PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at Doncaster Royal Infirmary in June 2011, while in the custody of HMP Doncaster

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the death of the man at Doncaster Royal Infirmary in June 2011 while in the custody of HMP Doncaster. The man died from heart disease. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. Staff at Doncaster cooperated with this investigation. An independent clinical reviewer was commissioned to review the health care received by the man while in custody. I apologise for the delay in issuing this report.

The man was one of the oldest prisoners in custody, and was serving a 10 year prison sentence imposed in 2006. He had been at Doncaster since that time. In 2007, he was diagnosed with a lymphoproliferative disorder (cancer of the blood) which was incurable. His condition gradually deteriorated and, by March 2011, he was considered by his Consultant Haematologist to have reached the end-of-life stage. The man became increasingly frail and, after suffering breathing difficulties on the night of 13 June, he was taken to hospital and died shortly after his arrival.

Before the man died, Doncaster made three unsuccessful applications to have him released on compassionate grounds. Two of these failed because of doubts over the imminence of his death and difficulties in finding suitable accommodation. However, the investigation raises a concern that the final application was rejected because it contained uncorroborated allegations against the man which had not been formally recorded or investigated.

While the clinical reviewer identified the need for Doncaster to ensure greater clarity about the resuscitation status of prisoners who are terminally ill, the man's overall healthcare was very good and equivalent to that which he could have expected in the community. Indeed, I commend the support he was given by prison and healthcare staff, as well as his prisoner carer.

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 **January 2013**

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SUMMARY

1. In August 2006, the man was sentenced to custody for the first time. He was given a 10 year sentence after being convicted of sexual offences. In 2007, he was diagnosed with myelodysplasia (a collection of blood related medical conditions that involve ineffective production of certain blood cells). He had regular hospital appointments and blood transfusions but the condition was incurable. Over the next few years he became gradually weaker and less able to care for himself. His eyesight also deteriorated because of glaucoma and he gradually lost most of his sight.

2. The man regularly went to the Over 50's group at HMP Doncaster. A prisoner carer helped the man with his day to day needs during most of his time at Doncaster. The man only moved from his houseblock to the healthcare centre during the last few months of his life, when his mobility became such that he needed inpatient support. His carer was still able to visit him frequently in the healthcare centre. Senior Nurse supported the man well and kept in regular contact with his daughter as his illness progressed.

3. For most of his time in custody the man denied the offences for which he was convicted. Consequently he could not complete the relevant offending behaviour course to try to reduce his risk of reoffending.

4. Doncaster made three applications for release on compassionate grounds for the man. Several meetings were needed in order to find suitable accommodation for him. A care home did agree to take the man in January 2011. The first application was rejected on 22 November 2010 because the man's death was not imminent and he did not have a suitable release address. A second application was turned down on 27 January 2011 because the consultant was not able to confirm that the man's prognosis meant he was not expected to live longer than three months. The third application was turned down on 12 May. At this time the man's consultant thought he had less than three months to live. However, the application was rejected because of uncorroborated allegations that the man made inappropriate comments of a sexual nature to nurses.

5. Late at night on 13 June 2011 the man called out to an officer that he felt ill. The officer requested medical assistance and staff went into his cell. The man's condition deteriorated and he stopped breathing. Nursing staff began cardio-pulmonary resuscitation (CPR) and when ambulance staff arrived they were able to revive the man. He was taken to Doncaster Royal Infirmary but died there a few hours later.

6. The clinical reviewer found that the man's care was equivalent to the care that he could have expected in the community. The only recommendation made by the reviewer was for healthcare staff to receive training regarding current national guidelines pertaining to DNAR (Do Not Attempt Resuscitation) decision making. We endorse the recommendation.

7. We make one further recommendation about the evidence used in applications for compassionate release.

THE INVESTIGATION PROCESS

8. This office was informed of the man's death on 14 June 2011. The investigator, was given access to the man's prison records covering his time at Doncaster since August 2006, including his clinical records.

9. Notices explaining the investigation were displayed around the prison, and invited anyone with information to contact the investigator. No responses were received. The investigator met the Independent Monitoring Board (IMB) Chair who said she regarded the care the man had received as exemplary. The investigator also met the Head of Healthcare and Nurse A, who worked closely with the man. The nurse kept in regular contact with one of the man's daughters.

10. One of our Family Liaison Officers contacted the man's family to explain the investigation process and give them the opportunity to raise any concerns or issues about the man's time in prison. At the consultation stage of this report, one of the man's daughters had the opportunity to read the draft report. She commented that although the information not to resuscitate her father should have been passed on to staff, she was extremely pleased that he was resuscitated as it meant that he did not die in prison. The man's daughter was relieved also that her father had not been handcuffed when he died. She said that by not investigating the allegations about inappropriate remarks to staff, Doncaster removed his opportunity to be released on compassionate grounds. She said that her father had told her he was not willing to admit to offences he did not commit and had insisted that he was innocent. Nevertheless, she considered staff to have cared for him in a 'fair and fantastic' manner. She described the healthcare staff as amazing and made mention in particular of Nurse A as kind and supportive. The man's daughter said she recognised the care and friendship the man's carer had offered to her father. He had written a eulogy for her father's funeral and she was grateful for his contribution.

11. A review of the clinical care the man received at Doncaster was carried out by the clinical reviewer, an independent clinical reviewer. The clinical reviewer was provided with copies of the man's prison medical record.

