Investigation into the death of a man whilst in the custody of HMP & YOI Holme House in June 2009

Report by the Prisons and Probation Ombudsman for England and Wales

This is the investigation into the circumstances surrounding the death of the man, who did not respond when staff entered his cell. He was terminally ill, and died shortly afterwards in the company of prison staff. He was 55 years old. I offer my sincere sympathy and condolences to his family and friends for their loss.

The investigation was carried out by my investigator. A clinical review of the man's healthcare was undertaken by a clinical reviewer on behalf of the local PCT. I am grateful for his review. I would also like to thank the Governor of Holme House and his staff for their co-operation and assistance. Particular thanks go to the liaison officer for his help throughout the investigation.

In 2006, the man was sentenced to an indeterminate sentence for public protection. He was adamant that he had been unfairly convicted and was bitter about his detention. He served almost two years in prison before he was diagnosed with cancer.

The man was keen to be able to die at home with his family and, in the first half of 2009, made several requests for compassionate release. All of which were refused. However, he was transferred to HMP Holme House on 24 June in order to be closer to his family.

After only five days at Holme House, the man died. His sister was in the prison on the morning of his death but unfortunately did not manage to see him before he died. When my investigator met with her she raised several concerns about the way she and her brother were treated by Holme House. I hope that this report answers her questions.

The man had suffered from a terminal illness for a long time. Although he was not released, he was moved to a prison closer to his family. Although I raise several concerns regarding his care, I believe it was largely satisfactory. However, I was disappointed to hear of the way the news of his death was broken to his sister.

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

Jane Webb
Deputy Prisons and Probation Ombudsman

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SUMMARY

The man was sentenced to an indeterminate sentence for public protection in August 2006. He began his sentence at HMP Leeds, where he occupied a single cell as he was registered disabled.

The first two years of his time at Leeds, were largely uneventful. He was briefly in trouble for verbally abusing nurses regarding his medication and complained of being bullied. However, this allegation was not investigated fully as he would not say who was responsible.

In June 2008 he exhibited certain symptoms of illness including jaundice and dark coloured urine. The prison doctor was concerned and referred him to a specialist. In September he was told that he was suffering from a form of pancreatic cancer. He underwent chemotherapy in October and November, but it was later confirmed that the cancer was untreatable.

He returned to hospital in March 2009 in order to relieve his jaundice but he continued to physically decline. He applied for compassionate release three times between April and June but it was rejected each time. His risk of re-offending was still considered to be too high to warrant his release.

Staff at Leeds contacted HMP Holme House, which was nearer to his family home, to see if they would consider accepting him. This was agreed, and he transferred on 24 June 2009. He was housed in the healthcare centre due to his medical condition. He did not respond to staff when they entered his cell and died shortly afterwards.

This report looks closely at certain aspects of his care, and four recommendations are made with regard to record keeping, medication, visits and family liaison.

THE INVESTIGATION PROCESS

1. The investigation was carried out by my investigator. He contacted HMP Holme House and requested the paperwork concerning the man. This included documents from his time at HMP Leeds. Notices of the investigation were sent to Holme House. No-one came forward in response to the notices.

2. My investigator asked the local PCT to undertake a review into the clinical care received by the man at Leeds and Holme House. A clinical reviewer was commissioned to undertake this review.

3. My investigator and one of my family liaison officers visited the man's sister on 15 September to discuss the investigation. The man's sister raised the following issues:

   - Was his medication given to him at Holme House?
   - Why was he brought to the visits section, instead of allowing visits in the healthcare centre?
   - Were his offences noted on his door?
   - Was his bed too uncomfortable to sleep?
   - Who was with him when he died?
   - Had he died earlier than the prison claimed?

4. I sincerely hope that this report answers the questions of the man's family.

5. My investigator travelled to Holme House on 6 October to interview prison and healthcare staff. The clinical reviewer was provided with the transcripts of the interviews.

HMP LEEDS

6. Leeds was built in 1847 and expanded in 1994 and 2002. It is a category B local prison accepting prisoners from West Yorkshire. It has an operational capacity of 1,004. Prisoners live in six residential wings, a segregation unit and in-patients healthcare unit.

