding whether to notify all named next of kin.

Doncaster prison's detailed response to my recommendations is on the final page of this report.

The man's mother raised a number of questions following the publication of my draft report. These related to clinical issues and the Primary Care Trust have responded to these in an additional annex to this report.

Jane Webb
Deputy Prisons and Probation Ombudsman

January 2010

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SUMMARY

The man died on 6 July 2008 from a drug overdose. He was 32 years old and had a longstanding history of alcohol and drug misuse. He had been remanded to HMP Doncaster the previous day.

The man arrived at Doncaster from court at around 11.00am on Saturday 5 July. He was known to staff from previous periods of custody at Doncaster. On this occasion, reception staff saw he was vomiting but it was not noted on the prisoner escort paperwork. During the reception process, he made several trips to the toilet to be sick. The reception nurse who assessed him identified that he was withdrawing from substance misuse and therefore suitable for Houseblock 3, detoxification wing. He was not placed on the wing immediately as there were no spaces at the time. He went to B wing cell 2-24 later in the day.

His cellmate, said that the man was clearly suffering withdrawal symptoms. He recalled the man obtaining Subutex from another prisoner and being sick every five or ten minutes thereafter. During the early evening, the man's cellmate remembered ringing the cell bell for help on the man's behalf because he was too ill to do it himself. Staff attended and the cellmate recalls that the man said staff had given him something to stop him being sick.

At around 8.00pm, the man was taken to see the prison doctor, for a routine first night appointment. The man told the doctor that he suffered from deep vein thrombosis and had suffered a recent heart attack. He said he took a spray to relieve angina symptoms. The doctor prescribed Clexane and warfarin for the deep vein thrombosis, 15 mgs of diazepam for withdrawal and 30 mgs of methadone. This prescription was based on nominal levels until the man's usual prescription could be confirmed on the following Monday.

The cell mate, who was awake during the night, confirmed that around 3.30am he saw the man sitting up in bed. The Prison Custody Officer (PCO) completed the Night Patrol Log but it does not record whether he received the required responses. An internal investigation following the man's death showed that another PCO, marked that he had completed the early morning checks on his cell when he had not. I make a recommendation regarding this and it is disappointing that it is not the first time that this has appeared in one of the Ombudsman's reports.

At 7.14am, a PCO accompanied the prison nurse as she dispensed medication to prisoners in their cells. As the PCO could not rouse the man, he called the nurse and, on her instruction, asked another officer to make a code red emergency call over the radio net. Nursing staff responded swiftly and began cardio pulmonary resuscitation. At 7.35am, ambulance paramedics arrived and following an examination, the man was pronounced dead. During this time, the man's cellmate was removed from the cell and cared for appropriately.

The prison discovered that during the reception and first healthscreen procedures, the man had named his partner and his mother, respectively, as his next of kin. The police broke the news to the man's partner on behalf of the prison. Prison Service guidance provides for more than one next of kin to be told of a prisoner's death. It

would have been sensitive and appropriate for the prison to have reflected upon the circumstances and visited the man's mother to tell her at the same time as the police spoke with his partner. This led to a wholly avoidable and regrettable sequence of events and I make another recommendation in respect of this.

I consider that the medical care he received at Doncaster was appropriate and in accordance with local policies at the time. Recordkeeping and the culture of falsifying records, as identified in a previous investigation, remains a concern. Nevertheless, I judge that the man's death could not have been predicted by the prison. Evidence was given by his cellmate that he illegally obtained and used Subutex. The toxicology report provided to the coroner suggests that methadone and Subutex were present in his body. These substances, combined with the effects of alcohol withdrawal and his poor health, proved to be a fatal combination.