12. The investigator contacted the Coroner, who shared the post mortem report with our office. The Coroner will be sent a copy of this report to assist with his enquiries.

13. We apologise for the considerable delay in issuing this report caused by workload pressures in the office which are now being tackled to reduce the backlog of cases.

HMP & YOI DONCASTER

14. HMP Doncaster opened in 1994 and is a purpose-built category B male local prison, privately managed under contract by Serco Home Affairs. The prison is made up of three houseblocks, each with four wings and has a maximum capacity of 1,145 prisoners. Typically, around 70% of the prisoners are sentenced, 20% on remand and the remainder are foreign national detainees and those convicted but not yet sentenced.

15. Primary care and inpatient services were the responsibility of Serco Health, but, from April 2011, the services were provided by Nottinghamshire NHS Trust. The prison has a healthcare unit with provision for up to 29 in-patients on the upper level. The lower level is dedicated to the delivery of primary care services. Resuscitation equipment, including a defibrillator, is kept in the pharmacy room.

Her Majesty's Inspectorate of Prisons (HMIP)

16. Her Majesty's Inspectorate of Prisons for England and Wales (HMIP) last inspection of HMP Doncaster took place in November 2010. The inspection report was largely positive.

17. The report said a policy for the management of older prisoners had recently been introduced. There was a disability liaison officer (DLA) and an older prisoners' liaison officer (OPLO). Older prisoners had care plans where needed and there was a prisoner carer scheme. The prisoner carers were involved in the support of older prisoners and reported weekly to the OPLO, raising any new concerns at this time. Prisoners over the age of 65, like the man, were entitled to a retirement pay of £4.75 per week. The inspectorate reported that prisoners were treated respectfully by health services staff and a senior nurse was responsible for the care of older men.

18. The report said the inpatient unit was functional but unappealing, with a mix of single, double and dormitory provision. Patients, nurses and officers developed "three way" care plans, signed by all three and written in prose that the patient could understand.

Independent Monitoring Board (IMB)

19. Each prison is monitored by an Independent Monitoring Board of independent, unpaid volunteers from the local community. Board members monitor all aspects of prison life to ensure that proper care and decency are maintained.

20. The most recent annual report published by the IMB at Doncaster covers the period from October 2010 to September 2011. The IMB expressed some concerns about healthcare. It reported that medication and pharmacy supplies continued to be a problem.

Previous deaths at Doncaster

21. Since the Ombudsman began investigating deaths in prison custody in 2004, there have been nine deaths through natural causes at Doncaster, before the man. In a previous report, we commented on the inappropriate use of restraints and in this report we have questioned the risk assessment in relation to the use of restraints, although in the event the man was not restrained.

KEY EVENTS

22. The man was born in November 1923. He was convicted in August 2006 and sentenced to 10 years in prison. He would have been eligible to apply for parole on 11 August 2011.

23. During his reception health screening at Doncaster it was noted that it was the man's first time in custody. His community GP had written a letter giving a brief outline of the man's medical conditions and a list of his current medications. The man said he had angina and heart problems so the assessing nurse referred him to see the prison doctor. The healthcare centre was thought to be the most suitable accommodation for the man's first night in custody and he went to the upper healthcare unit. The following day he was moved to one of the prison's houseblocks.

24. On 25 April 2007 a consultant haematologist, requested that the man attend Doncaster Royal Infirmary (DRI) so that further investigations could take place, following an abnormal finding on a routine blood test.

25. The consultant haematologist wrote on 27 April 2007 setting out his diagnosis that the man had myelodysplasia (a diverse collection of haematological (blood related) medical conditions that involve ineffective production of the myeloid class of blood cells). He highlighted that the condition is "progressive and non curative" and that the man would be at increased risk of infection and bleeding. He recommended a care plan of two weekly full blood count tests and a top up red cell transfusion should the man's haemoglobin level drop below 10gms. He recommended stopping clopidogrel medication (blood thinning agent) if the platelet count dropped below 50. He also considered that the man should be admitted urgently if he developed a febrile illness (an illness that suddenly occurs with an onset of fever) to enable treatment for neutropenic sepsis (neutropenia means a low neutrophil / white blood cell count. Sepsis is the presence of harmful bacteria and their toxins in tissues, typically through infection of a wound). Over the following years, the man received numerous top up red cell transfusions as his condition deteriorated according to the natural progression of the disease.

26. At the beginning of 2008, the man heard that his appeal against conviction was unsuccessful and appeared to accept the decision.

27. Early in April 2008, the man said if he stood up too quickly he felt dizzy and that sometimes he then fell over. He was given prochlorperazine (for treating vomiting and nausea, often used to help with motion sickness) to help him feel less dizzy. A note in his medical record on 17 April indicated that it was helping.

28. On 16 September 2008, Nurse B recorded that the man's wife was divorcing him. The man appeared to cope with this news. His daughter still supported him. In November, the man was given two sentence planning targets for the year ahead. One was to comply with the prison's rules and regime. The

second was to address his offending behaviour by undertaking the Sex Offender Treatment Programme (SOTP).

29. On 29 December 2008, the consultant haematologist wrote to the doctor at Doncaster following an appointment with the man in his clinic. He said:

> "His white cell count is clearly rising suggesting disease progression. However, at the present time his haemoglobin and platelet count remain stable … I am hence reluctant to initiate any treatment at this stage. His main problems relate to dizziness and tinnitus [ringing in the ears] and I think he needs treatment for the same. I plan to review him in 3 months time… we may need to start gentle oral chemotherapy".