Independent Monitoring Board

7. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report from the Leeds IMB is that of 2009. The report noted the improved healthcare that prisoners received, but claimed that the personal officer scheme was not working well. (This scheme gives each prisoner a specific officer that they can approach and talk to should they wish to.)

HM Chief Inspector of Prisons

8. HM Chief Inspector of Prisons conducted an unannounced inspection of Leeds from 5 to 14 December 2007. The report commented on how the prison's senior management were strenuously attempting to improve a prison that was still falling short of standards. Many prisoners still felt unsafe. Anti-bullying, self-harm and suicide prevention procedures were still poorly implemented on the wings. The report noted that staff shortages affected healthcare provision, and record-keeping was sometimes inadequate.

Previous deaths at Leeds

9. Leeds experienced two deaths from natural causes in 2007, three in 2008 and two in 2009.

HMP & YOI HOLME HOUSE

10. Holme House is purpose built category B prison, which opened in May 1992. Its population is primarily drawn from Tees Valley, South West Durham, East Durham and North Yorkshire. It has an operational capacity of 994. The healthcare department has room for 28 prisoners.

Independent Monitoring Board

11. There was no report available from the Holme House IMB for the last three years.

HM Chief Inspector of Prisons

12. HM Chief Inspector of Prisons conducted an unannounced short follow-up inspection of Holme House from 16 to 18 March 2009. It was described as a reasonably safe prison that had made progress in all areas since the last inspection. The report included the following description of the healthcare services provided at Holme House:

> "Healthcare services needed further development, but there were plans to improve governance, pharmacy and dentistry."

Incentives and earned privileges scheme (IEP)

13. The IEP system is a means of monitoring prisoners' behaviour and rewarding good behaviour and punishing poor behaviour. Prison Service PSO 4000 describes it as follows:

> "The IEP scheme complements the discipline system by rewarding good behaviour. In addition to any local aims, it is intended to encourage prisoners and YOs [young offenders] to behave responsibly, to participate in constructive activity, and to progress through the system. This will foster a more disciplined and controlled, and therefore safer environment for prisoners and staff. It should also contribute to the reduction of re-offending by encouraging prisoners to lead law-abiding, productive and healthy lives."

14. Within the local system prisoners are able to move up a level (basic, standard or enhanced) and earn various privileges. Poor behaviour can result in moving down a level or losing privileges. Privileges include association time and extra visits.

Previous deaths at Holme House

15. Holme House experienced one death from natural causes in 2007, and two in 2008. Although, in the first case, the prisoner also died shortly after arriving at Holme House there are no direct similarities between the deaths at Holme House since 2007.

KEY FINDINGS

16. The man was convicted of sexual offences against a child. He was sentenced to an indeterminate sentence for public protection with a minimum of 239 days on 7 August 2006. He began his sentence in HMP Leeds. The cell sharing risk assessment contained a reference to the man as being at low risk of attacking a cellmate. The nurse who filled out section three of the form noted that the man required a cell on the second landing (ground floor) due to being registered disabled. Having a cell on the second landing prevented the man from having to climb stairs to reach the facilities on the wing.

17. In August and September, the man complained of being threatened by other prisoners. Although officers investigated the claim, they were unable to determine whether he was being threatened as he did not provide staff with the names of the alleged perpetrators.

18. He was prescribed medication to treat arthritic pain, excess stomach acid and migraines. He was abusive to the nurse dispensing his medication on three occasions in November as she was only able to give him enough medication for one day, rather than two days. The nurse placed him on report, and issued a "strike" for abusive behaviour. (This was a warning under the Incentives and Earned Privileges scheme.) Having pleaded not guilty at the adjudication board, the man later apologised for his behaviour.

19. The man declined to participate in a parole interview in April 2007 as he complained that it was merely "a paper exercise". When the parole report was discussed with him, he became angry and complained about what he felt to be his wrongful conviction.

20. In early June 2008, he complained of a pain in his back. He saw the prison doctor at the end of July as he was jaundiced and was passing dark urine. The doctor recorded that he had lost a stone in weight in the last month. The doctor wrote in his medical notes that the man might have cancer of the pancreas. He referred him for tests at the hospital under the two week referral system (where the patient is seen by a specialist within two weeks). Blood was also taken to be tested. The doctor recorded on 1 August that the blood tests revealed some malignancy, and the man was told that he had been referred to hospital.