I make a further three recommendations for the Director of HMP Doncaster relating to recordkeeping and family liaison and one for GSL regarding recordkeeping while escorting prisoners.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 6 July 2008. Terms of Reference and notices were issued to staff and prisoners at Doncaster telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator, asked for copies of the man's prison records and clinical record relevant both to this period on remand and to a previous sentence served at Doncaster in January 2008.
2. The Investigator also contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. The report concludes that the man died of:
 - 1a. Alcoholic ketoacidosis in association with use of methadone and buprenorphine
3. The Coroner has requested a copy of this report upon completion and I am happy to comply.
4. The Investigator visited Doncaster in August 2008 and January and March 2009. She met the deputy director, head of internal affairs and members of healthcare staff. She visited B wing where the man had been located and talked informally with staff. She also went to HMP Leeds to talk to the man's cell mate.
5. A clinical review of the man's medical care at Doncaster was commissioned from NHS Doncaster and undertaken by the Quality Commissioning Governance Manager. His review appears as an annex to this report.
6. One of the Ombudsman's Family Liaison Officers, spoke with the man's mother and his partner and then with professionals involved with his partner. His mother raised a concern that she was told of her son's death by his partner and not the prison. She was also critical of the difficulty she had contacting anyone at the prison once she had been told the news. I hope her concerns have been addressed during the investigation.

HMP DONCASTER

7. HMP Doncaster is a local, privately run, category B prison. The accommodation is arranged in three identical triangular shaped Houseblocks, each with four wings. There are 95 prisoners per wing with cells arranged on two levels. Doncaster has an operating capacity of 1145 prisoners. It holds remand and sentenced young offenders and adult males. In her report of an unannounced inspection between 11 and 15 February 2008, HM Chief Inspector of Prisons described some aspects of the accommodation as squalid and poorly equipped. However, she commended the amount of time prisoners spent out of their cells and the prison's resettlement work.
8. The First Night Centre is located on Houseblock 3. The IMB described it as a busy and demanding unit with around 1170 prisoners per month moving on and off the unit. Dame Anne found the First Night Centre was better managed than in previous inspections, but there was a need for further improvements in detoxification arrangements.
9. Healthcare is provided by Serco Health and is based on two floors. A 29 bed in-patient unit is located on the upper floor with primary healthcare services on the lower floor. In her inspection, Dame Anne commented on a worrying deterioration in healthcare:

“There was no needs analysis, governance was weak, access to a GP and dentist poor, and medicines management and in patient services were inadequate.”
10. The integrated drug treatment system (IDTS) was only partially in place at the time the man died. Dame Anne noted that the clinical lead was also the drug strategy co-ordinator and had little time for the role.
11. Dame Anne's report also drew attention to the availability of drugs on the wings. This issue is very pertinent to the circumstances surrounding the death of the man and is supported by evidence within the toxicology report provided to the Coroner. The report found that:

“Statistics showed drug use was most prevalent on Houseblocks 2 and 3 and least on Houseblock 1 (which included the voluntary testing unit and vulnerable prisoners unit). In our survey, 34% of adult prisoners thought it was easy to get drugs in the prison compared to 19% in 2005.”
12. Although the inspection highlighted a “worrying deterioration” in healthcare, this was balanced against much that is positive in the prison.
13. The Independent Monitoring Board (IMB) report for 2007/2008 says that understaffing and overcrowding have affected the prison's ability to address serious problems such as drug addiction and offending behaviour. The IMB also highlighted that, following a criticism by Dame Anne, the practice of

nursing staff dispensing medication on the wings with discipline staff in attendance has ceased.

14. The purpose of IDTS is to address substance misuse problems in remand and sentenced prisoners. It enhances systems already in place such as first night prescribing of medication and opiate replacement therapy. There are specialist nursing staff who support and treat those with substance misuse problems. On the detoxification wing where the man was located, wing staff carried out checks every 30 minutes and recorded the outcome on a 5 Day Detoxification Record throughout the day and night.
15. Since 2004, the Prison and Probation Ombudsman's office has investigated a number of substance related deaths in prisons and approved premises. However, they continue to remain comparatively rare in prisons.