30. On 6 March 2009, the man was noted to be distressed and unsteady when collecting his medication and was helped back to his cell by a member of staff. It was agreed that, in future, the man's medication would be brought to him on the houseblock. The man fell in his cell on 3 April and had been on the floor until an officer had checked on him. He was unable to get up by himself or reach the cell emergency buzzer. It is not clear how long he had been on the floor before being discovered.

31. The man's records shows that he was seen on the wing on 23 April, it is not clear who by. He said he was still having to collect his medication. The man also said he was worried about using the shower in case he fell. The member of staff said they would look into whether a rail could be put in one of the showers for support and noted that they were going to speak to healthcare again about getting the man's medication brought to his cell. It is not clear from the records when this arrangement was finally put in place.

32. A memorandum, dated 26 June 2009, from the Director at Doncaster to the head of healthcare indicated the man had given permission for healthcare staff to discuss medical issues with his daughter and that she should be told about any significant changes in his health.

33. Nurse C went to visit the man on 9 July to assess his mobility and discuss the use of aids. The entry in the medical record indicated the man was able to wash and dress independently and could use a knife and fork but preferred a spoon. The man told the nurse that his legs 'gave way' sometimes and that he was prone to dizzy spells. He said it was becoming difficult to get on and off the toilet and that his biggest fear was of getting out of bed to use the toilet at night, falling and not begin able to reach the call button. The man declined the use of a walking frame, walking stick or urinal to use during the night, saying that he wanted to be as independent as possible. The man told the nurse he wanted to remain on the houseblock. The nurse made a referral to the GP and suggested an occupational therapy assessment.

34. Dr A, a visiting prison doctor, wrote a referral letter on 13 July to the Occupational Therapy unit at Doncaster Royal Infirmary. He said that the man's mobility was reduced and that he was struggling with self care. He requested that an Occupational Therapist visit the prison in order to be able to

advise on mobility aids. Shortly afterwards, a visiting physiotherapist, visited the man to assess him for walking aids. The man was subsequently given a frame and walking stick.

35. The man did not want to use a frame but wanted a hand rail put next to his toilet. The prison DLO (Disability Liaison Officer), PCO A, went to see the man to check on his needs and abilities. After this visit, PCO A agreed to request a hand rail and a different type of call button, with a pull cord, to be put into the man's cell.

36. The man agreed to join a new group for the Over 50's on a Tuesday and Thursday afternoon and went to the first meeting of the group on 21 July 2009.

37. An annual sentence plan review was held on 10 November. It recorded that the man still denied the offences of which he was convicted. The man said he planned to live with his son after release. The meeting noted the man was now registered blind. The man said he could see things only very close to him and that he spent a lot of time listening to audio books.

38. The sentence plan review kept the same two targets in place as the previous year although the man would not be able to do the SOTP while he denied his offences.

39. During 2010, the man went out for hospital appointments on several occasions, often receiving blood transfusions. Nurse C saw the man on 2 March and wrote that he was very upset because of his deteriorating eyesight. The man told the nurse he had asked to see the optician because he could not see with his current pairs of spectacles. The doctor saw him the next day and asked for his glasses to be chased up.

40. On 13 June, PCO B found the man in his cell shortly after midnight. The man had fallen while trying to get to the toilet. He requested assistance from nursing staff and the orderly officer and then he and a colleague went into the cell and were able to lift the man back to his bed before the nursing staff arrived. Nurse A went to see the man the following morning. She noted that the man had some difficulty sitting upright on his bed. She spoke to the man's prisoner carer who said the man was managing on a day to day basis but might need some aids to continue to do so. Nurse A noted in the medical record that she would discuss this with the physiotherapist and try to get an occupational health assessment.

41. The man was taken to healthcare on 26 June after concerns were raised by unit staff about his diet and his mobility. He was assessed as to whether he needed help with daily living activities by RMN A on 28 June 2010. The assessment concluded that the man could get himself washed and dressed, could use cutlery for meals, could transfer himself safely from his bed to his chair and back again, could walk without aids and that he was fully capable of using the toilet by himself. He therefore returned to the houseblock.

42. Senior Nurse A informed the prison's ROTL (release on temporary licence) and employment clerk, that the man was terminally ill on 29 June 2010. One of the prison's ROTL's roles in the prison is handling applications for early release on compassionate grounds. After discussions with staff at the prison and the National Offender Management Service it was decided to wait for the results of further blood tests due in September.

43. The consultant haematologist wrote a letter dated 13 July 2010 which said The man had lymphoproliferative disorder and that on several occasions he had been offered cytoreductive therapy (to reduce the number of cancerous cells) to help control the progression of the disease. He said the man had consistently refused such treatment and indicated he only wished to continue with supportive care of blood transfusions as required. At this time the consultant haematologist gave a prognosis of:

> "… months, since he has an incurable, malignant condition which would be well controlled with treatment if he had taken up the offer".

44. Nurse A spoke with the man's daughter about his deteriorating condition on 25 July. She said she would not be able to look after her father if he were released from prison because she sometimes looked after children and his offences precluded him having contact with children. She was anxious to be kept informed of her father's condition and asked whether she would still be able to visit, even when her father could not go to the usual visits room. The nurse assured the man's daughter that they would endeavour to put a palliative care package in place to address these concerns.