21. The man went to hospital on 12 August and remained there as an in-patient until 3 September. He was referred to a specialist in gastrointestinal cancer medicine, for consideration of palliative chemotherapy. He was told in September that he was suffering from cholangiocarcinoma (a form of biliary tract cancer) and was offered palliative chemotherapy. The prison doctor noted that the man appeared to have lost more weight and remained jaundiced.

22. The chemotherapy took place throughout October and November. They occurred every Friday for three weeks followed by a week's respite. He was

described in his medical notes as gradually physically deteriorating during this time.

23. The man did not receive his medication over the weekend of 18 and 19 October due to a failure to reorder his prescription. A second nurse wrote that the man was unhappy about this as he did not have access to Dihydrocodeine (a pain-relief medication). He was given his pain relief after returning from a hospital visit on 21 October, and the prison doctor saw him the following day to confirm his prescription.

24. The man applied for enhanced status on the Incentives and Enhanced Privilege system on 6 November 2008. Although wing staff considered him unsuitable for enhanced status, it was granted in early December as a result of his medical prognosis. He was refused compassionate release by the Secretary of State on 5 December. He was deemed to be insufficiently incapacitated as he was still able to walk unaided for a short distance. His risk to others was also deemed to be still too high for him to be released.

25. On 30 December, the man legally changed his name and made a will.

26. He told staff on 20 February 2009 that his urine had changed colour to a vivid yellow/brown. His medical record included reference to his poor prognosis and a third nurse suggested that plans should be started for his palliative care. However, the man was adamant that it was his family that should provide this care.

27. On 6 March, the man underwent surgery to relieve his bile duct. He stayed in hospital until 20 March, and was very jaundiced. The specialist at the hospital thought that further chemotherapy was not warranted, and that palliative symptomatic care should begin. The man was reviewed by the prison doctor on 17 April who was struck by his weight loss and reduced mobility. His morphine pain relief was increased as he was suffering from further abdominal pain. The prison doctor wrote in his medical record that the man was content with his treatment and had declined referral to Macmillan care (Macmillan Cancer Support provides practical and medical support to those affected by cancer.)

28. The prison doctor increased the strength of the man's morphine medication on 8 May and noted that he still refused to see the Macmillan nurses. The doctor wrote that the man was increasingly unsteady on his feet on 29 May and was declining solid food, so Ensure was prescribed. (Ensure is a liquid food supplement.) The doctor sent a memorandum to the prison's lifer manager, regarding the application for the man's compassionate release. The doctor concluded that the man had advancing terminal cancer.

29. On 1 June, healthcare staff received an enquiry from a member of staff in the Ministry of Justice (MOJ) regarding visiting arrangements for the man should he be placed in the healthcare unit. The MOJ staff member was told that visiting arrangements could be facilitated if a palliative care plan was in place. (Palliative care is the emotional, spiritual and nursing care for terminally ill

patients.) It was noted in the man prison file that three applications for a compassionate release were rejected from April to June.

30. The man told a fourth nurse that he was ready to move to the healthcare unit on 11 June and this was arranged later that day. The following day, the prison doctor saw him and wrote that, following a discussion, he told the doctor he did not wish to be resuscitated if he suffered heart failure. A full nursing care plan was started in line with the Gold Standards Framework and Oramorph (a morphine-based pain relief medication) was prescribed. (The Gold Standards Framework is a system used to optimise the care for people nearing the end of life.) The doctor also referred him to a consultant in palliative care at Wheatfield's Hospice, who agreed to visit him and make an assessment.

31. A fifth nurse wrote that the man was able to attend to his personal hygiene, although he found it difficult to move. The nurse contacted the prison's disability officer for advice and ensured that the man was made comfortable. The nurse advised him speak to staff if he had any problems or concerns.

32. On 15 June, the prison doctor noted that the man's pain was seemingly under control. Two days later, a MacMillan nurse saw the man in the healthcare unit. The prison doctor noted that he would write to the lifer manager about the possibility of the man being transferred to HMP Holme House, so that he could be nearer to his family.