KEY FINDINGS

16. The man appeared at a local Magistrates Court in July 2008, where he was remanded into custody to await sentence. He arrived at the prison at around 11.00am. Prison staff saw that he was unwell as he stepped off the prison van. Prison Custody Officers were on reception duty. One of them said he knew the man from his past sentences and did not recall him being ill when he arrived on previous occasions. He said that the man “got off the bus carrying a plastic bag into which he had been vomiting”. He said he was told by the escort van staff (GSL) that the man had been ill on the journey. The investigator, noted that the Prisoner Escort Record (PER) did not refer to him being unwell when he transferred from the escort company to the prison. However, one of the PCO officers completed an Officer’s Report indicating that the man was suffering from “illness” while in the reception area. Staff recalled that he was the only prisoner to arrive that day on that particular prison van and therefore the reception process was fairly swift.
17. The officers carried out of a full search of the man. They then asked him to sit outside the nurses’ office to await a first reception health check. Both officers commented to the investigator that he was able to carry out every task asked of him. The man told the officers he was very thirsty and asked for water on a number of occasions which they provided. One of the officers recalls that he also went to the toilet frequently to be sick. The other officer asked him if he was “alright and he kept saying he was ok, but he was very thirsty”. The officer estimated that it took around half an hour for a prisoner to go through the reception process. He told the investigator that, other than being sick, he could not recall any other indications that the man was unwell. The investigator gained the impression that as staff knew the man misused drugs, they assumed he was suffering from drug withdrawal symptoms.
18. As he was clearly unwell, he was given priority to see the nurse. He underwent a preliminary health screen and was assessed as needing to be located on the Integrated Drug Treatment Strategy (IDTS) wing.
19. In the IDTS/Substance Misuse Services document completed by nursing staff, it was recorded that the man had said that he had a heart attack three weeks earlier. However, the post mortem found no evidence that he had suffered a heart attack either recently or in the past. He said that he was “fine now” and was not on medication. The nurse recorded that he was to be monitored for signs of heart pain and start alcohol detoxification. However, he later told the prison doctor that he used a spray for angina. His methadone dosage was to be confirmed two days later on Monday and the “statutory dose of diazepam to be given after GP seen prisoner”. The sheet on which this information is recorded is clearly written, but the time is illegible.
20. At the time of the man’s imprisonment, Doncaster was in the early stages of implementing IDTS. However, prisoners identified through the reception

health screen as having substance abuse problems were “fast tracked” to the IDTS detoxification wing and he benefited from this.

21. Prisoners are permitted a telephone call shortly after they are received into prison so that they can tell a family member or friend where they are. One of the Prison Custody Officers recalls the man using the telephone but was unable to say to whom he made the call. (Prisoner telephone calls are recorded in the main prison but not at reception.) Reception staff said that he gave his partner as his next of kin, although the chaplain, acting as family liaison officer, found no next of kin details on the prison computer system.
22. At around 12.15pm, he was escorted to Houseblock 3. He could not go to the IDTS wing immediately as there were no spaces. In interview, one of the Prisons’ Custody Officers recalled that he might have taken the man up to the wing. He said “I’m sure it was me that day that took him up and [upon handing the man over to staff] we just said he’s not been very well, he had been sick in reception”. The other Prison Custody Officer was unable to say whether wing staff indicated that they would take any action.
23. When a space on the IDTS wing became available, the man moved to cell 2-24, B wing, a double cell which he shared with another prisoner – his cellmate. The investigator visited HMP Leeds and spoke with the man’s cellmate who was most helpful to the investigator, however he acknowledged that he too was suffering from substance withdrawal and had taken valium to ease his symptoms. Therefore, while there is little dispute over the sequence of events he related to her, she noted that his recollection of timings differed significantly in some respects to that of staff. He recalled that he had been taken to the cell five or six minutes before the man who had arrived at 5.05pm. The man’s cellmate said that he could tell which drugs the man had been misusing in the community from his symptoms as he too was detoxing from alcohol and drugs. He said the man asked if he could have the bottom bunk and he agreed.
24. Tea was served to prisoners at around 5.30pm. The cellmate said that the man did not eat his tea because he “couldn’t stomach it” due to sickness. He recalled that the man appeared to go over to where food was being served, but changed his mind. He watched as the man then went to another prisoner’s cell door located by the telephones. The cell door was already unlocked and the man went inside. He later emerged with a carton of milk and, according to the cellmate, some Subutex. (Subutex is a brand of buprenorphine, a drug which is used to replace heroin and reduce withdrawal symptoms.) The cellmate said in his statement to the Deputy Director that he was escorted by a prison custody officer to get his methadone at around 7.00pm. When he returned, the man admitted to him that he had snorted Subutex.
25. It was obvious to the man’s cellmate, that the man continued to suffer the effects of substance withdrawal. The cellmate tried to reassure the man that staff “had to give him something within 24 hours”. The cellmate said that the man revealed that he had used drugs the day before he came into prison,