45. The man had several blood transfusions during the second half of 2010. In September, he had some problems with pains in his right leg. Nurse D advised the man to use bottles overnight for urination instead of walking to the toilet. The man told her that he wanted to die because he had had enough of life but the nurse reassured him that he actually coped really well for a man of his age. There was no suggestion that the man wished to take his own life.

46. On 27 September, a meeting was held with the man's offender manager (probation officer), to examine where the man might live if he were released early on compassionate grounds. Prison Service Order 6000 Parole Release and Recall states that:

> "Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon … The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside the prison."

47. The social services, said the man was not deemed to be at the end of life (because he was thought to have more than three months to live) and therefore his application for accommodation could not be fast tracked and he would not receive funding for a care home. After further discussions amongst the staff team, an initial application for early release was made on 12

November 2010. At this time the man's consultant haemotologist could not say that he had less than three months to live, only that his prognosis was poor.

48. The man's prisoner carer when he was living on the houseblock. The man lived on the same houseblock during most of his time at Doncaster. His care plan showed the following:

> "Shower – day before visit, chair / frame required, Pad [cell] clean on Mon/Wed/Fri, laundry on Tues, bedding change on Fri, help needed stripping bed, help needed making bed, assistance needed to and from visits, application of eye drops 18.00 daily. This is crucial. Review in 1 month".

49. The man fell in the shower on 21 October 2010 and, although he did not injure himself, he was generally shaken. Nurse A saw the man's daughter in the visits area the next day. The man's daughter was concerned that her father appeared to be in pain. The nurse told her that she would put a care plan together to ensure the man had daily nursing input without taking him away from his peer and support group on the houseblock. She told his daughter that the man would be admitted to the healthcare centre if his condition deteriorated further.

50. The man's annual sentence plan review took place on 2 November 2010. It noted:

> "The man no longer plans to go to live with his son … upon release and he says he has discussed this with his daughter at great length and they have decided that it would be better to go and live near her … whereby she can look after him easier due to him being diagnosed with incurable cancer".

51. The sentence plan review recorded that, due to the man's deteriorating health, he had neither the motivation nor ability to complete any education courses or offending behaviour work. It was noted that the man was still denying the offences. His wing report noted that he was quite frail and spent most of his time in his cell.

52. On 8 November, as part of a review of the man's care as an older prisoner, the man's carer wrote that,

> "The man has lost an awful lot of self confidence since his fall in the shower. He is also attending DRI for blood more often (3 pints last week). I have liaised with HCC [Healthcare centre] with the aim of getting professional help both into and out of their shower first off then into and out of the bath (hoist)… The man still needs eye drops… They [HCC] need to be aware that he will be using the bath every weekend and that he will need a) undressed b) helped into and out of the bath and c) dried and dressed".

53. On 17 November, staff from social services came to Doncaster to assess the man and discuss what care he would need if he were given compassionate release. The man was assessed as being low priority. If the man lived in the community, social services would not offer the man a care home. He would be given assistance for washing and dressing and meals on wheels instead. The man did not meet the requirements for being offered local authority accommodation.

54. The application for early release was rejected by the Secretary of State on 22 November 2010. The reasons given were that the man's illness had not reached the point where death was imminent and no suitable release address had been identified.

55. The man's prisoner carer, carried out a review of the man's needs in December. He wrote "The man now attends DRI on a 3 weekly cycle in order to receive 2 – 3 units of blood". He commented that the man was leaving his cell more often and sitting with others during association. The man's prisoner carer said the man's baths were now taken in the healthcare centre.

56. Copies of the man's medical records were sent to NOMS headquarters on 6 December 2010, to assist a decision for compassionate release. The prison GP felt the man was unlikely to live more than three months, but the issue of a suitable release address had still to be resolved. More discussions followed with social services and they agreed to 'fast track' the man's case on 24 December. It was subsequently decided that the man needed to reside in a care home.

57. An "enablement assessment" form summarising what care had been provided for the man was completed in the prison. It is unsigned and undated but appears to have been completed in March 2011. It noted:

> "The man's prisoner carer helps the man on a daily basis with dressing and does his bedding change etc. for him and is a great help, he also takes the man by wheelchair to healthcare etc if the need arises. The staff also carry out any tasks that make life easier for the man, having his meals taken to his door, they have ensured he has a ground floor cell… [The man] has refused the last two sessions of chemotherapy as he feels he is too old to withstand treatment now. The man's eyesight is poor and I have told him that we are having some TV screen magnifiers delivered to the prison and when these arrive I will let him have one. I have also told him that we have some thermal underwear for him to use during the cold weather…"

Thermal underwear was provided in December 2010. A TV magnification screen was provided in January 2011 but this did not help, so was removed at the man's request.

58. A space in the China Cottage Nursing Home in Doncaster became available, and a meeting was held on 12 January 2011. Those present at the meeting were the care home manager, a police officer, the man's probation officer,

social services staff and prison and healthcare staff from Doncaster. A bed would be available from 28 January and it was felt that the man could be managed in the China Cottage Nursing Home with only the senior nurse of each shift being aware of the man's offences. The man's probation officer completed a report detailing the licence conditions that would apply to the man, were he to be given early release. NOMS headquarters requested further medical information about the man's treatment and life expectancy on 19 January. The consultant haematologist wrote on 24 January that the man had a malignant lymphoproliferative disorder requiring repeated red cell transfusions. He said that the man's prognosis was poor and that his life expectancy was limited to months. The application for early release was refused on 27 January because the man's illness had not progressed to a stage where death was imminent.

