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 Queen's Hospital, Burton upon Trent, while a prisoner at HMP Dovegate, in October 2010

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 died at Queen's Hospital, Burton upon Trent, on 28 October 2010, having been taken there four days earlier. He was 37 years old. The cause of death was found to be broncho pneumonia due to multiple sclerosis.

I offer my sincere sympathy and condolences to the man's family and all who have been affected by his death. I also apologise for the delay in issuing this report.

The investigation was carried out by two investigators. I am grateful for the assistance of all those involved, notably the clinical reviewer, who carried out a review of the man's medical care in prison, on behalf of the South Staffordshire Primary Care Trust; and the Director and staff at Dovegate who cooperated fully during the course of the investigation.

For the first few years of the man's imprisonment, he enjoyed good health. However, following the onset of symptoms over a period of several months, he was diagnosed with multiple sclerosis. Over the next four years, staff at Dovegate provided a great deal of dedicated care to manage his condition and also referred him to outside hospitals as appropriate.

Unfortunately, the investigation has identified several concerns about the man's clinical care in Dovegate. These relate to the need to expeditiously access appropriate equipment and services, the importance of ensuring the provision and availability of appropriately qualified staff, and improvements to recordkeeping. In addition, I am not persuaded that it was necessary to use restraints on a frail man who was in poor physical condition and had neither the mobility, nor the resources to make an escape during his final journey to hospital four days before his death. I make five recommendations in respect of the failings highlighted.

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

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

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SUMMARY

1. The man was remanded into custody at HMP Blakenhurst on 18 July 2001. He was subsequently sentenced to life imprisonment on 25 April 2002 and transferred to HMP Long Lartin six days later.

2. On arrival at HMP Long Lartin, it was noted that the man was in good health and had no medical problems. He was assessed as fit for work. On 22 September, he was admitted to Healthcare with a head injury after he had been attacked by other prisoners. He suffered from headaches on a daily basis and was given medication. When he transferred to HMP Gartree, on 8 October, he told staff about the daily headaches and intermittent dizziness since his assault. Staff referred him to the neurology department, but there is no record of the outcome.

3. On 19 July 2005, the man transferred to HMP Dovegate. A number of symptoms emerged during the course of 2006. On 11 November that year, due to concerns about his ability to walk, he was taken to Queen’s Hospital, Burton upon Trent, where he was diagnosed with multiple sclerosis (MS) (a disease of the central nervous system). The man returned to HMP Dovegate on 17 November and was admitted to Healthcare. Staff noted that he required intensive physiotherapy, occupational therapy and specialist equipment.

4. Following his diagnosis, the man was placed under the care of a the Consultant Neurologist, Consultant Neurologist at Queen’s Hospital, Burton upon Trent, and the South Staffordshire Primary Care Trust (PCT) Adult Ability Team (AAT). This is a group of medical and health professionals who provided a co-ordinated service for people with a progressive neurological condition in the community. He was also given speech therapy.

5. The man was also referred to the Queen’s Medical Centre in Nottingham to assess his eligibility for treatment to reduce the frequency and severity of relapses. However, it was explained that despite recent developments in drug therapies which impact on the course of MS rather than its symptoms, sound symptom management was still the best way of ensuring a reasonable quality of life. Over the next four years, the man’s condition deteriorated and he was diagnosed as having secondary progressive MS in October 2008.

6. On 24 October 2010, the man was taken to Queen’s Hospital, after reporting pain and numbness. Staff used handcuffs on the way to the hospital, but during his stay he was not handcuffed to either of the two escort officers. Hospital staff diagnosed pneumonia and four days later, on 28 October, he died.

7. The investigation has identified a number of concerns about the man’s medical care in Dovegate, including difficulties in accessing equipment and services, the availability of staff with appropriate skills, poor recordkeeping and the use of restraints. There are a total of five recommendations on these points.

THE INVESTIGATION PROCESS

8. The investigation was opened on 1 November 2010 when the investigator, by an investigator, issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. Three prisoners came forward as a result.

9. The investigator was given access to the man's prison files, including the medical record. He visited Dovegate on 4 November, accompanied by another investigator and spoke to five members of staff and one of the prisoners.

10. An independent clinical review of the man's healthcare whilst he was in custody was carried out by a clinical reviewer, on behalf of the South Staffordshire Primary Care Trust (PCT).

11. The investigator also wrote to HM Coroner to inform him of the nature and scope of the investigation. The Coroner replied to advise that the cause of the man's death was 1a bronchopneumonia (the acute inflammation of the walls of the bronchioles) and 1b multiple sclerosis. The investigator subsequently sent the Coroner a detailed account of the key events leading to the man's death, to assist with the inquest which took place in March 2011.

12. One of the Ombudsman's family liaison officers, contacted the Polish Embassy to obtain the contact details of the man's next of kin in Poland. She wrote to his father on 23 November, to inform him of the investigation and to give him the opportunity to raise any questions or concerns he had about his son's death.

13. We hope that this report helps to clarify any issues that might remain unclear for the man's family and helps them to better understand what happened in the time leading to his death. The significant delay in issuing this report is regretted. This was due to both delays in receiving the clinical review and, latterly, resource difficulties in this office.

14. The prison considered our draft report and recommendations. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP DOVEGATE

15. Opened in 2001, Dovegate is a category B prison for adult male prisoners sentenced to over four years imprisonment and local remand prisoners. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. Category B is for prisoners for whom the highest security conditions are not necessary, but for whom escape must be made very difficult. The prison is managed by Serco under contract to the National Offender Management Service (NOMS).