but did not say what he had taken. The cellmate recalled that having snorted the Subutex, the man was sick every five or ten minutes.

26. The cellmate remembered that, during the early evening, possibly around 8.00pm, he rang the cell bell because the man was vomiting badly and could not reach the bell himself. Cell bell records are not kept by the prison and therefore it is not possible to say when the cellmate rang the bell. He said that the man told the officer "you haven't given me any meds" (meaning medication). The cellmate explained that the officer escorted the man from the cell and he then set about cleaning it. He said the officer took the man to the office on the wing. When the man returned, he told his cellmate that staff had given him something to drink to stop him being sick.
27. He said that at around 9.00pm, an officer took the man outside the cell again, shut the door and spoke with him outside. He returned around five minutes later, sat down and had a cigarette. The cellmate said that he went back to his own bed and lay down. The cellmate told the investigator that the man was removed from the cell twice that night.
28. A third Prison Custody Officer was on duty on the IDTS wing. He escorted the man to see, the prison doctor at around 8.00pm. In his statement, the third PCO said that on the way, the man confided to him about the amount of weight he had put on since his release from his last prison sentence at Doncaster in February. He said this was due to his excessive drinking and drug misuse. He also spoke about his immediate concern about getting his methadone. The 3rd PCO said he told the man that these matters were best raised with the medical staff. During their conversation, The A third Prison Custody Officer said the man spoke very fondly of his partner, PCO White noted that the man's eye contact was poor and his "mood seemed low as if he had things on his mind".
29. The prison doctor, a general surgeon and part-time prison doctor assessed the man in the presence of the healthcare nurse. He explained that he saw the man as a matter of course as a new reception prisoner and not specifically because of his substance misuse. The prison doctor noticed that the man had evidence of deep vein thrombosis on his leg. He said that the man told him that he had suffered a heart attack and took a GTN spray to relieve symptoms of angina. This was the first time that he had mentioned he was taking this medication. As he seemed familiar with heart medication, the prison doctor thought there must be some truth in what he said but this would need to be confirmed with the man's doctor. In the meantime, he prescribed the GTN spray for the man to use in case he had an angina attack.
30. The prison doctor prescribed Clexane and warfarin for the DVT, along with 15 mgs of diazepam (to assist with alcohol withdrawal symptoms) and 30 mgs of methadone. Healthcare Nurse noted in her statement that she was unhappy that Clexane had been prescribed with the other medication. The prison doctor explained to the investigator that some nursing staff held this view because the effect of Clexane is immediate. (If all is normal, then

warfarin, which takes longer to act, can be given at the same time so that it remains active when the shorter acting Clexane has worn off. This gives both an immediate and a longer lasting effect.) The prison doctor explained that although one worked differently to the other, the result was the same. The man told the doctor that he had not had Clexane for the past four days which was why Mr Kharmis considered it safe to prescribe both Clexane and warfarin. The clinical reviewer noted that nursing staff made a decision not to give some of this medication because of their uncertainty about the prescription. The clinical reviewer said this decision was not a contributing factor to the man's death and staff were right to question a prescription for a treatment that they thought needed clarification.