59. The man was taking several prescription drugs at this time, including atenolol (a beta blocker drug used to treat hypertension/ high blood pressure that works by slowing down the heart and reducing its workload), clopidogrel (an antiplatelet agent used to inhibit blood clots), cyanocobalamin (vitamin B12 replacement) , prochlorperazine (used to treat nausea and vertigo), simvastatin (a drug used to control high cholesterol), isosorbide monoitrate (used to treat angina by dilating the blood vessels so as to reduce blood pressure) and xalatan eye drops (used to treat glaucoma).

60. The records show that the man's illness was monitored closely. On 10 February, the consultant haematologist said it was difficult to estimate life expectancy since:

> "with supportive blood transfusion he may live several months. However, without transfusion support he clearly will not survive a three month period".

61. On 14 February, the man's bed was lowered, to assist him with getting in and out and an extra mattress was provided for him the following day. He attended several appointments at the Haematology Unit at Doncaster Royal Infirmary during the period January to April 2011.

62. On 20 February 2011, PCO C wrote an assessment of the man's behaviour in prison as part of the dossier being prepared for the Parole Board. (The man's parole eligibility date was 11 August 2011.) Under the section headed, "Offending Behaviour" PCO C indicated that the man accepted responsibility for his offence and that it had been for "his own gratification". PCO C also noted that the man "accepts full responsibility for his offence and is truly sorry". This appears to be the first record that the man admitted his guilt.

63. The man was moved to the healthcare centre on 9 March 2011 as his poor physical state now required in-patient care. He was found by PCO C that morning on the floor of his cell. A comprehensive 'Assessment and Plan of Care' was commenced and continued with regular reviews, until the man died. The man's care plan noted that he was unable to maintain his own safety due to his poor mobility and risk of falls. All staff were to observe and assist the

man when he needed to move. A daily note about how the man was coping was made in his ongoing clinical record.

64. Prison doctor, wrote a summary of the man's terminal illness in his clinical record on 9 March and stated that "active resuscitation in the event of a cardiopulmonary arrest would be fruitless". The doctor does not appear to have discussed this with the man or with other healthcare staff.

65. PCO D made a note in the man's history file on 12 March that he had been "wet through" when his cell was unlocked that morning. The officer spoke to a senior nurse but was told the man did not need incontinence pants. He wrote, "This man cannot get out of bed unaided". Another officer also made a note about the same problem just over a week later and said, "Measures being implemented". It is not clear what these measures were.

66. On 14 March, the man went to DRI to see the consultant haematologist and was admitted for treatment. Following their meeting the consultant wrote to say that the man's prognosis was now less than three months. A space became available at the China Cottage Care Home again and an application for early release was therefore re-submitted on 17 March. While this third application was being considered, the place at China Cottage fell through. Social services struggled to find another care home willing to take the man. A hospice was also considered but found to be unsuitable because they were only able to offer pain control to the man and not a place to live.

67. The man stayed at Doncaster Royal Infirmary until 17 March for blood transfusions. He received four units of blood and antibiotics for a chest infection. His ongoing record noted on 19 March that his mobility remained poor, but he had eaten and drunk well and some friends had visited him from his houseblock. The man cut his forearm on 20 March after lowering himself awkwardly onto the toilet.

68. On 23 March, an assessment of the risk of pressure sores was completed. It looked at factors such as the man's build, age, skin type, continence issues, appetite and tissue malnutrition. His score came out as 'very high risk' of pressure sores or ulcers. This was monitored by nurses and cream was applied as required. The man's skin stayed intact over the coming months.

69. The man's probation officer wrote a parole assessment report on 31 March 2011. She said this about interventions to reduce risk:

> "For the majority of the man's sentence two targets have been set for him to achieve: [One was] to address sexual offending behaviour: The plan was that this objective would be achieved by him participating in the Sex Offender Treatment programme. HMP Doncaster do not run this course and it was anticipated that he would transfer during his sentence to an establishment that did. I understand that a combination of his health problems and assessment that he was not ready to start the programme because of his level of denial have prevented this happening".

70. Her recommendation was:

> "At the current time the man is not expected to live until his parole eligibility date. However, a great deal of planning has already been undertaken in preparation for an application for Compassionate Release. Although the man presents as ambivalent about being released it is important for his family that he should not die in prison. It may be that he is preparing himself for the worse. The man has not completed any offence focused work whilst he has been in custody but his risk of causing serious harm has never been considered imminent since his conviction. Although a risk to children can never be completely eliminated in the community, I believe with the risk management plan outlined, it is minimised as much as possible. I therefore support the man's application for early release."

71. During April the man was settled on the healthcare centre. Staff attended to his daily hygiene needs and gave him his medication. The man ate and drank well on most days. He was able to see his prison carer who visited frequently. The man fell on 19 April and banged his head - staff checked his blood pressure and pulse throughout the rest of the day and no further concerns were raised. The man continued to be incontinent and needed regular help from staff. After further discussions with social services another space became available at China Cottage on 24 April.

72. On 26 April, the Head of Health Care, emailed Doncaster's co-ordinator for the man's compassionate release application, to say that although she was happy for the man to move to the home, she felt that in order to provide safeguards, all those who were to be involved in the man's direct care, should be informed of his history.