16. Dovegate currently holds up to 1060 prisoners, 860 in the main prison and 200 in the therapeutic community (TC). (Democratic TCs provide a long term, residential, offending behaviour intervention for prisoners who have a range of offending behaviour risk areas, including emotional and psychological needs. Prisoners are expected to stay for at least 18 months to give sufficient time to learn from the experience and be able to practice new skills.) Healthcare services at the prison are provided by Serco Health.

17. HM Chief Inspector of Prisons last reported on Dovegate following an announced inspection in October 2008. Regarding the Healthcare Services, the Chief Inspector made the following comment:

> “Primary health services were reasonable, but were compromised by shortages of staff and accommodation, which needed a substantial increase in funding for healthcare to move forward. Chronic disease management was maintained despite staff shortages, but staff needed more time to give a quality service to prisoners. Many NHS appointments were cancelled or rearranged, and pharmacy services needed further development. Nursing staff administered medications on their own, which was unsafe. Mental health services were good and developing, and prisoners were well supported by the primary and secondary services.”

18. Every prison in England and Wales has an Independent Monitoring Board (IMB) whose members are volunteers appointed by the Secretary of State from the community in which the prison is situated. They are required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern. In their annual report for 2009/10, Dovegate’s IMB made the following comments regarding the healthcare services at Dovegate:

> “The new house block added to Dovegate to accommodate remand and IPP prisoners has increased the demand for all healthcare facilities and has stretched the ability of staff to cope. [Remand prisoners are those who have not been convicted or sentenced but have been sent to prison by the courts. Imprisonment for Public Protection prisoners have no automatic right to release at the end of their sentence.]
>
> “All grades of additional staff have been recruited over the last year: managerial, nursing, and administration staff. There have been problems

in all areas with turnover of staff and some agency staff have been used to fill the gaps. Currently the staff consists of two doctors, one dentist, one dental nurse and thirteen nurses including three team leaders. Other specialists are available as required.

"Over the last year, the IMB have seen many changes in Healthcare and this is where the highest number of applications originate from. The management structure has been strengthened and new systems introduced. We all hope that the staff will embrace these changes and give some much-needed stability to this facility."

19. Since April 2004, when the Ombudsman began investigating all deaths in prison custody in England and Wales, there have been 15 deaths at Dovegate. Thirteen of these occurred before the man's death. The majority of them have been due to natural causes. In three of the previous investigations, the Ombudsman recommended that the Director and Healthcare Manager ensure that medical records are to the standard required by the General Medical Council and the Nursing and Midwifery Council.

KEY EVENTS

20. The man was born in Poland in 1973. He was single with no dependants and had a father and brother living in Lodz in Poland, with whom he maintained contact by phone and letters. His mother died when he was 17 years old. Prison records make reference to the fact that English was a problem for the man and on several occasions it was suggested that the use of an interpreter might be appropriate.

21. The man was charged with murder and remanded into custody at HMP Blakenhurst on 18 July 2001. On initial assessment at the prison, it was recorded that he was not on any medication and that he was in good health. On 25 April 2002, he was convicted and given an indeterminate sentence with a tariff of 11 years. (This meant that he had no automatic right to be released and had to serve at least 11 years in prison before he would be considered for release.)

22. On 31 May, the man transferred to HMP Long Lartin, where it was noted that he was in good health and had no medical problems. He was assessed as fit for labour grades I-III, i.e. garden party, kitchen, laundry etc.

23. On 22 September, the man was admitted to the healthcare centre with head injuries. He claimed that he had fallen down the stairs. Healthcare staff recorded that his injuries were not consistent with a fall, and that he was more likely to have been assaulted. Two days later, the man claimed that the injuries were inflicted by others. He complained of pain to the back of his head, his scalp was tender and it hurt to lie down. The man also reported pain to his right lower ribs. He was prescribed ibuprofen.

24. The man transferred to HMP Gartree on 8 October, where he was initially placed in the segregation unit until a cell became available on a residential wing. On 11 October, he told healthcare staff that he had been assaulted by four prisoners on 22 September and had been kicked and beaten about the head. The man said that he suffered daily headaches and intermittent dizziness since the assault. He was admitted to the healthcare unit. On 14 October, The man was referred to a consultant neurologist, although there is no record of whether he attended.

25. During 2003 and 2004, the man had a number of sessions with a speech therapist in respect of his stammer. On 19 July 2005, he transferred to HMP Dovegate where it was recorded that he had a severe stutter.

26. Throughout 2006, the man complained of persistent headaches, dizziness, loss of balance, and weakness in his limbs. He was taken to the Queen's Hospital, Burton upon Trent, on 11 November as he was having difficulty walking. He was diagnosed with multiple sclerosis (MS) on 14 November and returned to Dovegate three days later where he was admitted to the healthcare unit. The symptoms of MS are extremely diverse and present in many different combinations and with variable severity on a daily basis. It was recorded that healthcare staff considered this to be an unsafe discharge

on physical grounds as he was unable to take care of personal needs or to stand. (The man moved between the prison wings and healthcare facilities over the next four years, dependent upon his condition.)

27. At a meeting on 22 November, at Queen's Hospital, to discuss the man's care, it was noted that he required intensive physiotherapy and occupational therapy (OT) and that he required a large rollator zimmer frame, self-propelling wheelchair with tray and Glideabout commode (all to assist his mobility).

28. On 23 November, the man reported that he was constantly in pain and said that he was fearful for the future, not knowing if he would walk again. It was noted that the Medical Officer had referred him to the University of North Staffordshire Neurology Department. The following day, he was admitted to Queen's Hospital with constipation. He returned to Dovegate on 29 November, when it was noted that adaptations needed to be made to his cell.