31. The prison doctor and the nursing staff were clear about the prison prescribing policy. Staff explained to the investigator and to the clinical reviewer that methadone is prescribed at the nominal level of 30 mgs until the amount that the prisoner had been prescribed in the community is confirmed by the relevant prescribing service. This is because prisoners' accounts of their level of medication in the community are not always accurate, and it is verified before a further prescription is given. As the man was received into the prison on a Saturday, confirmation would not have been possible until the following Monday. Therefore he was prescribed the nominal level until his dosage could be confirmed. He would receive the first dose the following morning.
32. The cellmate told the investigator that he heard the man being sick at around 12.30am. When he got up at around 2.00am to 2.30am to make a cup of tea and use the bathroom, he heard him snoring loudly in a rhythmic and slow manner. The cellmate said that he stayed awake for around an hour and during that time, while he was sitting in the chair, he saw the man sitting up in the bottom bunk. He said the observation flap on the cell was closed and no-one else could see in.
33. The cellmate could not remember whether officers checked their cell during the night. He said he thought that at about 5.00am the cell light went on, the flap was opened and went down again at around 5.30am. He thought that the officer had a clipboard and "checked people off" and that they did not carry keys at night to open the cells.
34. The Night Patrol log gives a clear instruction to staff before starting duty that when checking a prisoner, staff must be able to see part of his body clearly and obtain a physical and/or verbal response. It asks staff to confirm they have patrolled the prisoner living area twice hourly varying the route on each occasion. If there is any doubt, then the Night Orderly Officer is to be contacted. The night patrol log was completed by the night Prison Custody Officer who wrote that night checks had been carried out at 11.00pm, 1.30am and 4.30am. Routine visits by the duty director were noted at 11.12pm and 3.23am. There is no record as to whether the man gave a verbal or physical response to the night checks. It is possible that he did because the cellmate could say with some certainty that the man was alive at around 5.30am and he could feel him moving on the bottom bunk. He

said an officer opened the door at 7.15am. The man was lying on the bottom bunk with his arm outstretched and looked white. He said he checked the man's pulse but found him cold to touch.

35. The log entitled "5 Day Detox Watch For Prisoner" was completed by five staff over a seven hour 30 minute period. The cell number 2.24 is handwritten at the top of the page and suggests that the man was in cell 2.24 from 11.30am when the log started. It is unlikely that this is correct as, according to one of the Prison Custody Officers, he escorted the man to the Houseblock at 12.15pm and the other PCO supports this timing in his statement. The log gives a pre printed column for time in half observation spaces. The next column gives an initial and the final column a pre printed "NAD" and space for a comment next to it. [NAD stands for Nothing Abnormal Detected.] The log continues until 7.00am and each column is ticked next to the NAD space.
36. At 6.00am, 6.30am and 7.00am on 6 July, the day-shift PCO ticked against "NAD" in each timed column indicating that he checked cell 2-24 at these times and nothing abnormal was detected. After the man died, an internal investigation by the prison found that the day-shift PCO had not made the checks at these times. The prison dealt with the matter through their disciplinary procedures.
37. That morning, all the PCOs escorted the Healthcare & IDTS nurse, as she dispensed the morning medication on B wing. The PCO present task was to open the cell doors. He said that at 7.14am, while the other PCOs were with Nurse Smith at cell 2.23, he unlocked cell 2.24 to wake the man in readiness for his medication. He said that he called the man's name but did not get a response. He then shook the man and felt that he was cold, his fingers were blue and his chest was not moving. He called the Healthcare nurse and, upon her instruction, asked the day-shift PCO to make a code red emergency call over the radio net. (The code indicates the nature of the emergency.)
38. The Healthcare nurse told the investigator that she was issuing the morning medication to cell 2-23 during her round at around 7.13am when she was called to cell 2.24. She said that the man was not breathing and there was no pulse when she examined him. She told my investigator that she started cardio pulmonary resuscitation (CPR) even though she assessed that he had died some time earlier. My investigator asked her why she started CPR when she thought that he had died and she said that she did so because it was her duty and she was not qualified to pronounce death in an individual. She said that she had asked the other PCO to call a code red emergency medical response. The day-shift PCO confirmed that he did so and said that he then went to open the gates to allow the medical staff to come through. The Radio Operators Monitoring Log confirms that at 7.14am a code red medical response was called over the net by the day-shift PCO .
39. The Healthcare nurse said that all the nurses who formed the medical team, responded to the emergency call. She said they arrived with an emergency