73. Doncaster's co-ordinator emailed the Doncaster's public protection team manager, on 28 April, to highlight the issue concerning staff being made aware of the man's history. Doncaster's co-ordinator for the man's compassionate release application added 'there has been a comment to one of the nurses in hospital on the last occasion whereby the man was quite insistent wanting the nurse to put his penis into the urine sample bottle rather than do it himself. There has also been an "off the cuff comment" to one of our officers in Healthcare asking her if she wanted some of this – his penis."

74. On 30 April, nursing staff were called to the man's cell just before midnight. The man complained of chest pain. There was a delay in the orderly officer arriving because they were dealing with another incident, so PCO E used the sealed cell key (given to staff at night for use in an emergency) to open his cell. Nursing staff entered and saw the man was holding his chest and said it was the "worst chest pain that he had ever had". The nurse gave the man GTN spray (glyceryl trinitrate, which is used to make the heart work more easily) and carried out observations. The GTN spray did not seem to work and so the nurse contacted the prison GP. They advised that the man should be sent to the A & E department because of his medical history and because he might require an electrocardiogram (ECG), which records the rhythm and

electrical activity in the heart. The paramedic team arrived at the prison and the man left for Doncaster Royal Infirmary just after midnight on 1 May 2011. He received four units of blood and returned to Doncaster on 4 May. Over the next few days, the man settled back into the healthcare unit. Nurses made comments such as, “Very pleasant and settled in mood”, “The man was in good spirits again”, “Bright in mood, enjoying a joke with staff”.

75. On 4 May, the Care Home manager at China Cottage was told of the man’s two alleged inappropriate comments but was still prepared to take him as a resident. The next day, the co-ordinator for the man’s compassionate release application emailed the public protection team manager to say that the police were concerned that the plan for only the two nursing home managers to be aware of the man’s offending history would not provide a sufficient level of public protection.

76. On 12 May 2011, a reply to the man’s application for early release on compassionate grounds was sent. The letter said:

> “You have applied on the grounds that you are suffering from cancer and that you are registered blind. We have considered your suitability previously and your last application was rejected in January 2011 on the grounds that your illness had not progressed to the stage where death is imminent within the meaning of the criteria”.
>
> “However, we have since been informed that you have recently made inappropriate sexual comments towards nursing staff and healthcare staff. This inappropriate behaviour demonstrates that you may still pose some risk of reoffending. During your sentence you have not done any work to address your offending behaviour. We are very concerned that should you be released to a nursing home… then there would be the potential for you to subject other staff and visitors to similar behaviour”.

The application for early release was therefore rejected. The man was told of this decision on 13 May.

77. The man attended a hospital appointment on 20 May, returning back to Doncaster that same day. He had regular visits from his daughter and sister while he was in Doncaster. Visits took place in the healthcare centre as the man was not well enough to go to the usual visits area.

78. At the beginning of June, nursing staff noted the man appeared ‘chesty’ and that he had a cough. Staff continued to care for the man’s hygiene needs and provide him with his medication. The man continued to attend the over 50’s Group.

79. At about 11.45pm on 13 June 2011, the man shouted from his cell that he wanted to be sick. PCO F heard him and requested the assistance of the orderly officer (the most senior member of staff on duty with responsibility for safe management of the prison) and nursing staff via his radio. When the night orderly officer arrived with nurses E and F they unlocked the man’s cell.

The two nurses assisted the man to the toilet. One of the nurses listened to his chest and said it did not sound good. The man was helped back to his bed and the nurses then tried to take his blood pressure. At this point the man's breathing became more shallow and a few minutes later the man deteriorated further. The night orderly officer used his radio to request that an ambulance be called. The communications room logged their call to the ambulance service at 11.48pm. The man appeared to stop breathing and the staff could not find a pulse. Nurse F and PCO F started carry out cardiopulmonary resuscitation (CPR - a mixture of chest compressions and rescue breaths, in order to keep oxygen flowing around the body). While waiting for the ambulance, the night orderly officer organised PCO G and PCO F to escort the man to hospital. A paramedic arrived at 11.56pm and an ambulance at 00:06am. They continued resuscitation. The ambulance team were able to resuscitate the man and he was taken to hospital at 00.38am.

80. Doncaster's local instructions on the preparation of risk assessments for prisoners who need to leave the prison escorted by staff specify that: "the risk assessment will consider the following: a) the prisoner's medical condition. Where there is doubt, the prison medical officer must be asked to advise on any medical objections to the use of restraints and assess the prisoner's ability to escape b) the prisoner's category c) the nature of the offences, the risk to the public and hospital staff, including the risk of hostage taking d) the prisoners motivation to escape, likelihood of outside assistance and conduct while in custody e) the physical security of the hospital including the consulting room and, where possible, other areas where tests or treatment may take place".

81. The night orderly officer partially completed a Prisoner Escort Risk Assessment form prior to the ambulance leaving the prison. On the form, he circled 'yes' for using restraints (a single handcuff attached to the man and a prisoner officer) which could be removed for medical treatment or in an emergency without the prior knowledge of the duty manager. The instructions also said that the man was to be handcuffed in the vehicle. The assessment was authorised by the duty senior manager. However, the night orderly officer told the escorting staff shortly before they left the prison that the man did not need to be handcuffed unless he "made a drastic recovery". Restraints were not used on the journey or during the man's time in hospital.