29. A specialist MS nurse, and a physiotherapist, visited the man on 7 December. They devised a full physiotherapy and exercise programme. A discussion also took place about him returning to work on a part-time basis in the New Year. The man received regular visits, support and advice over the subsequent four years from both the MS nurse and the physiotherapist.

30. On 10 December, the man told healthcare staff that he was feeling "fine and strong now". He said that he was looking forward to returning to the wing soon, as he was able to attend to his personal hygiene and move from his bed to the wheelchair independently. He was discharged from healthcare to a residential wing three days later. Between December 2006 and March 2007, he was taken to hospital on three occasions as a result of worsening MS symptoms such as losing power in his lower limbs.

31. The MS nurse assessed the man on 19 March 2008. She recorded that there was evidence of a tremor (muscle contraction) and requested a re-referral to the neurologist for review. The MS nurse also re-referred him to the OT for an assessment of tremor and maintaining hand function. Records show that on 24 July the man told the MS nurse how upset and disappointed he was with the cancelled neurologist appointment, and that he would have to wait until October for another appointment. There is no other information in his records relating to this appointment.

32. The man had a fall on 18 August and felt pain in his back. Three days later, reports from wing officers and gym manager said that he was having a relapse of MS and needed assistance with routine activities.

33. On 17 October, the MS nurse wrote to the clinical psychologist at Dovegate, outlining the impact MS had on the man's cognitive functioning (his ability to process thoughts such as memory and speech). The MS nurse said that the man had difficulty sustaining concentration for long periods of time, keeping track of what he was doing if he was interrupted, and found it difficult to multi-task. He also had some behavioural symptoms associated with MS. She

recommended that he should have his cognitive functioning sensitively assessed, which would determine what support he might need regarding his ability to understand and participate adequately.

34. The Consultant Neurologist, a consultant neurologist, at Queen's Hospital, wrote to one of Dovegate's Medical Officers, on 28 October. He explained that he had reviewed the man in the Adult Ability Clinic with the physiotherapist and the MS nurse. He diagnosed the man with secondary progressive multiple sclerosis and noted that he was taking tolterodine 1mg daily (to treat urinary disorders), gabapentin (to prevent seizures) and propranolol (to treat high blood pressure, irregular heartbeats and shaking). The Consultant Neurologist recommended that physiotherapy should continue to assess further recovery. He said that he was going to refer him to the MS Clinic in Nottingham for consideration of disease modifying treatment which reduces the frequency and severity of relapses.

35. On 18 December, the MS nurse wrote to the Medical Officer at Dovegate listing the symptoms that the man experienced in different combinations and with variable severity on a daily basis:

- Bladder dysfunction
- Visual disturbances
- Fatigue
- Pain
- Spasm and muscle weakness
- Tremor
- Balance problems
- Mobility problems
- Cognitive dysfunction
- Depression
- Emotional problems

36. The MS nurse explained that in order to manage these symptoms, the man had input from a number of clinical specialists such as physiotherapists, and speech and language therapists (SALT). Other services involved were the Equipments Loan Service, and the Access to Communication and Technology Service. The MS nurse recommended:

> ”Continued access to the South Staffs Primary Care Trust multi-disciplinary team as per NICE (2003) guidelines, maintaining, where possible, relationships that have already been established.
>
> ”Training of all prison nursing staff in the procedure of male catheterisation.
> Inclusion of the Adult Ability Team (AAT) in review meetings in order to promote continuity of care needs every three months as previously identified.

"This is a necessary requirement in order to promote independence and quality of life, within the limitations of his condition."

37. The former Head of Healthcare at Dovegate, submitted an application to the Prison Service Pre-Release Section in the National Offender Management Service (NOMS) on 6 January 2009. She asked that the Parole Board hold a case review due to the man's deteriorating health. However, in his letter of 19 February, the MP, Parliamentary Under Secretary of State for the Ministry of Justice, explained the man's first review by the Parole Board was not due to begin until July 2010. He added that it was open to Dovegate to submit an application for compassionate release at any time.

38. The man expressed concern to a nurse on 14 February that his neurologist, the Consultant Neurologist, had turned down his request for beta interferon (a disease modifying drug that treats MS). He considered this a huge setback.

39. On 3 April, a meeting was held at HMP Sudbury about possibility of them accepting the man should he be re-categorised to category D. (Category D prisons are for offenders who can be reasonably trusted to serve their sentences in an open prison with no physical barriers to prevent them escaping.) The healthcare manager said that if a good care package from primary care services was in place he would consider accepting him.

40. On 5 June, the man transferred to HMP Birmingham while Dovegate's healthcare unit was refurbished. It was noted that his medication was gabapentin 300mg TDS, tolterodine 1mg OD, Cod Liver Oil 10mg BD, propananol 40mgs TDS, multivitamin OD. A care plan was put in place to provide adequate care and to meet his physical needs.

41. The man had an appointment on 11 June with a consultant neurologist at Queen's Medical Centre, who noted that he remained severely disabled by his aggressive MS. The consultant neurologist explained that it was likely that they were dealing with secondary progressive MS and that frequent relapses were contributing to his disability. In the circumstances, he did not think it unreasonable to try beta interferon to see if it would halt the progression of the man's illness. The consultant neurologist explained that the man had profound ataxia (loss of the ability to coordinate muscular movement) affecting his right arm, and that he could hardly stand up from his wheelchair, and had bladder and bowel symptoms.