33. A second doctor examined the man on 20 June and noted that his blood pressure had dropped to a reading of 111/73 (a normal blood pressure reading is 130/80). The doctor asked healthcare staff for his blood pressure reading to be repeated and 30 minutes later it was recorded as being within normal range. The doctor wrote that staff should check on the man's well-being every four hours and, if his blood pressure fell, then a transfer to hospital must be arranged. The doctor further wrote that the man was going to be transferred the following week.

34. Two days later, an out-patient appointment was cancelled, as the man was not well enough to attend. Later, the fifth nurse wrote that the man was going to be transferred to Holme House in two days time. The nurse spoke to the palliative care services to tell them of the man's transfer so that information could be passed on by their teams.

35. The man was transferred to Holme House on 24 June. I understand he was accompanied on the journey by a nurse. Leeds had contacted the Head of Offender Health at Holme House and asked if they would accept the man so he could be closer to his family. The Head of Offender Health at Holme House agreed to receive the man, having discussed it with the Head of Residence. The cell sharing risk assessment undertaken upon his reception at Holme House recorded that the man was at low risk of attacking a cellmate, but required a single cell due to his medical condition. The first nurse at Holme House who undertook the initial healthscreen with the man immediately upon his arrival due to his health conditions. The first nurse who

saw the man at Holme House told the Ombudsman's investigator that she wanted to complete the process quickly to minimise the time he spent in reception because of his poor health. She recorded his terminal illness and the treatments related to it in the healthscreen document. The nurse said that the man told her that he assumed that he would live for at least another month. He was accommodated in a cell in the healthcare centre.

36. A professor from the Butterwick Hospice visited the man in the afternoon and recommended that the prescribed medication should continue as required. At Holme House, the man was prescribed medication for many reasons including pain relief, nausea, inflammatory conditions, constipation and stomach acid. The professor from the Butterwick Hospice left contact details for himself and for the Macmillan nurses who were willing to come and visit the man.

37. There was initially some confusion at Holme House due the man's prisoner number being different to the number on his medication. A second nurse from Holme House called the Head of Offender Health who clarified that the man should be given his medication. The numbers were different due to a new prison computer system at Leeds which gave the man a number that was not in use at Holme House. The Head of Offender Health asked for the medication to be returned to the pharmacy to be re-numbered to prevent any further confusion.

38. The man told staff that he slept in a chair on the first night as he found the bed uncomfortable. The Head of Offender Health asked if he would prefer to move into the crisis suite which contained two hospital beds. (A crisis suite can be used for prisoners requiring emotional support. The second bed allows the presence of a prison listener, for example.) The man declined, saying that he had just tidied and organised his room and did not want to move again. She said that she would look into whether a hospital bed could be moved into his current cell, but he in the event chose to move to the crisis suite on 26 June. (Following the publication of the draft report, the investigator was informed that the bed the man used in the crisis suite had previously been purchased for another terminally ill prisoner in order to provide him with more comfort.)

39. The man's sister had spoken to staff after her brother's arrival at Holme House. She was told that she could book a visit to see him, and arranged one for 25 June. When the family arrived at Holme House, one of the man's sisters was refused access to the prison as the ID she had was not deemed appropriate by the prison. The man's family said that she had used the same ID when visiting the man at Leeds. The man's other sister was under the impression that the visit would happen in the healthcare centre. However, upon arrival at the prison, she was told that the visit would occur in the usual visits area. The man's family were kept waiting for a little while before he was wheeled over to see them. The man's sister told the investigator that she was shocked by how ill he seemed, and by the bruises on his legs that she thought had been caused by the wheelchair. He also mentioned that his pin number for the telephone was incompatible with the Holme House phone system.

40. A note was made in the medical record that the man did not receive his morphine medication until 11.00pm on 27 June. (It was usually administered in the late afternoon.) There was no explanation in the medical notes why this medication was given to him later than usual.

41. Early on 28 June, a note was made in his record explaining that the man did not like the taste of Oramorph (an opiate pain-killer) and so would refuse it until the pain became unbearable. He had taken a dose during the preceding night and had another one at 5.30am that morning. The first doctor who saw him that afternoon and agreed to increase MXL (morphine capsules) to four doses of 120mg daily to see if that would reduce his need for Oramorph. (However, he was still able to have the Oramorph when he needed it.)