82. The man was put on a ventilator when he arrived at the hospital. Blood tests showed that the man's haemoglobin (Hb) level was 5.8 g/dL (normal levels are 12.6 – 18 g/dL), confirming anaemia. A chest X-ray showed he had left ventricular failure (heart failure on the left means fluid will build up in the lungs due to congestion of the veins in the lungs). He had a computerised tomography (CT) scan (this is a special X-ray that shows multiple pictures of the inside of the body). At this point the medical staff asked for details of his next of kin. A nurse tried to ring the man's daughter (who was his nominated next of kin) but was unable to get through. The hospital asked the police to go to her home address, but when they went there they were unable to get an answer and said the property appeared to be empty. The man's breathing

tube was removed. He was able to breathe on his own for a short period of time but died at 3.21am.

83. The post mortem report concluded that the man died from a fatal cardiac arrhythmia (disturbances to the normal rhythm of the heart) caused by ischaemic heart disease (reduced blood supply of the heart muscle).

84. Doncaster tried to telephone his daughter but was unable to make contact. It was discovered that she was on holiday abroad. She received a text message saying that South Yorkshire police left a note at her home for her to contact the hospital. She did so on 14 June and a ward sister confirmed her father's death.

85. The man's daughter contacted the prison by telephone on the morning of 17 June and spoke to Nurse A. The prison family liaison officer telephoned the man's daughter later that day to explain her role and offer support. It was decided that, in the circumstances, it was not necessary for the family liaison officer to visit the man's family.

86. At the request of the man's daughter, Nurse A accompanied her that day to identify her father's body at the hospital. The man's sister and daughter were offered and accepted the opportunity to visit Doncaster and meet staff and prisoners who knew him. Doncaster appropriately supported the man's family. In 2010, the man had written to Doncaster's Director giving him details of a
funeral insurance plan he had already paid for should he die while in custody, and his wishes were complied with.

87. The man's carer was able to remain in contact with the man while he was on the healthcare unit. He told the disability liaison officer that he had seen the man the day before he died and he had told him "Doncaster was the best place that his 'time could end' as this was the place where he had felt most supported and most engaged with"

88. There was a debrief for staff on the day the man died, and our investigator was told that staff felt appropriately supported. Prisoners were informed through a notice from the Director and offered support. Those being monitored for risk of self-harm were reviewed. The man's carer in particular was well supported by both staff and chaplaincy.

ISSUES

Clinical issues

89. The clinical reviewer was asked to confirm whether the clinical assessment and treatment offered to the man in the period before his death was of satisfactory quality and equivalent to the standard of care provided in the community.

90. The clinical reviewer said:

> "The man suffered from a terminal illness for which he declined treatment which could have prolonged his life expectancy. The illness was diagnosed in a timely fashion and the medical records demonstrated clear examples of close working with haematology specialist services. There was evidence of timely referral to specialist services for supportive palliative care".

91. Although the clinical reviewer stated in the man's clinical record that "active resuscitation in the event of a cardiopulmonary arrest would be fruitless" this does not appear to have been discussed with the man nor was a Do Not Resuscitate notice completed. The message does not appear to have been conveyed to other healthcare staff at Doncaster.

92. The British Medical Association, the Resuscitation Council and the Royal College of Nursing produced a joint statement in October 2007 regarding decisions made by healthcare professionals relating to cardiopulmonary resuscitation (CPR). The statement said that decisions about attempting CPR raise very sensitive issues for patients and the people close to them. It acknowledged that health professionals do not find it easy to discuss CPR with their patients, but this should not prevent discussion, either to inform patients of a decision or involve patients in the decision making process, where appropriate. The statement also looked at decisions relating to "Do not attempt resuscitation (DNAR)". If the clinical team believes that CPR will not re-start the heart and maintain breathing, it should not be offered or attempted. The statement recommends that the patient's individual circumstances and the most up-to-date guidance must be considered carefully before such a decision is made. The statement acknowledged that there would be some patients for whom attempting CPR would be clearly inappropriate; for example a patient in the final stages of a terminal illness where death is imminent and unavoidable. The responsibility for making a DNAR decision rests with the most senior clinician currently in charge of the patient's care, although they may delegate the task to another person who is competent to carry it out. An additional recommendation is that wherever possible, a decision should be agreed with the whole healthcare team.

93. The clinical reviewer said in his clinical review:

> "Such a course of action does not appear to have been taken with regards to the man's care. A senior clinician made a DNAR decision on 9 March 2011 yet resuscitation was still attempted on 14 June 2011. To fulfil the recommendations made in the joint statement, the senior clinician should have discussed a possible DNAR decision with the whole healthcare team and the joint decision documented in the healthcare records".

94. The clinical reviewer felt that current national guidelines would support the DNAR decision made in March, but not all healthcare staff appeared to have been made aware of it.

95. In summary, the clinical said the man died from natural causes and that healthcare staff had acted appropriately from the time of his diagnosis of a terminal illness to his death over four years later. He made one recommendation which we repeat here:

The Head of Healthcare should ensure that healthcare staff receive training regarding current national guidelines pertaining to DNAR decision making. This training should then inform a local policy regarding resuscitation and the use of Do Not Resuscitate notices.

Compassionate Early Release

96. Under section 248 of the Criminal Justice Act 2003 the Secretary of State may release a prisoner on compassionate grounds at any point in their sentence if he is satisfied that this is justified by exceptional circumstances. The criteria for release may be when the prisoner is suffering from a terminal illness and death is likely to occur within a very short period of time (usually taken to mean within three months); or when the prisoner is bedridden or severely incapacitated.