42. On 15 June, the Consultant Neurologist reviewed the man in the Adult Ability Clinic with the MS nurse, the physiotherapist and an OT. He said that, in general, the man seemed to be deteriorating in that he could only stand and walk on parallel bars, and had to use a wheelchair for mobility. The Consultant Neurologist also said that moving to and from his wheelchair was a problem and that the man had trouble feeding himself because of the tremor. It was noted that he also had some swallowing problems, and that he had been seen in the MS Clinic the previous week where it was decided that he was due to start disease modifying treatment.

43. The Consultant Neurologist also said that they would have to review the impact of the disease modifying treatment and that he would ask the SALT to assess his swallowing. He added that the man had expressed concerns about feeling helpless and his difficulty in coping as a category B prisoner. The Consultant Neurologist agreed that a person with secondary progressive MS might not get the care and attention that they needed in a category B prison.

44. On 31 July, the man was started on interferon beta-1 250mcg injections every other day. The aim of this was to halt the deterioration of his physical health due to MS, and to stop further development of symptoms.

45. The man left Birmingham and returned to Dovegate on 18 August, where he was reviewed by the MS nurse on 28 August. In relation to the interferon beta injections, she recorded that:

> "The man is still holding on to thoughts that the injections will improve his condition and that he may even be able to walk in the future. I explained that the injections will keep him on an even keel and reduce the impact/disability following relapses".

46. On 11 September, the man told the MS nurse that he was suffering from increased fatigue, headaches and speech impediment. They discussed possible urinary tract infection, and disease modification treatment and compliance. It is recorded that the man agreed to restart the treatment.

47. The man was found on the floor during the morning of 30 September. He said that he felt weaker and tired due to the injections. Staff encouraged him to drink plenty and to take multivitamins. On 3 October, he refused his interferon beta injection as he did not feel they were helping him in any way. He also complained that his tremors were getting worse, particularly after the injections.

48. On 19 October, the man was reviewed by the Consultant Neurologist, the MS nurse, the physiotherapist and a member of SALT. He noted that the man was not able to tolerate the Extavia (beta interferon) prescribed by the consultant neurologist as he felt worse, with increased tremor, headaches, loss of speech and sleep.

49. The Consultant Neurologist recorded that the man used a wheelchair but could get out of it on his own. He added that he had tremors and spasms. The Consultant Neurologist suggested increasing the dose of propanolol, or, if this did not help, trying clonazepam (a muscle relaxant). He said he would write to the consultant neurologist to see if the man would be better with another beta interferon drug.

50. On 12 November, the consultant neurologist wrote to the Medical Officer at Dovegate to say that the man would shortly be given glatiramer acetate (Copaxone), for the treatment of MS, which involved daily injections. The man told the doctor on 31 December of a gradual deterioration over the

previous five months, predominantly weakness, tiredness, increase in tremor, and more difficultly in transferring from bed to chair. The doctor recorded that he would speak to the neurologist.

51. On 6 January 2010, the Director of Dovegate, told the man that he was eligible to be considered for parole. (This is at odds with the previous information about his parole eligibility, but nothing else is recorded.)

52. On 3 March, Dovegate's Medical Officer, wrote to the consultant neurologist asking for advice. He said that the man had requested a course of steroid therapy as he had no faith with the Copaxone injections. The medical officer added that he had not seen any improvements of significance. He also questioned whether the man was in the appropriate place as Dovegate did not have an "infirmary". He explained that he was held in the Acute Admissions Unit (AAU) and, with the exception of the man, all others there were psychiatric patients. The medical officer added that there was no dedicated "in-patient" unit for prisoners with predominantly physical health problems.

53. On 19 March, the consultant neurologist wrote to the medical officer and explained that the man had aggressive MS and he did not think they would be able to stop him getting worse. He said that the man seemed to be declining and was not surprised there had not been any significant change with Copaxone. The consultant neurologist explained his impression that the man was experiencing secondary progressive disease and the main benefit of Copaxone would be to reduce the number of relapses, but probably had no effect at all in the secondary phase of MS. He had no objection to stopping Copaxone if the medical officer felt he continued to decline without a clear relapse over the previous year.

54. The consultant neurologist explained that steroids only gave a very temporary improvement to some individuals with secondary progressive MS. He agreed that prison did not seem to be the most appropriate place for the man and suggested that it would be easier to have an assessment by the Consultant Neurologist. However, he added that they might not have a suitable treatment available. The man transferred to the healthcare unit on 4 April, where a plan of care was put into place.

55. On 8 April, a manager at Dovegate, submitted an application to the Public Protection Unit in the National Offender Management Service for consideration of the early release of the man on compassionate grounds. The documents relating to this application are missing.

56. On 12 April, the man had an appointment with the Consultant Neurologist and the AAT Manager. The man felt he was deteriorating slowly, and felt increasing weakness and lack of coordination in his legs. The doctor recommended increasing his medication. The Consultant Neurologist said that the man's mood was quite low and he had negative thoughts. He therefore suggested starting him on an antidepressant such as citalopram. He also asked for the vitamin B12 level to be checked and for him to be prescribed a supplement drink.

57. As the man's condition worsened, he required additional medical equipment. He was assessed by an occupational therapist on 8 June 2010, who recommended that he needed a new wheelchair with a head restraint and a new shower chair. (A 'recliner chair' was subsequently delivered on 30 September but had to be returned as it was the wrong one. Also, an entry in the healthcare records on 18 August 2010, referred to a request for an 'airflow' mattress to relieve the man's worsening skin condition. The prison received the mattress on 22 October 2010, two months after the request and six days before the man's death.)