42. A third nurse made a note in his medical file at 8.42am the following morning. She wrote that the man did not feel well, and had refused breakfast and his medication. He looked very frail and weak. The nurse noted that she left a message on a Macmillan nurse's answer machine asking her to call her back. However, the first nurse to see the man at Holme House told the investigator that the man had not actually refused his medication that morning. She had gone up to his cell at approximately 7.50am and asked him if he would like to come down to take his medication. The man replied by asking if he could come down later. The first nurse told him this would be fine, and she and the healthcare assistant had turned the man onto his side. The nurse recalled that the man had not spoken of any pain, and had not given her any cause for concern. She explained that although the man was ill he was still able to walk to collect his medication:

> "Up till that point the man was coming down twice a day, however many times. He was fully mobile coming down to the treatment room to get his medication."

43. At approximately 10.00am the third nurse asked a fourth nurse to review the man as he looked unwell. The fourth nurse agreed that he appeared to have declined, and asked a doctor to assess him.

44. The fourth nurse said he was lying in his bed and did not respond to them. The doctor wrote in the medical file that the man was unconscious and did not respond to verbal stimuli. The Macmillan nurses arrived at 10.25am and went to the man's bedside. The man's sister was also informed of the deterioration in his health and invited to come to the prison to be with him.

45. The fourth nurse again went to ask the doctor to assess the man as he had declined further. When she reached the cell the Macmillan nurse was at the man's bedside holding his hand. A specialist palliative care nurse and the fourth nurse were also in the room. The man was observed to stop breathing at 10.37am. The doctor examined him and established that there was no pulse, no respiration and his pupils did not respond to light. The staff agreed not to resuscitate the man because of the terminal nature of his illness, and the doctor pronounced his death at 10.45am.

46. The man’s sister had arrived at the prison at approximately 10.40am and was taken over to the healthcare unit. She was taken to a small waiting room where she sat at first with the third nurse and then with the fourth nurse. After a few minutes the Governor entered the room. He was under the impression that the man’s sister was aware that her brother had died. When he realised this was not the case, he broke the news to her. The man’s sister was understandably upset and wished to go and see her brother. She asked if he had died alone, but was reassured that staff were present with him when he died.

47. The investigator was told by the prison that the man’s sister and the Governor went to the man’s cell. His sister told my investigator that the room felt ‘staged’ and her brother felt cold to the touch. She said that this prompted her to suggest that her brother had actually died significantly earlier than the prison said. She told the investigator that when she put this to the fourth nurse who responded with words to the effect of ‘this is how I found him’. This troubled her as she said that she had previously believed that her brother had not died alone. (The fourth nurse told the investigator that he did not recall this conversation, and the Governor stated that it did not happen in the room where the man died.)

48. The man’s sister wished to leave the prison after seeing her brother, and the Governor accompanied her towards the gate. On the way, they were stopped by the family liaison officer. The man’s sister did not wish to speak to him then but agreed to accept a call from the family liaison officer the following day. In the event, the man’s sister spoke to the family liaison officer that same afternoon. The family liaison officer noted her concerns which related to her brother’s medication, and who was with him when he died.

49. The family liaison officer and a PO visited the man’s sister on 1 July 2009 to hand over his property and cash. The Governor contributed to the cost of the funeral.

ISSUES

Clinical care

50. The clinical reviewer, commented on the care provided by both Leeds and Holme House:

> "The man's condition was promptly detected and well managed by HMP Leeds. His transfer to HMP Holme House appears to have been appropriately arranged and he was assessed that same day by a consultant in palliative care who did not make any changes in his treatment ... His care on the morning of his death seems appropriate although the way the death was communicated to his sister was poor."

51. The clinical reviewer commented that the man was not seen by a doctor until 28 June in Holme House, which meant that it was not clear who had overall responsibility for his care. Despite this, the clinical reviewer writes later in his report that this did not lead to any problems in his care.

52. The clinical reviewer concluded in his review that:

> "His transfer to HMP Holme House and subsequent medical care was comparable to that he would have received in the community."