97. Guidance to prisons is provided in Prison Service Order (PSO) 6000 Parole, Release and Recall, chapter 12, Early Release on Compassionate Grounds. There are a number of general principles to be considered, namely; the release of the prisoner would not put the safety of the public at risk; a decision to approve release would not normally be made on the basis of facts that the sentencing or appeal court were already aware of when they made their decision about custody and there must be some specific purpose to be served by early release. A decision to release someone early is rare. The decision not to release the man was taken after taking into account all of the relevant current information, including his recent reported behaviour towards two nurses.

98. The co-ordinator for the man's application for early release kept comprehensive written records detailing the many efforts made to co-ordinate applications for early release. This involved liaising with the hospital

consultant, social services, the offender manager, care home staff, the police and the National Offender Management Service.

99. However, we are concerned that the third application was turned down, based in part on reports of sexually inappropriate comments made by the man to nursing staff that do not appear to have been formally recorded or investigated. The only record was an e-mail dated 28 April 2011, from the co-ordinator to the public protection manager Doncaster, to say that the Head of Healthcare at Doncaster had said the man had made sexually inappropriate comments to nurses and outlining what the comments were.

100. The investigator asked Doncaster for further documentary evidence about who had reported these incidents and what actions were taken as a result. The co-ordinator said that she had reported the comments to the public protection manager and told the investigator that the Head of Healthcare, had brought one of them to her attention verbally but she had not seen written incident reports with the details. The investigator contacted the Head of Healthcare on 19 April 2012 to ask how she had come by the information. At the time of writing this report, no reply has been received.

101. The investigator asked the public protection manager for any further information he had. He replied:

> ”I received no other evidence about the man’s inappropriate behaviour other than the email dated 28 April 2011 and I did not have prior knowledge of it. I was content to accept the information at face value and saw no need to request any further details. We would not seek to validate information received from prison staff in this format unless there was conflicting information elsewhere and clarification was needed. To do so would be to risk slowing the process down and by their nature compassionate release application must be considered as quickly as possible.”

This was a serious allegation against the man, which does not appear to have been further investigated or formally recorded. No dates were attached to the alleged incidents so it is difficult to know how current they were and how they affected his risk, which his offender manager had said had “never been considered imminent since his conviction.” The evidence provided was essentially based on uncorroborated hearsay rather than a corroborated account, yet it subsequently had serious consequences for the man. We therefore recommend:

The Director should ensure that any allegation against a prisoner included in a request for compassionate release is formally recorded and appropriately investigated.

Use of restraints

102. When the man left for Doncaster Royal Infirmary in the early hours of 14 June, he was extremely unwell, unable to get out of bed unaided, unable to see and unable to walk. We believe he represented little risk of escape.

103. The written escort instructions for the man's journey to hospital and time in hospital stated that he was to be handcuffed to an officer unless medical treatment necessitated that they be removed. This assessment was made by the orderly officer. However, PCO G, one of the officers on the escort, said the night orderly officer told her the man did not need to be handcuffed. Consequently the man was not handcuffed in the ambulance or during his time in hospital before his death. While it is difficult to see, based on the evidence available, how the written assessment of medium risk was reached, we are satisfied that in the event an appropriate operational decision was made.

CONCLUSION

104. The man was an elderly man who had been in custody for almost five years. He was seriously ill with a blood disorder and, from November 2010, his physical condition declined markedly and it was clear that the man's condition was terminal.

105. We are satisfied that Doncaster made genuine efforts to secure the man's compassionate release when death seemed likely. There were three well documented applications for the man to be released early on compassionate grounds. The first two were rejected as his anticipated death was not imminent and he did not have a suitable place to live. The third application did not succeed because there were concerns about sexually inappropriate remarks the man was alleged to have made to two nursing staff. There was no formal written record or investigation of the man's reported inappropriate remarks, yet these had significant consequences.

106. The clinical reviewer is concerned that there was a lack of communication from a senior physician, both with the man and healthcare staff, regarding whether rescuscitation should be attempted in the event of his collapse. Nevertheless, we agree with the clinical reviewer that the man received a good standard of healthcare while at Doncaster. Both healthcare and discipline staff appear to have taken a great deal of care of him. Nurse A, in particular, showed compassion and concern for both the man and his family.

107. We make recommendations about the proper recording and investigation of allegations against prisoners and the use of Do Not Resuscitate notices.

RECOMMENDATIONS

The National Offender Management Service's response is noted in italics below each recommendation.

1. The Head of Healthcare should ensure that healthcare staff receive training regarding current national guidelines pertaining to DNAR decision making. This training should then inform a local policy regarding resuscitation and the use of Do Not Resuscitate notices.

   This recommendation was accepted. 'Nottinghamshire Healthcare Trust revised the DNAR policy in June 2012. An operational implementation group for NHT's Offender Health Directorate is working on the supporting Standard Operating Procedures. This group is chaired by the Yorkshire Regional Manager. The most appropriate training is being sourced for staff in conjunction with the Forensic Resuscitation Training Officer. A programme of training will then be rolled out to all staff.'

2. The Director should ensure that any allegation against a prisoner included in a request for compassionate release is formally recorded and appropriately investigated.

   This recommendation was accepted. 'A simple inquiry will be commissioned for any allegation that has the potential to impact on a prisoner's compassionate release application. A record of the allegation and subsequent inquiry will be held by the prison's investigations officer.'