response bag and a defibrillator machine. (A defibrillator is a machine that delivers a controlled electric shock to restore normal heart rhythm after a heart attack.) The defibrillator machine was immediately attached to the man. The defibrillator indicated that cardio pulmonary resuscitation (CPR) should be carried out. This was started by two of the nurses of the medical team.

40. In her statement, one of the nurses of the medical team confirmed that the Healthcare Nurse gave the man 30 chest compressions and she gave two rescue breaths. She said they continued with CPR until the ambulance arrived at around 7.35am and paramedics took over his care.
41. One of the PCO's said that while efforts were made to resuscitate the man, he and the day-shift PCO took the man's cellmate out of the cell to the upper showers and he remained with him. They asked the mental health nurse, to speak to him. The cellmate was re-located to cell 3-40 on D wing.
42. One of the nurses from the medical team was one of the nurses who responded to the code red emergency call. She said that one of the other nurses carried the response bag. She confirmed that healthcare staff started CPR prompted by the spoken instructions from the defibrillator machine and that they carried on until the paramedics arrived. She said that the de-fibrillator pads were removed from the man at 7.40am and the ambulance paramedics put their own attachments on the man. She added that CPR was stopped on the paramedics' instruction. An Incident Report completed by the deputy director, records that, following examination by the paramedics, the man was pronounced dead.
43. Another nurse also responded to the emergency code red call. She had heard the call over someone else's radio as she arrived at the gate of the prison. When she entered the cell, she found one of her colleague nurses giving the man chest compressions, while another nurse was giving breaths. She assisted with CPR and noted that the man's body was too stiff to move or to insert an airway. In these circumstances, healthcare staff made a judgement as to whether or not to commence CPR.
44. The mental health nurse said she fetched the oxygen tank from healthcare. When she returned with it, she was asked if she would speak to the cellmate who had shared a cell with the man. In her statement, she said that the man's cellmate was moved to D wing because he had disclosed to an officer that the man had obtained Subutex from another prisoner and snorted it.
45. In the Incident Report prepared by the Deputy Director, he said that the man's cellmate had been relocated to the First Night Centre with Buddy Support. An Assessment, Care in Custody and Teamwork (ACCT) document was re-opened by the unit manager on Houseblock 3 in order to support the cellmate during this difficult time. (ACCT is a process to monitor and support prisoners at risk of self-harm and suicide.)

46. In accordance with Prison Service policy, the police were notified. A statement completed by the Gatehouse Supervisor confirmed that an Inspector and a Detective Sergeant, went to the prison to start their investigation into the man's death.
47. The chaplain, who also acted as family liaison officer, attended the man's cell at 7.45am and spoke with staff to offer support. He then went to Houseblock 3D and spoke with the man's cellmate.
48. An entry at 8.35am in his family liaison log records that the man did not have any next of kin recorded on the prison computer information management system. He spoke with the duty director and with Head of Internal Affairs., who told the investigator that a search of the prison records revealed two next of kin. The man's partner was recorded as his next of kin on his core record and he had given his mother as his next of kin to nursing staff as noted on his clinical record. Head of Internal Affairs said that only one named next of kin can be notified and, in these circumstances, the prison would look at who was visiting or, as in the man's case, with whom he was living at the time of his death. At the time of his death, he had been living with his partner. The police and the prison were aware that his partner was vulnerable. Therefore the police offered to assume this responsibility and visit her at home to give her the very sad news. The prison accepted this offer. Understandably, and as expected, the man's partner was most upset. Around six hours later when she was in a position to do so, she telephoned the man's mother and gave her the tragic news. This was said to have been delivered in an unfortunate and forthright way and must have been a very distressing experience for his mother.
49. A hot debrief was held on 6 July. Staff were given the opportunity to raise immediate issues and to seek support through their managers or the staff care team.