58. The man had an appointment with another consultant neurologist at Queen's Medical Centre, on 18 June. The consultant neurologist noted that his intention tremor (a tremor that is worse during voluntary movement) and cerebellar dysarthria (a disorder that results in jerky, uncoordinated movements of the muscles used in speech) were worsening, and that he needed 24 hour care because of his motor disability (a disability that affects a person's ability to learn motor tasks such as walking and running). He said that the man could not stand or walk for a few steps even with help, could operate his wheelchair for short transfers, but his tremor seemed to get worse with action. The consultant neurologist said it was more severe in the left limbs than in the right. He understood that the man had been prescribed propranolol but was not sure of the dose.

59. The consultant neurologist also mentioned other issues for which he recommended a review by the Continence Services and Urology department. (Urology is a surgical speciality, covering the diagnosis and treatment of disorders of the kidneys, ureters, bladder, prostate and male reproductive organs.) He prescribed topiramate for the man's tremor and Oxybutynin for his bladder symptoms.

60. On 1 July, a doctor noted that the man was unable to stand or move between his wheelchair and bed. Four weeks later, on 29 July, it was recorded that he had fallen from his toilet twice the previous day and had to be helped back onto his bed both times. On 16 August, the man had bed sores across his bottom. Staff were asked to take more care when assisting him with his personal care.

61. The man was seen by staff in the AAT on 24 August, who recorded that he was not getting out of bed, could not stand up or get in and out of his wheelchair. On 2 September, he told the doctor that he felt his speech was getting slower and that he had difficulty in swallowing most foods. He was advised to try soft foods such as soup and mashed potato.

62. The manager sent a further application for compassionate release by email to the Public Protection Unit, on 30 September.

63. On 18 October, the man was reviewed by the Consultant Neurologist, an OT, a member of SALT and an MS nurse. The doctor noted that there was an increasing tremor in both hands and also his head, that his speech was worse

and he was finding communication difficult. The man described pain, stiffness and weakness in both his legs. He continued to be incontinent of urine. He had lost weight and his appetite, and occasionally found it difficult to swallow. He was tired and not sleeping well at night. In addition, the man had pressure sores and was awaiting a pressure mattress.

64. The Consultant Neurologist reviewed the man's medication. On examination, he found nystagmus (involuntary eye movements) and tremor. His lower limb examination showed increased tone bilaterally and he could not stand up from his wheelchair. He concluded that the man's weight loss might be related to his medication and he recommended various changes. He added that the man would also be assessed by the SLT therapist.

65. On 20 October, the man was seen by an OT, and MS nurse. It was agreed that the OT would arrange to order a combination pressure mattress and pressure relief boots (for when he sat out in his chair).

66. Four days later, on 24 October, the man complained of a chest pain on inhaling and exhaling, a pain to the left side of his neck, and his arm on left side felt numb. An ambulance was called and he was taken to Queen's Hospital where he was diagnosed with pneumonia.

67. Prison staff completed a hospital/bedwatch risk assessment, which assessed the man's escape potential as medium. In approving the assessment, the Duty Director of Dovegate, commented:

> "The man is a MS sufferer with no mobility. He is going out in an ambulance. He will be escorted/supervised by 2 members of staff. Due to medical conditions the man will go out on the escort chain."

68. In view of the fact that the man's family lived in Poland and do not speak English, Dovegate liaised with them through the Polish Embassy. Prison staff sent a fax to the Polish Embassy on 25 October to inform them that he had been admitted to hospital. During his stay in hospital, the man was supervised by two officers but was not handcuffed to either of them.

69. On 27 October, a team leader within the Unit, told the manager that a doctor from the Department of Health, was still of the opinion that the man did not meet the criteria for compassionate release. She added that she had been advised to wait and see how his condition was over the next few days, as the doctor advised that sometimes people recover from pneumonia and, if that happened, MS on its own would not normally be enough to meet the criteria for compassionate release.

70. The man died in hospital on 28 October. Prison staff contacted the Polish Embassy to ask them to inform his family. Dovegate met the full costs of the repatriation of the man's body to Poland as well as the transport of his property.

71. HM Coroner for the Staffordshire (South) Coroner's District held an inquest into the man's death on 15 March. The jury concluded that his death was due to natural causes.

ISSUES

Clinical care

72. The clinical review was carried out by a clinical reviewer on behalf of the South Staffordshire Primary Care Trust (PCT). In addition to the management of the man's clinical care, the clinical reviewer was asked to consider whether there was a link between the head injury he sustained in HMP Long Lartin in September 2002 and the onset of MS diagnosed in November 2006. The clinical reviewer was also asked to investigate the inappropriate behaviour that he displayed towards female staff. It was subsequently decided that this was not an issue relevant to the investigation.

Diagnosis of the man's illness

73. Throughout 2006, the man experienced a number of symptoms of ill health. These included persistent headaches, dizziness, loss of balance, and weakness in his limbs. On 11 November 2006, he was taken to the Queen's Hospital, Burton upon Trent as he was having difficulty walking. Medical staff at the hospital diagnosed MS on 14 November.

> "Multiple Sclerosis is a disease of the central nervous system. The disease process is one of episodes where white matter within the brain or spinal cord becomes inflamed and then destroyed by the person's own immune system. Once present the disease never goes; there is no cure and the person lives with the diagnosis for life" (NICE 2003).
>
> "One of the main characteristics of MS is its unpredictability from one person to another, from one day to another, from one time of day to another." MS Trust 2007.

74. Prior to the symptoms which appeared in 2006, the state of the man's health was largely unremarkable. The investigation has found nothing to suggest that there was any delay in diagnosing his condition.

Whether there was a link between a head injury sustained in HMP Long Lartin in September 2002 and the subsequent onset of MS?