Medication

53. The man's sister was very concerned that her brother did not receive his medication properly while at Holme House. This investigation has found that there was some initial delay regarding his medication due to the prison number used. I am satisfied that this was resolved quickly when the Head of Offender Health authorised the dispensing of the medication to the man. The administration of medication to prisoners must be monitored closely due to the numerous risks of prisoners receiving the wrong medication. As the man's prison number did not match the number on the medication it was important for staff to clarify the situation. I believe that the Head of Offender Health, once she was sure that it was the correct medication, acted quickly to ensure that any delay was minimised. Any delay is regrettable when a prisoner is as ill as the man, but I do not think that this delay was unreasonable given the circumstances.

54. However, there was a delay administering of the man's morphine medication on 27 June. The clinical reviewer was unable to offer a reason for this delay. When prisoners are suffering from painful conditions it is important that their pain relief medication is not delayed unreasonably.

    The Head of Offender Health should ensure that medication is provided at the appropriate times as far as this is operationally possible.

55. The man did not have his medication on the morning of his death. Although it was recorded that he refused his medication, the first nurse to see the man at Holme House explained that he had actually asked if he could collect it later. It appears that his rapid decline in health prevented him doing so. Following the publication of the draft report, the man's family told the investigator that they did not accept this account. They said that they believed him to be too unwell to get about without a wheelchair. As noted in the 'Key Events' section of this report, the nurse explained that, the man walked to collect his medication. The investigator also spoke to the Head of Offender Health who said:

> "He was, in inverted commas, "fit, mobile", we know he was terminal but he wasn't bed-bound, he wasn't unconscious."

Record keeping

56. The record keeping at Holme House with regard to the man was disappointing. It was brief and, in places, inaccurate. The clinical reviewer wrote in his review:

> "The standard of clinical record keeping at HMP Holme House is poor compared to that of HMP Leeds and should prompt a review. For a patient with a terminal illness I would expect regular clinical observation both by nursing and medical staff of his overall condition and symptom control and clear entries made in the medical record."

57. The clinical reviewer explained that, between the man's admission to Holme House and his death, there was a lack of clinical observations. He also pointed out there was a entry in the 'care plan' section of the medical record dated 25 June containing information that does not appear to relate to the man, but to another prisoner entirely. This raises the concern that the information may not have been written in the correct prisoner's records.

58. A further issue with regard to record keeping was the 'care plan' section of the man's medical record. It is dated 28 June (meaning that it was not completed for four days after his admission) but also contains information about his death which did not happen. Although this is worrying, I do not consider it to reveal anything other than poor administration. Recommendations of this type have been made many times in the Ombudsman's reports (including those regarding deaths at Holme House), and it is disappointing to have to do so again:

The Head of Offender Health should undertake a review regarding record keeping, and ensure that the record keeping is consistent with the Nursing and Midwifery Council guidelines.

The man’s family visit to Holme House

59. One of the man’s sisters was refused access to the prison on account of her ID not being accepted. Hi family said that she had used the same ID without any problems when visiting him at Leeds. The investigator spoke to Holme House staff who said that his sister had tried to use a bus pass as ID which was not acceptable at Holme House.

60. The visit that the man’s family arranged took place in the usual visits section, rather than in the healthcare unit which his sister had anticipated. This seems to have placed an unnecessary physical effort on him as it would have been more comfortable for him had the visit taken place in the healthcare centre. As his sister pointed out, the wheelchair used to bring him to the visits area may have added to his discomfort. I am surprised that the visit did not take place in the healthcare centre, affording him more dignity and comfort. The prison’s Head of Offender Health was also surprised that he had been taken over to the visits area. She told the investigator:

> “I personally [would] of have expected a visit to have taken place in healthcare had the patient been unwell and wasn’t able to go to Visits … “

61. The clinical reviewer shared this concern and wrote in his report:

> “It was totally inappropriate for the man to be taken by wheelchair to the normal prison visits area.”

62. The clinical reviewer made a recommendation with regard to this issue which I endorse:

The Head of Offender Health and Governor should consider facilitating visits in alternative locations when significantly ill patients are involved.

Access to the telephone

63. When the man’s family visited him on 25 June, he told them that he did not have access to a telephone because his pin number was incompatible with the Holme House telephone system. His sister raised this issue with the investigator following the death of the man.