ISSUES

Clinical care

50. The clinical review was undertaken by the Quality Commissioning Governance Manager, on behalf of NHS Doncaster. He reviewed all necessary records and conducted joint interviews with the investigator. He noted that the man had entered Doncaster in July 2008, at a time when the service provided to people with substance misuse problems was evolving. The clinical review acknowledges that the way “care is arranged and provided is now, very different to that which was in place at the time”. He further judges that “It would appear from the evidence that the death of the man could not have been foreseen or prevented by the healthcare that he received”.

Record keeping

51. The man vomited a number of times on the vehicle escort from the Magistrates court to the prison and in reception. Escort staff did not record this on the Prisoner Escort Form.

The Director of GSL should ensure that staff responsible for escorting prisoners records any noticeable symptoms of ill health or injury on the Prisoner Escort Form.

52. The log entitled “5 Day Detox Watch For Prisoner” was inaccurately completed and is misleading. It said that staff checked on the man at half hourly intervals and that all was well. He was clearly very unwell and his cell mate had called staff. The investigator noticed that the log columns do not have sufficient space for staff to write informative entries. One of the PCO’s said he escorted the man up to Houseblock 3 from reception at 12.15pm. He did not immediately go to B wing where cell 2.24 is located but to D wing to await a space on B wing. However, the log starts at 11.30am and cell 2.24 is marked at the top of the page suggesting that he was located in cell 2.24 when he was probably still in reception. While these early entries do not have a direct bearing on his death, it casts doubt upon the professionalism of the staff completing them and renders the documents worthless. This is particularly pertinent in the light of the final entries made by the day-shift PCO that are relevant to the investigation and are misleading.
53. At 6.00am, 6.30am and 7.00am, the day-shift PCO ticked the section of the form to indicate nothing abnormal. As part of the prison’s procedures when a death in custody occurs, the Head of Internal Affairs conducted an internal investigation into the man’s death on behalf of the prison. During his investigation, he viewed the closed circuit television tapes showing the man’s cell. He noted that although the day-shift PCO ticked the column to say that he had checked cell 2.24 from 6.00am onwards, the tape showed that he had not done so. It is possible that the record was completed at the beginning of his shift without him actually making the checks. The

investigator was informed that disciplinary action has been taken against the day-shift PCO..

54. The falsification of documents is a very serious matter. It gives misleading information and falls well beneath the professional standards required of prison staff. I am concerned that the falsification of documents is not confined to one area of the prison but appears to form part of a wider culture as similar practices were found by the Ombudsman following an investigation into a self-inflicted death at Doncaster in 2006. I therefore repeat the recommendation.

The Director should develop a strategy to reduce the incidence of falsifying documents, which is a grave breach of trust. This should include ensuring that all staff are fully aware of the necessity of accurately recording observations at the time they take place and that management checks ensure compliance.

55. The clinical review acknowledges that there is little healthcare documentation because of the short period of time the man was in custody. However, the clinical reviewer found that the man had two prescription charts. He also noted that some entries within the prison healthcare were difficult to read, were not timed and incomprehensible abbreviations were used. I often make recommendations regarding the importance of making proper and legible entries in the clinical record. It is a key component of delivering effective medical care.