75. The clinical reviewer explained that following the assault, the man suffered various neurological symptoms including headaches and insomnia. He was given analgesia and referred to a neurologist in December 2002. He was also described as fearful, anxious and unsettled after the incident and a stammer was noted. The clinical reviewer found no record of a neurology appointment or results in the healthcare record, although there was an entry in February 2004 stating, "…(the man) would like scan of head despite findings of neurologist", suggesting that an appointment and assessment did take place.

76. It was unclear to the clinical reviewer whether the symptoms noted were a direct consequence of the increased levels of anxiety or a result of the physical assault. In order to address the question of a causal link between

head injury and the onset of MS, she sought medical advice from a doctor, a member of the Quality team at the PCT. In response, the doctor indicated that the link between the head injury and diagnosis of MS was not substantiated in the man's case.

77. The clinical reviewer identified a number of concerns from the man's healthcare record.

Access to appropriate equipment and services

78. The clinical reviewer drew attention to instances of delays in providing medical equipment. For example, the delays in providing an appropriate wheelchair, shower chair and 'airflow' mattress. The clinical reviewer also said that from the outset it was recognised that an interpreter would be helpful to assist with communications between staff and the man. This need was identified on a number of occasions during his period of imprisonment. However, she said that there were no entries showing that interpreter services were ever sourced.

79. The clinical reviewer discussed her concerns with the healthcare manager at Dovegate who expressed disappointment and confusion about why the equipment would take so long to arrive. He said that he would access services outside the Prison Service, if necessary, including South Staffordshire Provider services.

80. The healthcare manager described the importance that was now placed upon partnership working and the value of engaging with other organisations. He saw this as a key part of his role and believes it would ultimately improve patient care as those involved in healthcare work more closely. The clinical reviewer made a recommendation in respect of provision of equipment and services which we endorse and recast:

The Director and Healthcare Manager should ensure that staff order and obtain necessary equipment and services promptly. Delays in acquiring such facilities should not result in a reduction in the quality of care provided.

The provision and availability of appropriately qualified staff

81. The clinical reviewer explained that:

> "Within the healthcare records there are a number of areas where the knowledge and skills of the staff are not clear and as a consequence, care fell below that which would be expected within an NHS establishment…"

Assessment and care following falls and assaults

82. As the man's condition deteriorated, the number of falls increased and, on occasion, he was found on the floor. The clinical reviewer pointed out that there was nothing in the healthcare records to indicate that a full assessment

was carried on these occasions. Although he was found conscious on each occasion, staff had not considered whether there had been a loss of consciousness on impact and asked insufficient questions to identify where any injury may have been sustained. Also, there was little evidence of subsequent observations to monitor any immediate deterioration.

83. Dovegate's healthcare manager explained to the clinical reviewer that the clinical skill set of the healthcare staff were being reviewed, and that discussions were underway with the Staffordshire and Stoke on Trent Partnership Trust to look at opportunities for formal and informal working to develop knowledge and expertise.

84. As well as the healthcare facility, the healthcare manager explained that prisoners may also receive 'care closer to home' through the siting of healthcare staff in three offices within the prison blocks. He said that whilst this provided quick access to healthcare, it supported the development of more generalised skills. The healthcare manager added that there were plans to review these teams and look to develop specialist knowledge within the workforce that can be utilised across the prison.

Continence Care and Catheterisation

85. The man had an ongoing problem with passing urine and using catheters. On these occasions, the man was taken to the accident and emergency department of an outside hospital. An example of this, cited by the clinical reviewer, was the man's attendance at Queen's Hospital, Burton upon Trent, on 23 December 2006. The healthcare records suggested that the outcome was re-inserting a catheter which had been removed two or three days previously. The clinical reviewer pointed out that the man had been catheterised previously and there were no clear contraindications (a condition which makes a particular treatment or procedure inadvisable) as to why a catheter could not be re-inserted. Therefore, an appropriately trained nurse could have carried out this procedure and prevented an unnecessary hospital visit. By 2010, the man required some help with daily activities and was incontinent on occasions.

Pressure area care

86. The clinical reviewer pointed out that there had been minimal entries in the healthcare records about assessments of tissue viability (the management of complex wounds). On 26 March 2010, an occupational therapy assessment was carried out in which pressure areas were said to be intact.

87. By the middle of April, a hoist had been installed over the man's bed as his condition had further deteriorated. There was no record at this time of any preventative measures to prevent pressure sores. The first entry relating to skin damage was not recorded until 14 August, following a fall in which he sustained a graze to his leg. Two days later, one of the man's regular carers made an entry in the healthcare records which said that there are, "…bed sores across his bottom". She noted that a dressing was applied and advice

from the tissue viability nurse sought immediately. The clinical reviewer noted the frequency of the records made by this carer and assumed that this was a non-registered member of staff. She added that, other than the tissue viability nurse, there was no evidence of significant involvement of a registered nurse in the man's care despite his deteriorating condition.

88. Furthermore, the clinical reviewer pointed out that weight was a good indication of the general condition and deterioration of an individual. She referred to a weight chart with four entries between 28 April and 30 August 2010, which all said 'unable to weigh'. No entries were recorded between 30 August and 1 October 2010, which she considered was a missed opportunity to implement any additional nutritional requirements.

89. The clinical reviewer explained that once skin tears and pressure sores developed, appropriate care was provided, including, in some instances 15 minute turns. However, she thought that if a suitably qualified nurse had given care, this might have prevented pressure sores.

90. The healthcare manager told the clinical reviewer that, in line with the skill set review, there was an intention to increase the registered to non-registered ratio. He said that at the present time the registered ratio is said to be above the national average.