64. The family liaison officer said in his interview with the investigator that, because of the nature of the man’s offences, all telephone numbers on his PIN account had to be verified and checked. The investigator asked Holme House to provide further information on this issue. The investigator was told that, due to the nature of the man’s offences, a particular process is carried out with regard to access to the telephone. Since no public protection file came to Holme House with the man, it was necessary for the prison to follow the usual child safeguarding procedures. These procedures involve the

numbers being checked by the security department and then, if necessary, being passed to the public protection unit (PPU). The PPU would then contact the numbers to seek approval for contact before they are put on the PIN system. The investigator was told that this process can take from a few days to a few weeks depending on the prisoner.

65. I understand that the man's PIN account was identified for screening by the PPU on 26 June and his PIN phone request was sent to the man to nominate his numbers but he died before it could be returned to him. The investigator was told that the man was able to make telephone calls on an office telephone while the PIN system was being set up.

The alleged publication of the man's offences

66. The man's sister told the investigator that her brother said that staff had put details of his offences on a piece of paper and stuck it by his door. The nature of the man's offences meant that he was fearful of reprisals were they to become widely known. Any such publication of a prisoner's offence by staff would be inappropriate.

67. The investigator asked the first nurse to see the man at Holme House whether she was aware of such a situation occurring. Her response was:

> "Absolutely a 100 per cent not. All the years I've worked in this prison things like that it just wouldn't happen … I couldn't tell you what his offences were; I've no idea at all. And we have people in healthcare with some not so nice offences and there's no difference in anything. As nurses we're not interested in their offences, we're only interested in looking after them."

68. The investigator also spoke about this issue with the Head of Offender Health. She was adamant that this did not occur.

Contact with the man's next of kin

69. The man's sister was very upset by the manner in which the prison broke the news of her brother's death. Once she arrived at the healthcare unit, she was shown to a waiting room where she waited with the third nurse, and then the fourth nurse. Neither told her that her brother had died. The Governor arrived at the healthcare unit in his role as Duty Governor expecting the man's sister to have been told of the man's death. When it became clear that she did not know, the Governor broke the news to her.

70. It is unfortunate that no-one in the healthcare unit took responsibility for telling the man's sister that her brother had died. While I understand that staff were concerned that they did not interfere with the prison's contingency plans for a death in custody and did not know who should perform such a role, any delay risks looking like insensitivity or collusion. Although this was a relatively uncommon situation, this is not the first time the Ombudsman has found that a family has been in the prison when their relative has died. I would therefore

suggest that the Governor and Head of Offender Health consider a protocol for any similar occurrence.

The Governor and Head of Offender Health should consider developing a protocol to manage the breaking of news of someone's death when the next of kin is already in the establishment.

71. The man's sister also wished to know who was with her brother when he died. The second doctor, the Macmillan Nurse, palliative care nurse and the fourth nurse were all with the man when he died.

72. The man's sister thought that he felt cold and was concerned that this suggested that he had died significantly earlier than the prison claimed. I can confirm that the man was seen to stop breathing at 10.37am and declared dead at 10.45am. The investigator was told by the clinical reviewer that when people decline and die over a few hours their body temperature can cool down considerably so that at the point of death their body is already much cooler than a healthy person. This may have been why he felt cold to the man's sister.

Good practice

73. I commend Leeds and Holme House for arranging the transfer of the man. This allowed the man to spend his last days closer to his family, and should be recognised as good practice.

CONCLUSION

74. The man was a very ill man for the last 18 months of his life. Despite this, he was not released on compassionate grounds. This upset him and his family as he wished to die in their company. However, he was transferred to a prison closer to where they lived. Although I am satisfied that he was generally well cared for, it is unfortunate that his medication and the visit of his family presented problems. It is also regrettable that the news of his death was broken in the manner it was to his sister.

RECOMMENDATIONS

1. The Head of Offender Health should ensure that medication is provided at the appropriate times as far as this is operationally possible.

   The National Offender Management Service accepted this recommendation.

2. The Head of Offender Health should undertake a review regarding record keeping, and ensure that the record keeping is consistent with the Nursing and Midwifery Council guidelines.

   The National Offender Management Service accepted this recommendation.

3. The Head of Offender Health should ensure that visits to significantly ill patients take place in the Healthcare Unit.

   The National Offender Management Service accepted this recommendation.

4. The Governor and Head of Offender Health should consider developing a protocol to manage the breaking of news of someone's death when the next of kin is already in the establishment.

   The National Offender Management Service accepted this recommendation.