The Head of Healthcare should ensure that staff are reminded of the requirements to keep accurate and legible records

Breaking the news of the man's death to family

56. Prison Service Order (PSO) 2710 "Follow up to deaths in custody" gives instructions to prisons on actions to be taken after a death in custody. The only mandatory requirement in this PSO is "Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner". Further instructions in "Guidance supplementary to chapter 4 of the PSO – Liaison with bereaved families following a death in custody" set out who should be regarded as the family. It says "every family is different and has its own dynamics. A Family Liaison Officer needs to be flexible and open-minded and should approach the family in accordance with its individual needs" and "the family may... at odds amongst themselves... and there may be several branches all with equal rights to information...the Family Liaison Officer should be prepared to deal with different sections of one family if necessary". The instructions also list good practice in delivering the news and cites face to face notification by the prison as best practice.
57. The police broke the news of the man's death to his partner and, as expected, she found it extremely difficult. Prison staff had been aware of his partner's vulnerability and the possible response. In these circumstances,

the prison agreed that the police should visit her. However, given their knowledge of his partner's fragility and that he had also cited his mother as next of kin, it would have been more sensitive and appropriate for the duty director and the chaplain to visit the man's mother at the same time to personally give her the tragic news of her son's death, rather than leave this task to his partner. Head of Internal Affairs was under the mistaken impression that only one next of kin could be notified. The result is that the man's mother learned of her son's death in a most unfortunate way. I am pleased, however, that his mother said that when the chaplain visited her home with her son's property he had been very supportive.

The Director should ensure that prison managers and staff, particularly those acting as Family Liaison Officers, comply with the requirements of PSO 2710 and the supplementary guidance. They should consider all the circumstances when breaking bad news to the prisoner's family. In the event of more than one next of kin or a divided family, they should consider the right of equal access to information and make a judgement as to whether it would be more appropriate for all members to be told at the same time.

CONCLUSION

58. The man was clearly suffering badly from drug and alcohol withdrawal symptoms when he arrived at Doncaster. It is possible that he had learned from his previous custodial experiences at Doncaster that it was unlikely that he would receive any medication until the day after his arrival because of the policies and procedures in place at the time. In these circumstances, it is likely that he chose to self-medicate with Subutex, illegally obtained from another prisoner, in order to ease his symptoms rather than wait until the following morning for medical relief. He was discovered by staff and healthcare attended his cell and acted very quickly, but sadly he was pronounced dead shortly afterwards. The post mortem report concludes that he died from alcoholic ketoacidosis caused by a combination of methadone and Subutex use.
59. The ease with which he was able to obtain drugs in the prison is a concern I share with Dame Anne Owers. It is difficult to say whether if staff had properly carried out the necessary night checks and obtained the appropriate responses, that the outcome would have been different. It may not have made a difference to him, but could be crucial in the future. The culture and practice of falsification of documents must cease.

RECOMMENDATIONS

1. The Director of GSL should ensure that staff responsible for escorting prisoners record any noticeable symptoms of ill health or injury on the Prisoner Escort Form.

Prison response: None

2. The Director should develop a strategy to reduce the incidence of falsifying documents, which is a grave breach of trust. This should include ensuring that all staff are fully aware of the necessity of accurately recording observations at the time they take place and that management checks ensure compliance.

Prison response: The issue of falsifying documents is being addressed. Management checks are regularly carried out by the Head of Internal Services. This involves routinely checking CCTV evidence against records of procedures carried out by staff i.e cell searches, night patrols, roll checks etc. Where it is found that recorded checks have not been carried out those staff involved face disciplinary procedures. It is considered a matter of gross misconduct and in the absence of exceptional circumstances the most likely outcome is a dismissal.

3. The Head of Healthcare should ensure that staff are reminded of the requirements to keep accurate and legible records.

Prison response: Healthcare staff are reminded of their obligation to keep accurate and legible records keeping on an ongoing basis.

4. The Director should ensure that prison managers and staff, particularly those acting as Family Liaison Officers, comply with the requirements of PSO 2710 and the supplementary guidance. They should consider all the circumstances when breaking bad news to the prisoner's family. In the event of more than one next of kin or a divided family, they should consider the right of equal access to information and make a judgement as to whether it would be more appropriate for all members to be told at the same time.

Prison response: Staff acting as Family Liaison Officers will continue to comply with the requirements of PSO 2710. However, on occasion it will be necessary to make a judgment on the best information available to them at the time. The decision they make will always be in the best interest of the next of kin of the deceased but will nevertheless be an 'judgment call'.