91. The clinical reviewer's recommendations are endorsed and slightly recast.

The Healthcare Manager should ensure that staff should have skill sets that respond to the needs of those in their care, specifically:

- **assessment and observations as a result of falls and assaults.**
- **an understanding of chronic conditions, particularly where patients remain in prison until the end of their lives. This includes basic nursing care, such as continence and pressure area care as well as nutritional status.**

The Director and Healthcare Manager should ensure the availability of appropriate staff so that timely care is delivered. This should include liaising with non-healthcare prison staff to ensure care is delivered appropriately.

Recordkeeping

92. The clinical reviewer said that "the healthcare records proved to be a significant challenge to the review of the man's case". She found that, although staff signed their entries, there was nothing to identify them or indicate their status. In particular, it was hard to tell whether the individual was registered or non-registered. In addition, notes were fragmented and not chronological. This raised questions about the accessibility of patients' notes, continuity of care, and shared communication about an individual. As notes were made in a number of different places within the healthcare record, the

clinical reviewer had to move between records and considered this must have been problematic and disruptive for those responsible for the man's care.

93. The clinical reviewer said that between 30 April 2010 and 29 July 2010, four charts were completed showing the man's temperature, blood pressure, pulse and respirations. She noted that the daily blood pressure recordings on three of the four charts were almost identical for each day. She added that the unusual regularity raised questions about the validity of the recordings and the accuracy of the equipment being used.

94. Dovegate's healthcare manager told the clinical reviewer that he knew about these issues. He explained that staff were now using electronic care records on SystmOne which would address the points about documentation.

95. The healthcare manager said that there was an area of the Dovegate site where healthcare is given that does not have access to SystmOne. He has asked staff to take patient records to the Healthcare facility to be entered onto SystmOne for completeness. We endorse the clinical reviewer's recommendations for improvement and slightly recast them:

The Director and Healthcare Manager should put in place measures to improve recordkeeping. In particular, the name and status of carers should be clear; entries in medical records should be chronological to aid communication between staff and provide a legal record of the care provided; and observations should be recorded accurately.

96. Although the clinical reviewer had concerns about some elements of the man's clinical care, she noted that the man received high quality treatment from specialists outside the prison healthcare system such as dentistry, chiropody, physiotherapy and occupational therapy and these were readily available. One aspect of his care that she considered deserved special mention was the support and specialist knowledge provided by the MS and Neurology Clinical Nurse Specialists in the PCT. The clinical reviewer said " healthcare records demonstrated regular interactions with the man both within HMP Dovegate and when admitted to the acute services". She added that "visits were frequent, regular and resulted in very practical solutions which served to enhance the man's healthcare experience".

Early Release on Compassionate Grounds (ERCG)

97. Prison Service Order (PSO 6000) sets out the procedures for the permanent early release on licence of prisoners on compassionate grounds. Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits but three months is considered to be an appropriate period. The PSO emphasises that it is essential to obtain a clear medical opinion on the likely life expectancy of the prisoner. Also, the Secretary of State needs to be satisfied that the risk of re-offending has reduced and that there are adequate arrangements for the prisoner's care and treatment outside prison.

98. Early release may also be considered when the prisoner is bedridden or severely incapacitated. This might include those confined to wheelchairs, paralysed or severe stroke victims. Applications may also be considered if further imprisonment would endanger the prisoner's life or reduce his or her life expectancy. As part of the application process, the prison is required to obtain information from a number of sources including a medical officer and the prisoner's community offender manger/probation officer.

99. On 8 April 2010, a manager at Dovegate, submitted an application to the National Offender Management Service's Public Protection Unit for consideration of the compassionate early release of the man. The documents relating to this matter are missing, so it has not been possible to establish whether this application was appropriately administered. The manager submitted a further application for consideration of early release on compassionate grounds on 30 September. This was subsequently refused on 27 October, the day before he died, as he did not meet the criteria of suffering from a terminal illness with death likely to occur soon.

100. As people with MS can live for many years, we are satisfied that the application for the man's compassionate release was appropriately considered in accordance with Prison Service policy.

Restraints, security and bed watch

101. A concordat (agreement) is in place between the National Offender Management Service and NHS Counter Fraud and Security Management Service in relation to prisoner escort and bed watch function. This advises that levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and be balanced by considerations of care and decency for the prisoner. Using handcuffs or other restraints on terminally or seriously ill prisoners is considered inhumane by the courts, unless justified by security considerations. Terminally, or seriously ill prisoners may present a lower risk of escape and this should be considered as part of the assessment process.

102. Staff completed an escort and hospital risk assessment when the man was admitted to hospital on 24 October. They concluded that restraints were to be used, but could be removed for medical treatment. Restraints were used to escort the man to hospital but not during his stay there.

103. The Concordat and NOMS security policy guidance lists a number of factors to be taken into consideration when carrying out a risk assessment. This includes the prisoner's conduct in custody, as well as his motivation or risk of escape and the likelihood of outside assistance. Given the man's poor condition and immobility, as well as the improbability of having the resources to assist an escape, it is extremely disappointing that Dovegate considered it necessary to use restraints on the journey to hospital.

The Director should ensure that staff adhere to the Concordat between the National Offender Management Service and the National Health

Service, as well as the security policy on the use of restraints. In particular, when assessing risk, account should be taken of the immobility of the prisoner and if they are in the latter stages of a terminal illness.

104. In relation to the man's stay in hospital, we are pleased to learn that the decision was taken not to use restraints.

Notification of the man's death

105. The man died at 8.25pm on 28 October and the prison informed the Polish Embassy the following morning. We are satisfied that Dovegate informed the Embassy promptly of the death. In addition, we are pleased to learn that Dovegate met the full costs of the repatriation of the man's body to Poland.

CONCLUSION

106. The man was a 37 year old prisoner with no long standing health problems. During 2006, he complained of a number of symptoms such as persistent headaches, dizziness, loss of balance, and weakness in his limbs. He was taken to the Queen's Hospital, Burton upon Trent on 11 November 2006, as he was having difficulty walking and diagnosed with Multiple Sclerosis (MS) three days later. As a result of his declining health, the man was taken to Burton Hospital on 24 October 2010, where he died four days later. It was not considered appropriate to approve early release on compassionate grounds as a life expectancy prognosis could not be given.

107. Staff at Dovegate were dedicated to the man's care over a number of years and it is clear that they engendered good relationships. They also ensured that he was referred to appropriate medical specialists to manage his condition. However, the investigation found a number of concerns about the clinical care that he received at Dovegate. This included shortcomings in access to appropriate equipment and some services, as well as the availability and training staff. Recordkeeping was also considered to be substandard.

108. The clinical reviewer concluded that in some respects the man's care fell below that which would be expected within an NHS hospital. We agree and have made recommendations on these areas of performance.

109. The clinical reviewer also found some examples of best practice. It is particularly satisfying to learn about the support and specialist knowledge provided by the MS and Neurology Clinical Nurse Specialists in the South Staffordshire Primary Care Trust.

110. In addition to clinical matters, there are concerns about the perceived need to restrain the man during his final journey to hospital given that he was immobile and not in a position to make an escape from the custody of the escort officers. Accordingly, there is also a recommendation about the risk assessments for using restraints on seriously ill prisoners.

RECOMMENDATIONS

1. The Director and Healthcare Manager should ensure that staff order and obtain necessary equipment and services promptly. Delays in acquiring such facilities should not result in a reduction in the quality of care provided.

2. The Healthcare Manager should ensure that staff should have skill sets that respond to the needs of those in their care, specifically:

   - assessment and observations as a result of falls and assaults.

   - an understanding of chronic conditions, particularly where patients remain in prison until the end of their lives. This includes basic nursing care, such as continence and pressure area care as well as nutritional status.

3. The Director and Healthcare Manager should ensure the availability of appropriate staff so that timely care is delivered. This should include liaising with non-healthcare prison staff to ensure care is delivered appropriately.

4. The Director and Healthcare Manager should put in place measures to improve recordkeeping. In particular, the name and status of carers should be clear; entries in medical records should be chronological to aid communication between staff and provide a legal record of the care provided; and observations should be recorded accurately.

5. The Director should ensure that staff adhere to the Concordat between the National Offender Management Service and the National Health Service, as well as the security policy on the use of restraints. In particular, when assessing risk, account should be taken of the immobility of the prisoner and if they are in the latter stages of a terminal illness.

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1.	The Director and Healthcare Manager should ensure that staff order and obtain necessary equipment and services promptly. Delays in acquiring such facilities should not result in a reduction in the quality of care provided.	Not accepted	It is suggested that this recommendation does not rest with Serco Health as the responsibility for the equipment was that of the adult ability team from the PCT (referred to in the report as AAT) to source and provide the equipment referred to and this was where the delays occurred.		
2.	The Healthcare Manager should ensure that staff should have skill sets that respond to the needs of those in their care, specifically: - Assessment and observations as a result of falls and assaults; - An understanding of chronic conditions, particularly where patients remain in prison until the end of their lives. This includes basic nursing care, such as continence and pressure area care as well as nutritional status.	Not accepted	- Triage Algorithms are freely available and used by the appropriate staff; - A full range of material is available for staff to keep themselves updated on chronic conditions and each nurse is now responsible for a particular disease area. Additional Comments from HMP Dovegate: It is difficult to ascertain the skills identified as the statement is not specific. The patient's needs in this instance were not 'basic'. Serco Health is commissioned to deliver Primary Care Services. Any such recommendation should reflect the need to review the contractual requirements and detailed inpatient care if this is required.		
3.	The Director and Healthcare Manager should ensure the availability of appropriate staff so that timely care is delivered. This should include liaising with	Not accepted	Serco is keen to discuss customer requirements and make appropriate adjustments at a contract level. It is suggested that the report is not specific as to the type of staff or relevant skill-sets which would be deemed to be 'appropriate'. Referral to		

	non-healthcare prison staff to ensure care is delivered appropriately.		appropriate services to access specific skills was made in this case. It is suggested that delays were not within the responsibility of Serco Health.		
4.	The Director and Healthcare Manager should put in place measures to improve recordkeeping. In particular, the name and status of carers should be clear; entries in medical records should be chronological to aid communication between staff and provide a legal record of the care provided; and observations should be recorded accurately.	Accepted	SystemOne is now in place. This recommendation was based on the old fragmented paper based records. This has been superseded and therefore Serco Health has rectified this problem.	In place	
5.	The Director should ensure that staff adhere to the Concordat between the National Offender Management Service and the National Health Service, as well as the security policy on the use of restraints. In particular, when assessing risk, account should be taken of the immobility of the prisoner and if they are in the latter stages of a terminal illness.	Accepted	The Assistant Director for Security and Operations will review and revise, where appropriate, Dovegate's Local Security Strategy and relevant Director's Rules in respect of the use of constraints when escorting prisoners in the latter stages of terminal illness. Following that revision, they will notify, in writing, guidance to Duty Directors and Duty Managers in respect of actions which should be considered/taken should escort from the premises be required.	April 2012	